

SERFF Tracking Number: MGCC-127174546 State: Arkansas
Filing Company: The Chesapeake Life Insurance Company State Tracking Number: 49000
Company Tracking Number: CH-26109-APP (04/11)
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: 2011 ANCIL APP
Project Name/Number: 2011 Spring Ancillaries/CH-26109-APP (04/11)

Filing at a Glance

Company: The Chesapeake Life Insurance Company

Product Name: 2011 ANCIL APP

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Filing Type: Form

SERFF Tr Num: MGCC-127174546 State: Arkansas

SERFF Status: Closed-Approved- State Tr Num: 49000
Closed

Co Tr Num: CH-26109-APP (04/11) State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Authors: Lavonda English, Julie

Addy, Kim Perkins

Date Submitted: 06/07/2011

Disposition Date: 06/23/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: 2011 Spring Ancillaries

Project Number: CH-26109-APP (04/11)

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Individual Market Type: Individual

Filing Status Changed: 06/23/2011

State Status Changed: 06/23/2011

Created By: Julie Addy

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Lavonda English

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

The above referenced application form is hereby submitted for your review and approval. This form is new and not intended to replace any forms previously approved by your Department. To the best of our knowledge, information and belief, the form submitted herewith is in compliance in all respects with the provisions of the insurance laws, rules and regulations of your state.

This application form is intended to be used to solicit coverage under the various supplemental policy forms specified on the attached "Forms Listings" page, that are marketed through various Agent/Broker channels. The "Forms Listing" document is intended to be supporting documentation only in order to assist the Department in its review.

SERFF Tracking Number: MGCC-127174546 State: Arkansas
Filing Company: The Chesapeake Life Insurance Company State Tracking Number: 49000
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It is our hope that we may also be granted the flexibility to solicit coverage using this application for any future submitted/approved supplemental health insurance policies. Of course, if/when this occurs, it will be appropriately noted in the respective form filing. This application may also be used in an electronic format.

The bracketed information is intended to be variable and to allow flexibility. For example, some of the variable brackets are to allow product information to be included or omitted in the insurance coverage selections and various sections of the application form should the plan marketing names and/or benefit options be changed for various Agent/Broker channels, and to allow changes to the billing information and information intended for home office use only. Please accept our assurance that at no time will any bracketed text ever be included, omitted, or changed to reflect information that is not in compliance with applicable law.

Should you need anything further in order to expedite this filing, please do not hesitate to contact me at any of the options referenced below.

Your assistance in this matter is greatly appreciated.

Respectfully submitted,

Lavonda English
Compliance Analyst
Lavonda.english@healthmarkets.com

Company and Contact

Filing Contact Information

LaVonda English, Senior Compliance Analyst LaVonda.English@healthmarkets.com
9151 Boulevard 26 817-255-3155 [Phone]
North Richland Hills, TX 76180 817-255-8153 [FAX]

Filing Company Information

The Chesapeake Life Insurance Company CoCode: 61832 State of Domicile: Oklahoma
9151 Boulevard 26 Group Code: 264 Company Type: Health
North Richland Hills, TX 76180 Group Name: State ID Number:
(817) 255-3100 ext. [Phone] FEIN Number: 52-0676509

Filing Fees

SERFF Tracking Number: MGCC-127174546 State: Arkansas
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Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No
Fee Explanation: \$50.00 per form
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Chesapeake Life Insurance Company	\$50.00	06/07/2011	48414615

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/23/2011	06/23/2011

SERFF Tracking Number: MGCC-127174546 *State:* Arkansas
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Disposition

Disposition Date: 06/23/2011

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: MGCC-127174546 State: Arkansas
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes

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Form Schedule

Lead Form Number: CH-26109-APP (04/11)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 06/23/2011	CH-26109- APP (04/11)	Application/ Enrollment Form	Application/ Enrollment Form	Initial		51.000	CH-26109- APP _0411_.pdf



APPLICATION FOR POLICIES UNDERWRITTEN BY
THE CHESAPEAKE LIFE INSURANCE COMPANY

[SECTION 1 -] DEMOGRAPHICS AND INSURANCE COVERAGE SELECTIONS

New Applicant Re-apply

Primary Applicant Name: _____ Agent Name: _____ Agent ID #: _____
Last First MI

Applicant's Home Address: _____

City: _____ State: _____ Zip: _____ County: _____

Daytime Phone: (____) _____ Home Phone: (____) _____

Cell Phone: (____) _____ Fax Number: (____) _____

Best Time to Call: AM PM Home Work Cell

Email Address: _____

Marital Status: Single Married Common Law

Are all Applicants U.S. Citizens? Yes No If "No," explain: _____

How long in the U.S.? _____ Work Permit Visa Type of Visa: _____ Expiration Date: ____ / ____ / ____

SCHEDULE OF APPLICANTS								
Please Print (Full Name)	Sex	Relationship	DOB	Please check below for any Dependent Applicant age [26] or over (other than spouse) who is incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent on the primary Applicant for support and maintenance	Ht.	Wt.	Tobacco or Nicotine substitute use in last 12 months?	Social Security #
(1)		Primary		N/A			<input type="checkbox"/> YES <input type="checkbox"/> NO	
(2)		Spouse		N/A			<input type="checkbox"/> YES <input type="checkbox"/> NO	
(3)				<input type="checkbox"/>			<input type="checkbox"/> YES <input type="checkbox"/> NO	
(4)				<input type="checkbox"/>			<input type="checkbox"/> YES <input type="checkbox"/> NO	
(5)				<input type="checkbox"/>			<input type="checkbox"/> YES <input type="checkbox"/> NO	
(6)				<input type="checkbox"/>			<input type="checkbox"/> YES <input type="checkbox"/> NO	
(7)				<input type="checkbox"/>			<input type="checkbox"/> YES <input type="checkbox"/> NO	
(8)				<input type="checkbox"/>			<input type="checkbox"/> YES <input type="checkbox"/> NO	



APPLICATION FOR POLICIES UNDERWRITTEN BY
THE CHESAPEAKE LIFE INSURANCE COMPANY

[SECTION 1 -] DEMOGRAPHICS AND INSURANCE COVERAGE SELECTIONS

[Vision Plan VSC1 (Vision Insurance Policy Form CH-26023-IP (5/07), or its state variation): Applicant(s): 1 2 3 4 5 6 7 8]

[Premiere Vision Plan VSP1 (Vision Insurance Policy Form CH-26120-IP (04/11), or its state variation):
Applicant(s): 1 2 3 4 5 6 7 8]

[Dental Plan (Dental Insurance Policy Form CH-26099-IP (1/08), or its state variation): Applicant(s): 1 2 3 4 5 6 7 8
 Gold DCG1 Silver DCS1 Bronze DCB1]

[PPO Dental Plan (Dental Insurance Policy Form CH-26121-IP (04/11), or its state variation):
 Basic DPB1 Premiere DPP1 Applicant(s): 1 2 3 4 5 6 7 8]

[Accident Direct Bundle ADBC Applicant(s): 1 2 3 4 5 6 7 8
[Hospital Confinement Direct] (Hospital Confinement Indemnity Policy Form CH-26116-IP (01/10), or its state variation):
 \$[250] Daily Benefit Amount
[Accident Direct] (Accidental Injury Only Insurance Policy Form CH-26118-IP (01/10), or its state variation):
 \$[10,000] Maximum Accidental Injury Benefit Amount
[Accident Disability Direct] Applicant(s): 1 2
(Accident-only Disability Income Insurance Policy Form CH-26114-IP (01/10), or its state variation):
 \$[500] Monthly Indemnity Benefit [30 Day] Elimination Period [12 Month] Duration]

[Complete Direct Bundle KDBC Applicant(s): 1 2 3 4 5 6 7 8
[Hospital Confinement Direct] (Hospital Confinement Indemnity Policy Form CH-26116-IP (01/10), or its state variation):
 \$[250] Daily Benefit Amount
[Accident Direct] (Accidental Injury Only Insurance Policy Form CH-26118-IP (01/10), or its state variation):
 \$[10,000] Maximum Accidental Injury Benefit Amount
[Critical Illness Direct] (Specified Disease/Condition and Major Organ Transplant Policy Form CH-26113-IP (01/10), or its state variation):
 \$[5,000] Lifetime Maximum Benefit Amount
[Income Protection Direct] Applicant(s): 1 2
(Disability Income Insurance Policy Form CH-26115-IP (01/10), or its state variation):
 \$[500] Monthly Indemnity Benefit [30 Day] Elimination Period [24 Month] Duration]

[Hospital Direct Bundle SDBC Applicant(s): 1 2 3 4 5 6 7 8
[Hospital Confinement Direct] (Hospital Confinement Indemnity Policy Form CH-26116-IP (01/10), or its state variation):
 \$[250] Daily Benefit Amount
[Accident Direct] (Accidental Injury Only Insurance Policy Form CH-26118-IP (01/10), or its state variation):
 \$[10,000] Maximum Accidental Injury Benefit Amount
[Critical Illness Direct] (Specified Disease/Condition and Major Organ Transplant Policy Form CH-26113-IP (01/10), or its state variation):
 \$[5,000] Lifetime Maximum Benefit Amount]

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APPLICATION FOR POLICIES UNDERWRITTEN BY
THE CHESAPEAKE LIFE INSURANCE COMPANY

[SECTION 1 -] DEMOGRAPHICS AND INSURANCE COVERAGE SELECTIONS

[ProtectFit Plus Plan (Accidental Injury Only Insurance Policy Form CH-26110-IP (06/09), or its state variation):

High Option FPRH] Low Option FPRL]

Applicant(s): 1 2 3 4 5 6 7 8]

[HospitalFit Plus Plan (Hospital and Surgical Indemnity Policy Form CH-26111-IP (06/09), or its state variation):

High Option FPIH] Low Option FPIL]

Applicant(s): 1 2 3 4 5 6 7 8]

[PersonalFit Plus Plan (Sickness-only Scheduled Indemnity Policy Form CH-26112-IP (06/09), or its state variation):

High Option FPEH] Low Option FPFL]

Applicant(s): 1 2 3 4 5 6 7 8]

[[CancerWise ECA1 (Cancer Benefit Policy Form CH-26055-IP (5/07), or its state variation):

Applicant(s): 1 2 3 4 5 6 7 8

First Diagnosis Cancer Benefit Amount: \$20,000] \$30,000] \$40,000] \$50,000]]

[Critical Illness Direct CIIC (Specified Disease/Condition and Major Organ Transplant Policy Form CH-26113-IP (01/10), or its state variation):

Lifetime Maximum Benefit Amount:

\$5,000] \$10,000] \$15,000] \$20,000] \$25,000] \$30,000] \$40,000]

Applicant 1

Lifetime Maximum Benefit Amount:

\$5,000] \$10,000] \$15,000] \$20,000] \$25,000] \$30,000] \$40,000]

Applicant 2

Lifetime Maximum Benefit Amount:

\$5,000] \$10,000] \$15,000] \$20,000] \$25,000] \$30,000] \$40,000]

Applicant(s): 3 4 5 6 7 8

[Critical Accident Direct CAIC (Critical Accidental Injury Policy Form CH-26123-IP (04/11), or its state variation):

Lifetime Maximum Benefit Amount:

\$10,000] \$15,000] \$20,000] \$25,000] \$30,000] \$40,000]

Applicant 1

Lifetime Maximum Benefit Amount:

\$10,000] \$15,000] \$20,000] \$25,000] \$30,000] \$40,000]

Applicant 2

Lifetime Maximum Benefit Amount:

\$10,000] \$15,000] \$20,000] \$25,000] \$30,000] \$40,000]

Applicant(s): 3 4 5 6 7 8



APPLICATION FOR POLICIES UNDERWRITTEN BY
THE CHESAPEAKE LIFE INSURANCE COMPANY

[SECTION 1 -] DEMOGRAPHICS AND INSURANCE COVERAGE SELECTIONS

[Accident Disability Direct DSIC (Accident-only Disability Income Insurance Policy Form CH-26114-IP (01/10), or its state variation):

Monthly Indemnity Benefit: \$500 \$1,000 \$1,500 \$2,000 \$2,500 Applicant 1
Elimination Period: 14 Days 30 Days
Duration: 6 Months 12 Months 18 Months 24 Months

Monthly Indemnity Benefit: \$500 \$1,000 \$1,500 \$2,000 \$2,500 Applicant 2
Elimination Period: 14 Days 30 Days
Duration: 6 Months 12 Months 18 Months 24 Months]

[Income Protection Direct DIIC (Disability Income Insurance Policy Form CH-26115-IP (01/10), or its state variation):

Monthly Indemnity Benefit: \$500 \$1,000 \$1,500 \$2,000 \$2,500 Applicant 1
Elimination Period: 14 Days 30 Days
Duration: 6 Months 12 Months 18 Months 24 Months

Monthly Indemnity Benefit: \$500 \$1,000 \$1,500 \$2,000 \$2,500 Applicant 2
Elimination Period: 14 Days 30 Days
Duration: 6 Months 12 Months 18 Months 24 Months]

[Hospital Confinement Direct DBIC (Hospital Confinement Indemnity Policy Form CH-26116-IP (01/10), or its state variation):

Daily Benefit Amount: \$250 \$500 \$750 \$1,000 Applicant(s): 1 2 3 4 5 6 7 8]

[Accident Direct ACLC (Accidental Injury Only Insurance Policy Form CH-26118-IP (01/10), or its state variation):

Maximum Accidental Injury Benefit Amount: Applicant(s): 1 2 3 4 5 6 7 8
 \$5,000 \$10,000 \$15,000 \$20,000 \$25,000]

[Accident Companion AGLC (Accidental Injury Only Insurance Policy Form CH-26122-IP (01/11), or its state variation):

Level \$2,500 Level \$5,000 Level \$7,500 Level \$10,000 Applicant(s): 1 2 3 4 5 6 7 8]



If applying for [VISION PLAN] and/or [DENTAL PLAN] ONLY, please proceed to [SECTION 9].

[SECTION 2 -] APPLICABLE TO THE FOLLOWING PLANS ONLY:

[♦ ACCIDENT COMPANION]
[♦ ACCIDENT DIRECT]
[♦ ACCIDENT DIRECT BUNDLE]
[♦ ACCIDENT DISABILITY DIRECT]
[♦ COMPLETE DIRECT BUNDLE]
[♦ CRITICAL ACCIDENT DIRECT]

[♦ HOSPITAL CONFINEMENT DIRECT]
[♦ HOSPITAL DIRECT BUNDLE]
[♦ HOSPITALFIT PLUS]
[♦ INCOME PROTECTION DIRECT]
[♦ PROTECTFIT PLUS]

1. Does any Applicant currently or in the future plan to participate in any volunteer police or firefighting activities; plan to participate in mountaineering using ropes and/or any other equipment; parachuting/skydiving; base jumping; heli-snowboarding; heli-skiing; hang gliding; plan to participate in any hazardous sport or activity; or plan to race any type of vehicle in an organized event? Yes No

If "Yes," indicate Applicant(s): 1 2 3 4 5 6 7 8

[SECTION 3 -] APPLICABLE TO THE FOLLOWING PLANS ONLY:

[♦ ACCIDENT COMPANION]
[♦ ACCIDENT DIRECT]
[♦ ACCIDENT DIRECT BUNDLE]
[♦ ACCIDENT DISABILITY DIRECT]
[♦ CANCERWISE]
[♦ COMPLETE DIRECT BUNDLE]
[♦ CRITICAL ACCIDENT DIRECT]

[♦ CRITICAL ILLNESS DIRECT]
[♦ HOSPITAL CONFINEMENT DIRECT]
[♦ HOSPITAL DIRECT BUNDLE]
[♦ HOSPITALFIT PLUS]
[♦ INCOME PROTECTION DIRECT]
[♦ PERSONALFIT PLUS]
[♦ PROTECTFIT PLUS]

2. Is any Applicant eligible for or covered under Medicare or Medicaid? Yes No
If "Yes," indicate Applicant(s): 1 2 3 4 5 6 7 8
3. (a) Occupation/duties of Primary Applicant: _____ Blue Collar White Collar
(Complete if applying for Spouse)
(b) Occupation/duties of Spouse Applicant: _____ Blue Collar White Collar
4. Has any Applicant been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex, or tested positive for Human Immunodeficiency Virus (HIV) or an AIDS-related test? Yes No
If "Yes," indicate Applicant(s): 1 2 3 4 5 6 7 8
5. Within the past 60 days has any Applicant had or been advised by a Physician to have any testing or any treatment which has not yet occurred, for which results are still pending, and/or that requires follow-up that has not been completed? Yes No
If "Yes," indicate Applicant(s): 1 2 3 4 5 6 7 8



If applying for [ACCIDENT COMPANION,] [ACCIDENT DIRECT BUNDLE,] [COMPLETE DIRECT BUNDLE,] [HOSPITAL DIRECT BUNDLE,] [PROTECTFIT PLUS PLAN] ONLY, please proceed to [SECTION 9].

[SECTION 4 -] APPLICABLE TO THE FOLLOWING PLANS ONLY:

[♦ ACCIDENT DIRECT]

[♦ ACCIDENT DISABILITY DIRECT]

[♦ CRITICAL ACCIDENT DIRECT]

6. Has any Applicant had symptoms that resulted in a diagnosis or treatment (including medication) for **any** of the following: Stroke, Multiple Sclerosis, Huntington's disease, Muscular Dystrophy, Guillain-Barre syndrome, Epilepsy, seizures, paralysis, Parkinson's, Cerebral Palsy, or Alzheimer's, in the last 12 months?
If "Yes," indicate Applicant(s): 1 2 3 4 5 6 7 8 Yes No



If applying for [ACCIDENT DIRECT PLAN,] [CRITICAL ACCIDENT DIRECT] ONLY, please proceed to [SECTION 9].

[SECTION 5 -] APPLICABLE TO THE FOLLOWING PLAN ONLY:

[♦ CANCERWISE]

[♦ CRITICAL ILLNESS DIRECT]

Family History:

7. Does any Applicant have two or more immediate family members (biological parents or siblings), living or deceased, who have had any form of cancer (other than skin cancer) prior to age 65? Yes No
If any "Yes," indicate Applicant(s): 1 2 3 4 5 6 7 8
8. Does any Applicant have two or more immediate family members (biological parents or siblings), living or deceased, who have had Heart Disease, Stroke, Diabetes (type I), Kidney Disease, Liver Disease, Alzheimer's or Senile Dementia prior to age 65? Yes No
If any "Yes," indicate Applicant(s): 1 2 3 4 5 6 7 8

[SECTION 6 -] APPLICABLE TO THE FOLLOWING PLANS ONLY:

[♦ **CANCERWISE**]
[♦ **CRITICAL ILLNESS DIRECT**]
[♦ **HOSPITAL CONFINEMENT DIRECT**]

[♦ **HOSPITALFIT PLUS**]
[♦ **INCOME PROTECTION DIRECT**]
[♦ **PERSONALFIT PLUS**]

9. Has any Applicant had symptoms, been diagnosed, received medical advice to be tested, hospitalized, treated, or been treated for any of the following:
- (a) 2 or more occurrences of Skin Cancer other than melanoma, within last 12 months? Yes No
 - (b) recurrent breast tumors, polycystic disease, non-malignant growths/tumors, or neoplasms, within the last 3 years? Yes No
 - (c) melanoma, breast cancer, prostate cancer, colon cancer, Hodgkin's Disease, non-Hodgkin's Lymphoma, leukemia, or other malignant growths or tumors (*excluding conditions listed in 9 (a) or 9 (b)*), within the last 10 years? Yes No
- If "Yes," indicate Applicant(s): 1 2 3 4 5 6 7 8
10. Within the last two years, has any Applicant been advised of any abnormal diagnostic test results for pelvic exam/pap smear, mammogram, prostate/PSA exam or colorectal cancer screening that were not later confirmed as normal (i.e., a false positive test), or been advised to have any diagnostic testing which has not yet been completed? Yes No
- If "Yes," indicate Applicant(s): 1 2 3 4 5 6 7 8
11. Has any Applicant had symptoms, been diagnosed, received medical advice to be tested, hospitalized or treated, or been treated for: emphysema, hemochromatosis, ulcerative colitis or Crohn's, cirrhosis, hepatitis (excluding type A), COPD (chronic obstructive pulmonary disorder), within the last 10 years? Yes No
- If "Yes," indicate Applicant(s): 1 2 3 4 5 6 7 8



If applying for [CANCERWISE] ONLY, please proceed to [SECTION 9].

[SECTION 7 -] APPLICABLE TO THE FOLLOWING PLANS ONLY:

**[♦ CRITICAL ILLNESS DIRECT]
[♦ HOSPITAL CONFINEMENT DIRECT]
[♦ HOSPITALFIT PLUS]**

**[♦ INCOME PROTECTION DIRECT]
[♦ PERSONALFIT PLUS]**

12. Is any Applicant currently confined in a hospital or nursing home, or has any Applicant received medical advice or treatment for Alzheimer's Disease or Senile Dementia, or does any Applicant require human assistance of any kind to perform activities of daily living (bathing, dressing, continence, eating, or using the toilet)? Yes No

If "Yes," indicate Applicant(s): 1 2 3 4 5 6 7 8

13. Is any proposed female Applicant now pregnant, or being tested for or receiving treatment for fertility/infertility? Yes No

If "Yes," indicate Applicant(s): 1 2 3 4 5 6 7 8

14. Has any Applicant had symptoms, been diagnosed, received medical advice to be tested, hospitalized or treated, or been treated for **any** of the following:

(a) Cholesterol/Blood Pressure: Uncontrolled hyperlipidemia (an LDL cholesterol reading of 150 or greater or a triglycerides reading of 325 or greater), uncontrolled hypertension (a Systolic reading of 150 or greater or Diastolic reading of 95 or greater), within the last 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	(e) Endocrine System: Diabetes (type I or II), within the last 10 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		(f) Connective Tissue Disease or Disorder: Systemic Lupus (SLE) or sarcoidosis, within the last 10 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) Mental Diseases or Disorders: Bipolar disorder, Schizophrenia, major depressive disorder, manic disorder, alcoholism, alcohol abuse, drug abuse or drug addiction, within the last 3 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	(g) Respiratory System: Lung disease or Cystic Fibrosis, within the last 10 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(c) Heart and Circulatory System: Heart disorder or disease, blood clots, blood vessel blockages, myocardial infarction (heart attack), stroke, mini-stroke (including transient ischemic attack), any form of heart surgery, or aneurysms, within the last 10 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	(h) Nervous System: Multiple Sclerosis, Huntington's disease, Muscular Dystrophy, Guillain-Barre syndrome, Epilepsy, seizures, paralysis, or traumatic brain injury, within the last 10 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) Renal System: Abnormal kidney functions (excludes kidney stones), chronic renal failure, or End Stage Renal Disease, within the last 10 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	(i) Fainting, dizziness, chronic headaches, sudden vision deterioration, loss of depth perception, sudden hearing loss, or loss of balance control, any of which were unexplained and occurred within the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If "Yes" to any of the above, indicate Applicant(s): 1 2 3 4 5 6 7 8



If applying for [HOSPITALFIT PLUS,] [PERSONALFIT PLUS,] [CRITICAL ILLNESS DIRECT,] [HOSPITAL CONFINEMENT DIRECT] ONLY, please proceed to [SECTION 9].

[SECTION 8 -] APPLICABLE TO THE FOLLOWING PLANS ONLY:

[♦ ACCIDENT DISABILITY DIRECT]

[♦ INCOME PROTECTION DIRECT]

15. Has any Applicant ever been convicted of any felony activity? Yes No
If "Yes," indicate Applicant(s): 1 2
16. (a) Within the last 12 months, has the Primary Applicant been unemployed for more than one month or consistently worked less than 25 hours per week? Yes No
(Complete if applying for Spouse)
(b) Within the last 12 months, has the Spouse Applicant been unemployed for more than one month or consistently worked less than 25 hours per week? Yes No
17. (a) Does the Primary Applicant work less than 25 hours per week in the occupation/duties previously listed? Yes No
(Complete if applying for Spouse)
(b) Does the Spouse Applicant work less than 25 hours per week in the occupation/duties previously listed? Yes No
18. (a) What is the Primary Applicant's annual gross income from the occupation/duties previously listed? \$ _____
(Complete if applying for Spouse)
(b) What is the Spouse Applicant's annual gross income from the occupation/duties previously listed? \$ _____
19. In the last five years has any Applicant been hospitalized or had surgery for spine, neck or back, or surgical joint repair or replacement? Yes No
20. Within the last 6 months has any Applicant received treatment (excluding chiropractic treatments or physical therapy, less than once per month) or has any Applicant taken prescription medication for conditions/disorders related to the spine, neck or back, or joints (shoulders, knees, hips or ankles)? Yes No
21. Has any Applicant currently or within the last 5 years filed a claim or received benefits from any disability insurance or salary continuation plan for disability (other than pregnancy)? Yes No
22. Has any Applicant had symptoms, been diagnosed, received medical advice or been treated for sleep apnea, fibromyalgia, Parkinson's, chronic fatigue syndrome, unresolved carpal tunnel syndrome, rheumatoid arthritis, or Epstein Barr, within the last 12 months? Yes No

If any "Yes" to questions 19 - 22, indicate Applicant(s): 1 2



Please proceed to [SECTION 9].

SERFF Tracking Number: MGCC-127174546 State: Arkansas
 Filing Company: The Chesapeake Life Insurance Company State Tracking Number: 49000
 Company Tracking Number: CH-26109-APP (04/11)
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: 2011 ANCIL APP
 Project Name/Number: 2011 Spring Ancillaries/CH-26109-APP (04/11)

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachments: AR -APP READ.pdf Arkansas Rule and Regulation 19 26109.pdf ARGA 0104.pdf	Approved-Closed	06/23/2011
Bypassed - Item: Application Bypass Reason: Please refer to the Forms Schedule Tab. Comments: Please refer to Form Schedulle Tab.	Approved-Closed	06/23/2011
Bypassed - Item: Health - Actuarial Justification Bypass Reason: Not Applicable Comments:	Approved-Closed	06/23/2011
Bypassed - Item: Outline of Coverage Bypass Reason: Not Applicable Comments:	Approved-Closed	06/23/2011
Bypassed - Item: PPACA Uniform Compliance Summary	Approved-Closed	06/23/2011

SERFF Tracking Number: MGCC-127174546 State: Arkansas
Filing Company: The Chesapeake Life Insurance Company State Tracking Number: 49000
Company Tracking Number: CH-26109-APP (04/11)
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: 2011 ANCIL APP
Project Name/Number: 2011 Spring Ancillaries/CH-26109-APP (04/11)
Bypass Reason: This is not a PPACA related filing.

Comments:

Satisfied - Item: Cover Letter

Comments:

Attachment:

CH-26109_0411_ Supplemental App Filing Letter.pdf

Item Status:

Approved-Closed

Status

Date:

06/23/2011

FLESCH READABILITY CERTIFICATE

Policy or Rider
Form Number

Flesch Score

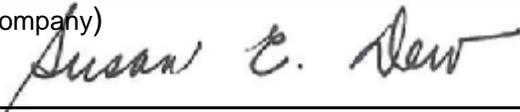
CH-26109-APP (04/11)

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I certify that to the best of my knowledge and belief, the above-referenced form(s) meet or exceed the readability, legibility and format requirements of any applicable laws and regulations in the state of Arkansas.

The Chesapeake Life Insurance Company

(Company)



(Signature)

Susan E. Dew

(Printed Name)

SVP, Associate General Counsel & Chief Compliance Officer

(Title / Department)

June 7, 2011

(Date)

Arkansas Rule and Regulation 19

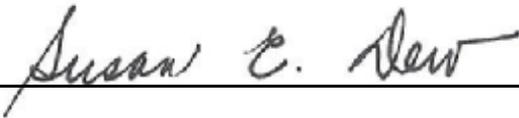
Insurer: The Chesapeake Life Insurance Company

Form Number(s):
CH-26109-APP (04/11)

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.

The Chesapeake Life Insurance Company

(Company)



(Signature)

Susan E. Dew

(Printed Name)

SVP, Associate General Counsel & Chief Compliance Officer

(Title / Department)

June 7, 2011

(Date)

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract..

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice.

**The Arkansas Life and Health Insurance Guaranty Association
C/O The Liquidation Division
1023 West Capitol, Suite 2
Little Rock, Arkansas 72201**

**Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904**

The state law that provides for this safety-net coverage is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and they hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies or contracts are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose Guaranty Association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;

- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to suture assessments, or by an insurance exchange.

The Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans, to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- Portions of any unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliated benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 – no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits for net cash surrender values – again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.]



**The Chesapeake
Life Insurance Company**
Home Office: Oklahoma City, OK

9151 Boulevard 26
North Richland Hills, TX 76180

June 7, 2011

Commissioner Jay Bradford
Arkansas Department of Insurance
Life and Health Division
1200 W 3Rd ST
Little Rock, AR 72201-1904

RE: THE CHESAPEAKE LIFE INSURANCE COMPANY
NAIC#: 264-61832 FEIN#: 52-0676509

Form Number

CH-26109-APP (04/11)

DESCRIPTION

Application for Insurance

Dear Commissioner Bradford:

The above referenced application form is hereby submitted for your review and approval. This form is new and not intended to replace any forms previously approved by your Department. To the best of our knowledge, information and belief, the form submitted herewith is in compliance in all respects with the provisions of the insurance laws, rules and regulations of your state.

This application form is intended to be used to solicit coverage under the various supplemental policy forms specified on the attached "**Forms Listings**" page, that are marketed through various Agent/Broker channels. The "Forms Listing" document is intended to be supporting documentation only in order to assist the Department in its review.

It is our hope that we may also be granted the flexibility to solicit coverage using this application for any future submitted/approved supplemental health insurance policies. Of course, if/when this occurs, it will be appropriately noted in the respective form filing. This application may also be used in an electronic format.

The bracketed information is intended to be variable and to allow flexibility. For example, some of the variable brackets are to allow product information to be included or omitted in the insurance coverage selections and various sections of the application form should the plan marketing names and/or benefit options be changed for various Agent/Broker channels, and to allow changes to the billing information and information intended for home office use only. Please accept our assurance that at no time will any bracketed text ever be included, omitted, or changed to reflect information that is not in compliance with applicable law.

If you have any questions or if anything further is needed to expedite the review of this filing, please call me collect at (817) 255-3155.



**The Chesapeake
Life Insurance Company**

Home Office: Oklahoma City, OK

Your assistance in this matter is greatly appreciated.

Respectfully submitted,

Lavonda English

Compliance Analyst

Lavonda.english@healthmarkets.com



**The Chesapeake
Life Insurance Company**
Home Office: Oklahoma City, OK

FORMS LISTING

THE CHESAPEAKE LIFE INSURANCE COMPANY

List of policy forms approved and/or pending approval by Arkansas that
CH-26109-APP (04/11); et al will be used to solicit coverage under:

PREVIOUSLY APPROVED FORM	FORM TYPE	APPROVAL DATE	SERFF ID
CH-26023-IP (5/07) AR	Vision Insurance Policy	8/6/07	MGCC-126182588
CH-26055-IP (5/07) AR	Cancer Benefit Policy	5/25/07	MGCC-125182595
CH-26099-IP (1/08) AR	Dental Insurance Policy	4/22/08	MGCC-125612182
CH-26110-IP (06/09) AR	Accidental Injury Only Insurance Policy	7/29/09	MGCC-126242277
CH-26111-IP (06/09) AR	Hospital and Surgical Indemnity Policy	7/29/09	MGCC-126242370
CH-26112-IP (06/09) AR	Sickness-Only Scheduled Indemnity Policy	7/29/09	MGCC-126242394
CH-26113-IP (01/10) AR	Specified Disease/Condition & Major Organ Transplant Policy	1/15/10	MGCC-126418917
CH-26114-IP (01/10) AR	Accident-Only Disability Income Insurance Policy	12/16/09	MGCC-126419061
CH-26115-IP (01/10) AR	Disability Income Insurance Policy	12/16/09	MGCC-126419166
CH-26116-IP (01/10) AR	Hospital Confinement Indemnity Policy	12/16/09	MGCC-126419273
CH-26118-IP (01/10) AR	Accidental Injury Only Insurance Policy	12/16/09	MGCC-126419306

RECENTLY SUBMITTED/PENDING FORM	FORM TYPE	SUBMISSION DATE	SERFF ID
CH-26120-IP (04/11) AR	Vision Insurance PPO Policy	6/7/2011	MGCC-127174566
CH-26121-IP (04/11) AR	Dental Insurance PPO Policy	6/7/2011	MGCC-127174168
CH-26122-IP (01/11) AR	Accidental Injury Only Insurance Policy	6/7/2011	MGCC-127174326
CH-26123-IP (04/11) AR	Critical Accidental Injury Policy	6/7/2011	MGCC-127174356