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## **The Chesapeake Life Insurance Company**

Home Office: Oklahoma City, Oklahoma 73118

Administrative Office: P. O. Box 548801

1331 W. Memorial Road, Suite 112

Oklahoma City, OK 73114

Toll Free: #1-800-725-7887

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# **Graded Death Benefit APPLICATION**

## **DESCRIPTION OF INFORMATION PRACTICES**

To Our Policyholders, Applicants and Insureds:

This description of the Information Practices of The Chesapeake Life Insurance Company and your agent is being provided in accordance with the requirement of the Insurance Information and Privacy Protection Law in effect in your state of residence.

In order to properly underwrite and administer your insurance coverage we must collect a certain amount of information. You are our most important source of information, but we may also collect or verify information by contacting other sources, such as medical professionals, which have provided care to you or members of your family proposed for coverage. In some circumstances we may disclose personal information to third parties without your specific authorization. You have the right to be told about and obtain access to certain items of personal information in our files. You also have the right to request correction of information you believe to be inaccurate. If you would like to receive a more detailed description of our information practices, please write us at our Administrative Office: 1331 W. Memorial Road, Suite 112, Oklahoma City, OK 73114.

**NOTICE CONCERNING THE MEDICAL INFORMATION BUREAU**

Information regarding your insurability will be treated as confidential. The Company, or its reinsurers, may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or file a claim for benefits to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address for the Bureau's information office is P. O. Box 105, Essex Station, Boston, MA 02112, telephone (617) 426-3660. The Company, or its reinsurers, may also release information in its file to other life insurance companies to which you may apply for life and health insurance, or to which a claim for benefits may be submitted.

**PRE-NOTIFICATION  
PUBLIC LAW 91-508 – FAIR CREDIT REPORTING ACT**

This is to inform you that as a part of the Company's underwriting procedure for processing applications for insurance, an investigative report by a consumer reporting agency may be made concerning you and any person requesting insurance whereby information is obtained from personal interviews with neighbors, friends, associates or others acquainted with you, and those to be insured, as to character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation. This written request should be directed to the Company at P.O. Box 548801, Oklahoma City, OK 73154.

If you are an employer please note that by offering an insurance benefit to your employees, you may be establishing an "employee benefit plan" under federal laws, such as the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). No information collected concerning the sexual orientation of the Proposed Insured will be used to determine his or her eligibility for insurance. If an employee benefit plan is established, whether intentionally or unintentionally, the employer may be considered a fiduciary who has certain duties, responsibilities, and limitations, including responsibilities relating to reporting and disclosure, and other fiduciary duties.

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**Receipt of Advanced Premium**

The following should be completed if an application is taken and the advanced premium is collected.

Received from \_\_\_\_\_ the sum of \$ \_\_\_\_\_ as an advanced premium on an Insurance Application on the life of \_\_\_\_\_.

If issued, the insurance will not be in force until the effective date shown in the policy. If for any reason the application is not approved, this payment will be refunded in full.

Date \_\_\_\_\_ Agent's Signature \_\_\_\_\_

The Company accepts payment by check, draft, or money order subject to its being honored upon presentation. Checks, drafts, or money orders must be made payable to The Chesapeake Life Insurance Company. Do **NOT** leave payee blank or make payable to the agent.

**The Chesapeake Life Insurance Company**  
 1331 W. Memorial Road, Suite 112, Oklahoma City, OK 73114  
 Application for Graded Death Benefit

Telephone Interview Completed:  
 Yes  No   
 If No, best time to call:  
 Day \_\_\_\_\_ Time \_\_\_\_\_

**Part I - SECTION 1 – APPLICATION FOR INSURANCE**

First Name	MI	Last Name (indicate if hyphenated name)	State of Birth	<input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Age
Address		City	State	Zip Code		
Automatic Premium Loan will be provided. <input type="checkbox"/> No Check if APL is NOT desired.		Social Security No.	Phone No.			
Will the proposed insurance replace any existing life insurance or annuity? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, give name of Company and face amount:			Have you used tobacco in any form in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> Graded <input type="checkbox"/> Graded With ADB Rider	Face Amount \$ _____	Premium Amount \$ _____	Effective Date Requested (if other than issue date)			
Billing Modes: <input type="checkbox"/> A <input type="checkbox"/> S/A <input type="checkbox"/> Q <input type="checkbox"/> M (EFT)			<input type="checkbox"/> Draft my account for the First Premium			

**SECTION 2 – BENEFICIARY DESIGNATION**

Primary \_\_\_\_\_ Relationship \_\_\_\_\_  
 Contingent \_\_\_\_\_ Relationship \_\_\_\_\_

**SECTION 3 - OWNER FOR POLICY IF OTHER THAN PROPOSED INSURED:**

First Name	MI	Last Name (indicate if hyphenated name)	Social Security No. or Tax ID			
Address	City	State	Zip Code	Relationship to Insured		

**IF ANY QUESTION IS ANSWERED "YES," COVERAGE CANNOT BE ISSUED.**

1. <b>Are you now:</b> confined to a Hospital, Psychiatric or Nursing Facility; receiving Home Health Care or need personal assistance performing activities of daily living such as bathing, dressing, toileting, moving about or taking medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. <b>Have you been medically diagnosed as having:</b> a life expectancy of 12 months or less; Alzheimer's Disease or Dementia?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. <b>Have you ever received or been advised you needed to receive:</b> an Organ or Tissue Transplant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. <b>In the past 12 months have you had or been medically advised to have:</b> Brain, Heart or Circulatory Surgery; Amputation caused by disease; or Kidney Dialysis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. <b>In the past 12 months have you had or been medically diagnosed as having:</b> Brain Tumor; Stroke; Heart Attack; Congestive Heart Failure or Cardiomyopathy; or used oxygen equipment to assist in breathing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. <b>In the past 18 months have you had, been medically diagnosed, treated or taken prescription drugs for:</b> Alcohol or Drug Abuse, Internal Cancer, Leukemia or Melanoma (excluding Basal/Squamous cell skin cancer)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. <b>Have you ever been diagnosed or treated by a medical professional for:</b> Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or tested positive for Human Immunodeficiency Virus (HIV)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**MAIL TO:  Applicant  Agent**

**MEDICAL AUTHORIZATION: I, THE PROPOSED INSURED, AUTHORIZE** any physician, medical practitioner, hospital, clinic, pharmacy benefit manager, other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc. ("MIB"), consumer reporting agency, employer, relative, friend or neighbor to give to the Company or its reinsurer(s) all information it holds that pertains to medical consultations, treatments, surgeries, prescription drug records, and hospital confinements which relate to the physical and mental condition of myself. This Authorization also includes information about drugs or alcoholism or any other medical history information. I understand that such information will be used to determine eligibility for insurance, or for benefits under existing insurance. I further authorize the Company to release any information obtained only to reinsuring companies, MIB, or other persons or Organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required or as I may further authorize. As to this Authorization, I agree that a photographic copy will be as valid as the original and that it will be valid for 24 months from the date the Authorization is signed. I know that I, or my representative may request a copy of this Authorization.

**APPLICANT'S STATEMENT:** I have read the completed Application. The above representations are true to the best of my knowledge and belief. I agree the policy shall not be in effect until the initial premium has been paid in full and the policy has been issued by the Company during the lifetime of the Proposed Insured. I understand that the information on this Application will be relied upon to determine insurability and that incorrect information may result in coverage being contested, subject to the policy Incontestability Provision. I understand that the agent has no authority to approve the Application, change the policy, or waive any policy provisions. I understand no insurance will be effective until the date stated in the policy and all eligibility requirements are met. I understand that I am applying for a Graded Death Benefit policy with a reduced death benefit during the first two years it is in force. The Death Benefit in the first policy year will be 30% of the Death Benefit Amount, during the second policy year the Death Benefit will be 70% of the Death Benefit Amount, and the Death Benefit in the third and later years will be the full Death Benefit Amount. During the first two policy years, if death is due to an accident, the Death Benefit will be the full Death Benefit Amount. There is no reduction in benefit for a death due to an accident.

**Any person who knowingly and with intent to defraud any insurance company submits an application for insurance or statement of claim containing any materially false information, or conceals information concerning any fact material thereto for the purpose of misleading may be committing a crime which is subject to criminal and civil penalties.**

**I Acknowledge** receipt of the following notices and disclosures:

- (a) "Description of Information Practices" required by Public Law 91-508 and other information practices statutes,
- (b) Pre Notification - Fair Credit Reporting Act, and
- (c) Notice Concerning the Medical Information Bureau.

I have paid the sum of \$ \_\_\_\_\_ with this Application, dated at \_\_\_\_\_ CITY \_\_\_\_\_ STATE  
 this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_.

\_\_\_\_\_  
 Signature of Owner (if other than Proposed Insured) **X** \_\_\_\_\_  
 Signature of Proposed Insured

**AGENT'S STATEMENT:** To the best of my knowledge the insurance applied for  will  will not replace any existing life insurance or annuity. I certify that any information recorded by me on this application is true and accurate to the best of my knowledge. I further certify that I have interviewed the applicant face to face, and witnessed the applicant's signature.

➡ \_\_\_\_\_  
 Licensed Agent's Signature State License No. \_\_\_\_\_ 2<sup>nd</sup> Licensed Agent's Signature State License No. \_\_\_\_\_

Print Agent #1 Name Agent # % Split \_\_\_\_\_ Print Agent #2 Name Agent # % Split \_\_\_\_\_

**IF MONTHLY BANK DRAFT - ATTACH VOIDED CHECK AND SIGN AUTHORIZATION**

As a convenience to me, I hereby request and authorize you to initiate debit entries, whether by electronic or paper means, with these debits made to my account and drawn by The Chesapeake Life Insurance Company, Oklahoma City, Oklahoma provided there are sufficient collected funds in that account to pay the same upon presentation. I agree that your rights in respect to such debit shall be the same as if they were a check drawn on you and signed personally by me. I hereby agree that if any debit is not paid by me for any reason with or without cause or whether such nonpayment is intentional, inadvertent or otherwise, you shall be under no liability whatsoever, even though such nonpayment results in the forfeiture of insurance. This authorization is to remain in full force and effect until revoked by me upon 30 days advance written notice, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such debit to my account.

<b>Transit / Routing #</b>	<b>Account #</b>	<b>Draft Start Date</b> Month _____ Day _____	<input type="checkbox"/> Checking – Attach Void Check (Deposit slip not acceptable)
			<input type="checkbox"/> Savings – Deposit slip acceptable

\_\_\_\_\_  
 Printed name, as it appears on bank records **X** \_\_\_\_\_  
 Signature, as it appears on bank records \_\_\_\_\_ Date \_\_\_\_\_