
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

Modified 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.

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 Modified Death Benefit

Telephone Interview Completed: Yes <input type="checkbox"/> No <input type="checkbox"/> 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"/> Modified	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. Have you been medically diagnosed as: having a life expectancy of 12 months or less?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever been diagnosed or treated by a medical professional for: 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
3. Have you ever received or been advised you needed to receive: an Organ or Tissue Transplant?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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 shown below. I know that I, or my representative may request a copy of this Authorization.

MAIL TO: <input type="checkbox"/> Applicant <input type="checkbox"/> Agent
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