EXHIBIT 13

Annuity & Life Reassurance America, Inc.
Home Office:
Hartford, CT 06103
("the Company")

Service Bureau:
P O Box 1147
Jacksonville, IL 62651
(800) 825-0003

POLICYOWNER PLAN CHANGE/ REINSTATEMENT REQUEST
PART 1

INSTRUCTIONS: • Check [ ] for service desired • Indicate to what address items should be returned • Mail form (and policy if required) to Servicing Office • For Change of Beneficiary, complete separate form.
SIGNATURE REQUIREMENTS. • Insured, if age 15 or older • Owner, if other than the Insured • Assignee, if policy assigned • Corporate officer with title, if policy is corporate-owned.

Policy Number: 1009208	Insured (also called "you"): Simon Bernstein	Insured's Date of Birth: 12-2-35
Insured's Address: 7020 Lions Head Lane		Insured's Social Security Number*: [redacted]
Owner or Assignee		Owner's Social Security Number
Owner or Assignee Address and Phone Number		Agent's Phone Number
Servicing Agent's Name	Agency Code	Agent Code

Will not process without valid Insured's Social Security Number and Owner's Social Security or Tax Identification Number.
Return all items to ☐ Owner ☐ General Agency ☐ Other (specify) ______

☐ TRADITIONAL ☐ UNIVERSAL LIFE

Old Plan, ______ Old Benefit Amount: $ ______ | New Plan ______ New Benefit Amount, $ ______

If converting part of a term policy or term life rider, is the balance to be retained or dropped? ☐ Retain $ ______ ☐ Drop

Death Benefit Option (Universal Life ONLY). ☐ Level ☐ Increasing | ☐ I declare the Original Policy Contract has been lost or destroyed.

Benefits:	Currently on Policy (Check Answer)	Add	Delete	Increase	Decrease	New Amount
Accidental Death	☐ Yes ☐ No	☐	☐	☐	☐	$
Waiver of Premium (or COI if UL)	☐ Yes ☐ No	☐	☐	☐	☐	$
Monthly Disability Benefit (UL ONLY)	☐ Yes ☐ No	☐	☐	☐	☐	$
Guaranteed Purchase Option	☐ Yes ☐ No	☐	☐	☐	☐	$
Riders						
Spouse's Level Term Rider	☐ Yes ☐ No	☐	☐	☐	☐	$
Children's Term Rider	☐ Yes ☐ No	☐	☐	☐	☐	$
Primary Insured Term Rider	☐ Yes ☐ No	☐	☐	☐	☐	$
Other Insured Term Rider	☐ Yes ☐ No	☐	☐	☐	☐	$
Other Riders (specify)						
______	☐ Yes ☐ No	☐	☐	☐	☐	$
______	☐ Yes ☐ No	☐	☐	☐	☐	$
______	☐ Yes ☐ No	☐	☐	☐	☐	$

Do you currently use any tobacco product?	☐ Yes ☒ No	If "YES", what form of tobacco do you use? ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Smokeless
Have you ever used any tobacco product?	☐ Yes ☒ No	If "YES", what was the date on which you last used tobacco?

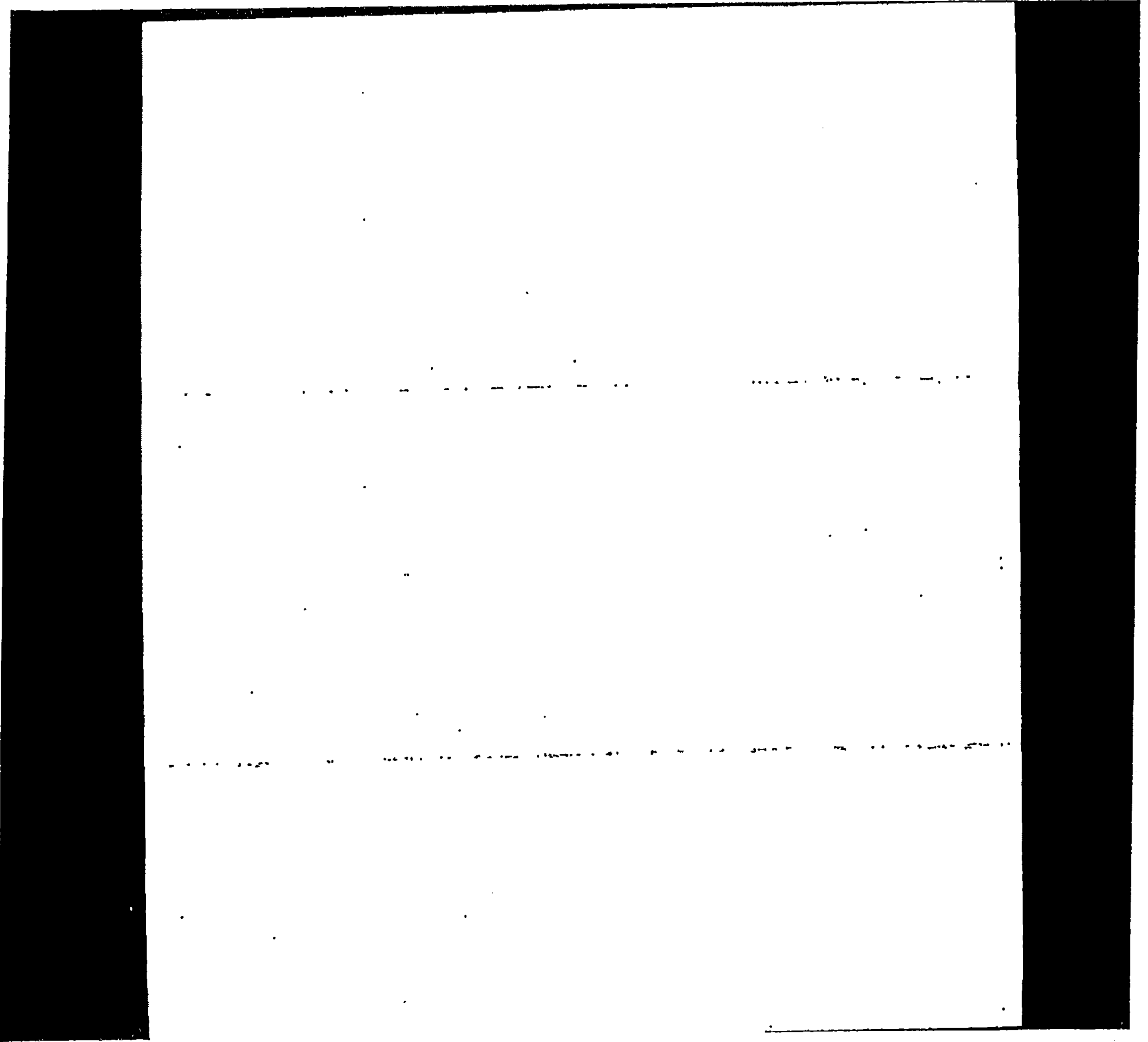
BILLING INSTRUCTIONS:
MODE ☐ Annual ☒ Semi-Annual ☐ Quarterly ☐ Monthly ☐ Non-bill BILLING TYPE. ☐ Direct ☐ List Bill ☐ PAC
☐ Government Allotment

New Planned Periodic Premium: $ ______ Amount Enclosed: $ ______

SPECIAL INSTRUCTIONS:

AL-A-01

JCK000213



PART II APPLICATION FOR ☐ Increase $25,000 or less ☒ Reinstatement ☐ Add Rider or Benefit
☐ Preferred Non-Smoker ☐ Select Non-Smoker ☐ Term Conversion Policy Number

(Print first name, middle initial, and last name)	Occupation	Relationship To Proposed Insured	Date of Birth Month	Day	Year	Age Nearest Birthday	State of Birth	Sex	Height Feet	Inches	Weight Now	Yr. ago
1. a. Proposed Insured Simon Bernstein		[illegible]	12	2	35	75	MI	M	5	8	163	167
b. Second Proposed Insured												
Complete for Family Plan, Spouse Rider, Other Insured Rider or Children's Term												
2. a. N/A		Spouse										
b.		Children										
c.												

Give details in "Comments" section following the questions for any "YES" answers to questions 3 through 8 and 10 through 15.

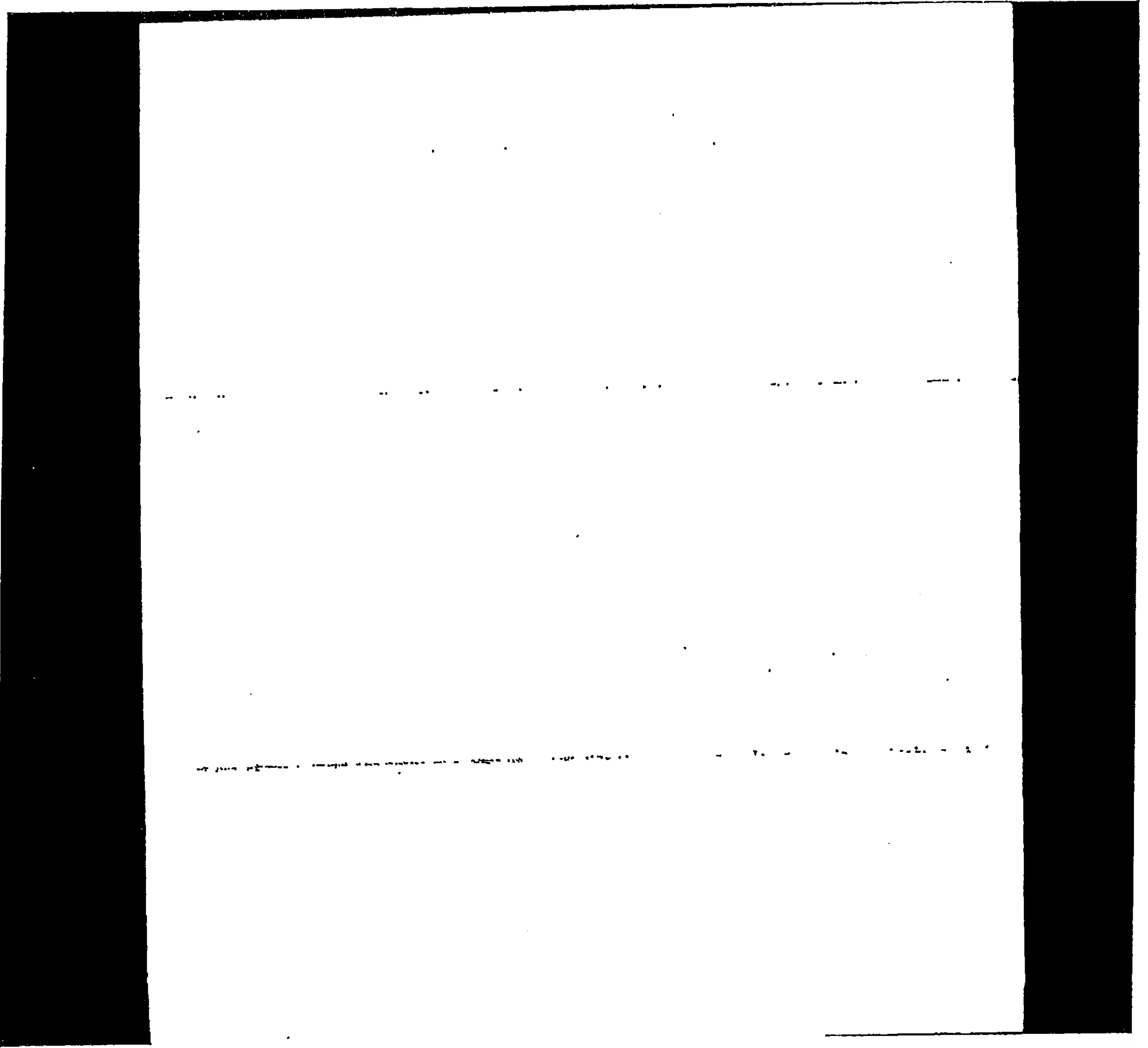
Question	Answer
3. Within the past 10 years, has any person proposed for coverage:	
a. Been examined by or consulted a physician or other practitioner?	☒Yes ☐No
b. Been under observation or treatment in a hospital or any other form of health care facility?	☐Yes ☒No
c. Had an X-ray, electrocardiogram, blood test, urine or other laboratory tests?	☒Yes ☐No
4. Within the past 10 years, has any person proposed for coverage:	☐Yes ☐No
a. Received benefits or compensation for sickness or injury, or had life or disability insurance modified, rejected, not renewed, or issued as a substandard risk?	☒Yes ☐No
b. Sought advice or treatment for, or been arrested for or been addicted to, the use of alcohol or drugs?	☐Yes ☒No
c. Had any disease of the reproductive organs, genital organs, breasts, or any amputation or bodily infirmity, hernia or rupture, hemorrhoids or varicose veins?	☐Yes ☒No
d. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed?	☐Yes ☐No
5. Within the past 10 years, has any persons proposed for coverage had or been treated for:	☐Yes ☐No
a. Any disease or disorder of the eyes, ears, nose, throat, or thyroid gland?	☐Yes ☒No
b. Any deformity or disorder of the back, spine, muscles, bones or joints?	☐Yes ☒No
c. Chest pain, heart murmur, high blood pressure, or any other disease or disorder of the heart, circulatory system, blood or blood vessels?	☒Yes ☐No
d. Peptic ulcer, indigestion, or other disease of the stomach, intestines, gall bladder, liver, pancreas, spleen, or enlarged lymph glands?	☐Yes ☒No
e. Tuberculosis, asthma, pleurisy, or any other disease of the chest or lung?	☐Yes ☒No
f. Albumin, pus, blood or sugar in urine, urinary stone, or other disease of the kidneys, bladder or prostate?	☐Yes ☒No
g. Severe headaches, fainting spells, dizziness, vertigo, syncope, epilepsy, convulsions, paralysis, mental disorder, depression, or any other disease or disorder of the brain or nervous system?	☐Yes ☒No
h. Rheumatic or other fever, diabetes, syphilis, gout, arthritis, goiter, cancer, tumor or disorder of the lymph nodes?	☐Yes ☒No
i. Any surgical operations, treatment, or any illness, ailment, abnormality, or injury not mentioned above within the past 10 years?	☐Yes ☒No
6. Within the past 7 years: To the best of your knowledge, has any person proposed for coverage had or been told by a medical professional, he or she had an immune deficiency disorder, AIDS or AIDS-Related Complex (ARC)?	☐Yes ☒No
7. Is any person proposed for coverage now pregnant? (If "YES", provide the child's expected due date in "Comments")	☐Yes ☒No
8. Is any person proposed for coverage now under medical treatment or taking any prescription drugs?	☒Yes ☐No
9. To the best of your knowledge, are all persons proposed for coverage now in good health? (If "NO", provide details in "Comments")	☐Yes ☐No
10. Has any person proposed for coverage any intention to travel or reside outside the United States or Canada?	☐Yes ☒No
11. Has any person proposed for coverage within the past two years flown as a pilot, student pilot or crew member or intend to do so?	☐Yes ☒No
12. Has any person proposed for coverage engaged in, or intend to engage in, underwater diving, hang gliding or parachuting?	☐Yes ☒No
13. Has any person proposed for coverage engaged in, or intend to engage in, competitive racing of any kind?	☐Yes ☒No
14. Has any person proposed for coverage had a driver's license suspended or revoked, or been convicted in the last 3 years of a moving violation or of driving while impaired, intoxicated or under the influence of drugs or alcohol?	☐Yes ☒No
15. Has any person proposed for coverage ever been convicted of a felony?	☐Yes ☒No

Please list Question Number and detail(s) that you are referring to: Onset/Duration, Diagnosis, Physician Name and Address, and name of the Health Care Facility.

Dr. Baum 561·367·8155
Dr. Homer 954·491·2140

16. Family History	Age(s) if living	Condition of Health*	Age(s) at Death	Cause of Death
Wife or Husband	77	FAIR		
Father	[illegible]		97	Heart
Mother			87	[illegible]
Sister(s)	80	Good	88	
Brother(s)	[illegible]			Cancer

* If not answered "Good," give details above.



AGREEMENT AND SIGNATURE FOR PARTS I & II

(See "Notice to Applicant" on reverse side)

The undersigned hereby declare(s) that to the best of his knowledge and belief the foregoing statements and answers are complete and true and have been made to induce the Company to change the above numbered policy. The undersigned agree(s) that the policy shall not be so changed until the Company has received payment of all arrears and has formally approved the application at its Home Office and further agree(s) to accept a return of any payments made in connection with this application for change, should the Company decline to approve it.

The undersigned further agree(s) that if the Company approves this application for change, such approval shall be based upon the above statements and answers which shall be deemed to be representations and not warranties. The undersigned further agree(s) as an express condition of such change, that if any such representation is untrue in whole or in part, and is material, the Company shall be under no liability by reason of the change, except to return all premiums paid in connection with and subsequent to such change; but on the condition that the change shall be incontestable after the same period following such change and with the same conditions and exceptions as provided in the policy with respect to the incontestability thereof. It is understood that, unless otherwise provided, the reinstatement of a policy reinstates interests of any assignees, beneficiaries or owners.

The undersigned understand(s) that if making a policy change, unless the change will be to the same plan of insurance, no disability benefits will be allowed for any condition existing at the present time. If the above policy is to be surrendered with this service request, the undersigned hereby surrender(s) the policy for cancellation and agree that this request together with the application for the original policy, shall constitute the application for any new policy and that the original application shall be changed only to the extent provided.

The undersigned request(s) that all transactions marked above be completed by the Company and agree for myself/ourselves, heirs, beneficiaries and all others claiming under the above policy to release, indemnify and hold the Company harmless from any liability incurred because of completing the above transactions. The undersigned expressly warrant(s) that all persons signing below are of legal age and that no proceedings in bankruptcy are pending against any of them.

Dated at (City and State) Boca Raton FL this 30 Day of NOV 2010

[signature]

Witness (not related) or Agent | Insured(s), Owner(s), Assignee(s) (Please indicate title)

Address | Address

City State Zip | City State Zip

AUTHORIZATION FOR PART II

The undersigned authorize(s) any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health or the health of any family dependent applying for insurance, to give to the Company, or its reinsurers, any such information. A photostatic copy of this authorization shall be as valid as the original. I agree that this authorization shall be valid for two and one half years from the date I sign this application.

Dated at (City and State) Boca Raton, FL this 30 Day of Nov 2010

[signature]

Proposed Insured (if age 18 or over) | Spouse (if to be insured) or Second Proposed Insured (if J.W.L.)

[signature]

Witness (not related) or Agent | Owner (if not Proposed Insured) and relationship

Telephone Number (days) ( ) | (night) ( )

AL-A-21