EXHIBIT 3

PART I OF APPLICATION TO

Capitol Bankers Life

CAPITOL BANKERS LIFE INSURANCE COMPANY
Home Office: Minneapolis, Minnesota
Administrative Office: 735 North Water St. P.O. Box 2016
Milwaukee, Wisconsin 53201 (414) 277-9988

(For an Annuity "Proposed Insured" means "Annuitant")

PERSONS TO BE INSURED (Print First Name, Middle Initial, Last Name)	Sex	Age	Birthdate	State of Birth	Build Ht.	Build Wt.	Social Security Number
PROPOSED INSURED Simon Bernstein	M		12/3/35	Mich	5'7½	180	
SPOUSE (if to be insured or Payor)							

DEPENDENT CHILDREN IF TO BE INSURED	NAME	Age	BIRTHDATE Mo. Day Yr.	NAME	Age	BIRTHDATE Mo. Day Yr.

Residence Address 620 SHERIDAN DR. Employer S B LEXINGTON, INC.
City Glencoe, State IL Zip Business Address 9933 LAWLER SUITE 210
County Telephone No. Occupation SKOKIE, ILL. CHAIRMAN OF BOARD

Proposed insured will be owner of policy unless otherwise indicated.
Owner's Name First Arlington National Bank Trustee of S.B. Social Security Number
Mailing Address Lexington, Inc. Employee Death Benefit Trust
Relationship to Proposed Insured

	Yes	No
1. Is this insurance intended to replace or modify any insurance or annuity now carried?	☐	☑
2. Are there any other applications now pending for Life or Health Insurance?	☐	☑
Has any person to be covered:		
3. Flown in past 3 years other than as a fare paying passenger or is such contemplated?	☐	☑
4. Ever participated in sky diving, skin diving, scuba diving, auto racing, mountain climbing or any avocation of a similar nature?	☐	☑
5. Had drivers license suspended or revoked? Drivers license number	☐	☑
6. Do you now smoke cigarettes?	☐	☑
7. If no, have you ever smoked cigarettes?	☐	☐
8. If yes, when did you stop?		

LIFE INSURANCE OR ANNUITY APPLIED FOR:

Plan CVL
Amount $2,000,000
☐ Level Term for Yr. $
☐ Reducing Term for Yr. $
☐ Waiver of Premium ☐ G.P.O. Units
☐ ADB ☐ Other

If available, automatic premium loan provision? Yes ☑ No ☐
Premiums ☑ Ann. ☐ Qtr. ☐ List Bill ☐ Other
Payable ☐ S.A. ☐ PAC ☐ Allotment

Total insurance in force? — 0 —
(If space is insufficient, enter under Remarks.)

Name of Company	Coverage (Life)	Amount of Acc. Death	Year of Issue

Beneficiaries: (Full names and relationship. If minor, give date of birth.)
Primary? First Arlington National Bank Trustee of S.B. Lexington, Inc. Employee Death
Contingent? Benefit Trust

Send Notices to: see below
☐ Proposed Insured at Address Above
☐ or to Owner at Address Above ☐ Business Address Above

Remarks/Amendments S.B. Lexington, Inc. Employee Death Benefit Plan
c/o National Service Assoc.
Please send list billing to: 9933 Lawler, Suite210
Skokie, Ill. 60077

I represent that the statements and answers given in this application are true and complete to the best of my knowledge and belief. I understand and agree that insurance upon this application will not become effective (A) unless this application is accepted by the Insurance Company during my lifetime and the lifetime of each dependent listed above and (B) unless the first premium is paid in full during my lifetime and the lifetime of each dependent listed above.

ACKNOWLEDGEMENT AND AUTHORIZATION

I hereby acknowledge receipt of a notice titled "Notice to Applicants for Insurance" respecting the filing and distribution of medical information concerning myself and receipt of a notice respecting the Fair Credit Reporting Act. Public Law 91-508.
I hereby authorize 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 to give to the Capitol Bankers Life Insurance Company or its reinsurers any such information. A photographic copy of this authorization shall be as valid as the original.

Is there a replacement involved in this transaction? ☐ Yes ☑ No

Signed at Chicago, Illinois (City, State)
Signature of Proposed Insured
Signature of Applicant (if other than Proposed Insured)

10/12/12
Lic. Agent Date

APP-4 - 5/81

JCK000419