AWD History for Work object key 2010-09-09-14.26.54.846221T01
JLIFE - MINPREM - PROCESSED - END - Updateable
[redacted] - 1009208 - - BERNSTEIN - SIMON - 19 -
Social Security Num: [redacted] Policy Number: 1009208
Agent Number: Insured's Last Name: BERNSTEIN
Printed on Tuesday, May 07, 2013 at 1:47:50PM

User Id:	JWIERTJ	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:		DTM Next Task:	
Type:		End Date:	2010-09-15
Status:		End Time:	14:42:25
Queue:			
User Name:	WIERSMA, TONY J		
DTM Description:			
Comments:	po needs to pay 11,180 now, then 31,830.05/q to carry to 12/27/2011		

Begin Date:	2010-09-10	Flags:	
Begin Time:	06:07:18	DTM Job Name:	
User Id:	AMGWN	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:		DTM Next Task:	
Type:		End Date:	2010-09-10
Status:		End Time:	06:07:18
Queue:			
User Name:	MGWALI, NOMA		
DTM Description:			
Comments:	kindly verify values.		

Begin Date:	2010-09-10	Flags:	4000N0
Begin Time:	06:06:19	DTM Job Name:	
User Id:	AMGWN	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:	JLIFE	DTM Next Task:	
Type:	QUOTES	End Date:	2010-09-10
Status:	ACTUARY	End Time:	06:07:27
Queue:	ACTUARY		
User Name:	MGWALI, NOMA		
DTM Description:			
Comments:			

Begin Date:	2010-09-09	Flags:	
Begin Time:	14:28:02	DTM Job Name:	
User Id:	JCOONWR	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:		DTM Next Task:	
Type:		End Date:	2010-09-09
Status:		End Time:	14:28:02
Queue:			
User Name:	COONS, WILLIAM RAY		
DTM Description:			

AWD History for Work object key 2010-09-09-14.26.54.846221T01
JLIFE - MINPREM - PROCESSED - END - Updateable
[redacted] - 1009208 - - BERNSTEIN - SIMON - 19 -
Social Security Num: [redacted] Policy Number: 1009208
Agent Number: Insured's Last Name: BERNSTEIN
Printed on Tuesday, May 07, 2013 at 1:47:50PM

Comments: PLS FAX QUOTE SHOWING MIN PREM TO FUND POLICY FOR NEXT YEAR TO PO @ 561-988-0833

Begin Date:	2010-09-09	Flags:	4000N0
Begin Time:	14:26:56	DTM Job Name:	
User Id:	JCOONWR	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:	JLIFE	DTM Next Task:	
Type:	QUOTES	End Date:	2010-09-09
Status:	ALPHAMATCH	End Time:	14:28:04
Queue:	CSPROC2		
User Name:	COONS, WILLIAM RAY		
DTM Description:			
Comments:			

Begin Date:	2010-09-09	Flags:	9990N0
Begin Time:	14:26:54	DTM Job Name:	
User Id:	JCOONWR	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:	JLIFE	DTM Next Task:	
Type:	PHONE	End Date:	2010-09-09
Status:	PHONE	End Time:	14:26:54
Queue:	CSPROC		
User Name:	COONS, WILLIAM RAY		
DTM Description:			
Comments:			

Heritage Union Life Insurance Company
PO Box 1147, Jacksonville, IL 62651-1147
Phone 800-825-0003 Fax 803-333-7842

September 20, 2010

SIMON BERNSTEIN
7020 LIONS HEAD
BOCA RATON, FL 33496

Insured Name: SIMON BERNSTEIN
Policy Number: 1009208
Correspondence Number: 09202460

Dear Simon Bernstein:

Thank you for contacting Heritage Union Life Insurance Company. We have received your request to calculate the minimum premium required for the above referenced policy. In order to bring this policy to a current status, please remit a premium payment of $11,180.00 prior to grace period ending date of October 28, 2010.

Effective September 17, 2010 the annual premium has been changed to $31,831.00.

As you are paying the minimum premium, it may be necessary to increase the premium to cover the cost of insurance each year which increases according to the insured's attained age. We encourage you to review the terms of your policy and your Policyholder Statement each year to determine if and when an adjustment in your minimum premium is necessary.

If you have any questions, please call the Client Service Center at 800-825-0003, Monday through Friday from 7:30 AM to 4:30 PM Central Standard Time.

Sincerely,

Client Services

Enclosure(s): Return Envelope

AWD History for Work object key 2010-11-02-16.10.30.748281T01
JLIFE - POLRES - QPASS2 - END - Updateable
[redacted] - 1009208 - - BERNSTEIN - SIMON - 19 -
Social Security Num: [redacted] Policy Number: 1009208
Agent Number: Insured's Last Name: BERNSTEIN
Printed on Tuesday, May 07, 2013 at 1:48:18PM

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Begin Date:	2010-11-10	Flags:	9990N0
Begin Time:	09:02:49	DTM Job Name:	
User Id:	JSIMOJJ	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:	JLIFE	DTM Next Task:	
Type:	POLRES	End Date:	2010-11-10
Status:	QPASS2	End Time:	09:02:56
Queue:	END		
User Name:	SIMONS, JINA J		
DTM Description:			
Comments:			

Begin Date:	2010-11-09	Flags:	9990Y2
Begin Time:	10:56:21	DTM Job Name:	
User Id:	ACARRLX	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:	JLIFE	DTM Next Task:	
Type:	POLRES	End Date:	2010-11-09
Status:	QPASS	End Time:	10:57:09
Queue:	CSQC		
User Name:	CARR, LIEZEL		
DTM Description:			
Comments:			

Begin Date:	2010-11-09	Flags:	
Begin Time:	10:04:05	DTM Job Name:	
User Id:	AKOBOF	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:		DTM Next Task:	
Type:		End Date:	2010-11-09
Status:		End Time:	10:04:05
Queue:			
User Name:	KOBO, FLORINE		
DTM Description:			
Comments:	Letter mailed to PO		

Begin Date:	2010-11-09	Flags:	9990Y2
Begin Time:	09:54:34	DTM Job Name:	
User Id:	AKOBOF	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:	JLIFE	DTM Next Task:	
Type:	POLRES	End Date:	2010-11-09
Status:	PROCESSD3	End Time:	10:04:14

AWD History for Work object key 2010-11-02-16.10.30.748281T01
JLIFE - POLRES - QPASS2 - END - Updateable
[redacted] - 1009208 - - BERNSTEIN - SIMON - 19 -
Social Security Num: [redacted] Policy Number: 1009208
Agent Number: Insured's Last Name: BERNSTEIN
Printed on Tuesday, May 07, 2013 at 1:48:18PM

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Queue: CSQC2
User Name: KOBO, FLORINE
DTM Description:
Comments:

Begin Date:	2010-11-09	Flags:	9990N0
Begin Time:	03:47:37	DTM Job Name:	
User Id:	ASALIM	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:	JLIFE	DTM Next Task:	
Type:	POLRES	End Date:	2010-11-09
Status:	CSPROC2	End Time:	03:47:37
Queue:	AKOBOF		
User Name:	SALIE, MARIAM		

DTM Description:
Comments:

Begin Date:	2010-11-08	Flags:	9990N0
Begin Time:	15:46:24	DTM Job Name:	
User Id:	JHICKC	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:	JLIFE	DTM Next Task:	
Type:	POLRES	End Date:	2010-11-08
Status:	CSPROC2	End Time:	15:46:27
Queue:	CSPROC2		
User Name:	BONJEAN, CORTNEY		

DTM Description:
Comments:

Begin Date:	2010-11-05	Flags:	9990N0
Begin Time:	10:08:22	DTM Job Name:	
User Id:	JWIERTJ	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:	JLIFE	DTM Next Task:	
Type:	POLRES	End Date:	2010-11-05
Status:	CS1	End Time:	10:08:27
Queue:	CSPROC		
User Name:	WIERSMA, TONY J		

DTM Description:
Comments:

AWD History for Work object key 2010-11-02-16.10.30.748281T01
JLIFE - POLRES - QPASS2 - END - Updateable
[redacted] - 1009208 - - BERNSTEIN - SIMON - 19 -
Social Security Num: [redacted] Policy Number: 1009208
Agent Number: Insured's Last Name: BERNSTEIN
Printed on Tuesday, May 07, 2013 at 1:48:18PM

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Begin Date:	2010-11-05	Flags:	
Begin Time:	10:08:19	DTM Job Name:	
User Id:	JWIERTJ	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:		DTM Next Task:	
Type:		End Date:	2010-11-05
Status:		End Time:	10:08:19
Queue:			
User Name:	WIERSMA, TONY J		
DTM Description:			
Comments:	the premium was enough to get policy back to postive cash value but only had a cash surrender value 2,333.09. Policy then ran out of value on 10/27/2010.		

Begin Date:	2010-11-04	Flags:	
Begin Time:	10:20:49	DTM Job Name:	
User Id:	ASALIM	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:		DTM Next Task:	
Type:		End Date:	2010-11-04
Status:		End Time:	10:20:49
Queue:			
User Name:	SALIE, MARIAM		
DTM Description:			
Comments:	pls advise if the $11,180.00 prem received 10/15/2010 was too little to keep policy in force , is this the reason y the policy surr....if not please advise why the policy terminated after payment was received?		

Begin Date:	2010-11-04	Flags:	4000N0
Begin Time:	10:18:59	DTM Job Name:	
User Id:	ASALIM	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:	JLIFE	DTM Next Task:	
Type:	POLRES	End Date:	2010-11-04
Status:	ACTUARY	End Time:	10:20:58
Queue:	ACTUARY		
User Name:	SALIE, MARIAM		
DTM Description:			
Comments:			

Begin Date:	2010-11-04	Flags:	4000N0
Begin Time:	04:10:19	DTM Job Name:	
User Id:	ASALIM	DTM Return Code:	
Workstation Id:		DTM Task Name:	

AWD History for Work object key 2010-11-02-16.10.30.748281T01
JLIFE - POLRES - QPASS2 - END - Updateable
[redacted] - 1009208 - - BERNSTEIN - SIMON - 19 -
Social Security Num: [redacted] Policy Number: 1009208
Agent Number: Insured's Last Name: BERNSTEIN
Printed on Tuesday, May 07, 2013 at 1:48:18PM

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Business Area:	JLIFE	DTM Next Task:	
Type:	POLRES	End Date:	2010-11-04
Status:	ALPHAMATCH	End Time:	04:10:19
Queue:	ASALIM		
User Name:	SALIE, MARIAM		
DTM Description:			
Comments:			

Begin Date:	2010-11-02	Flags:	
Begin Time:	16:13:31	DTM Job Name:	
User Id:	JHILLAN	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:		DTM Next Task:	
Type:		End Date:	2010-11-02
Status:		End Time:	16:13:31
Queue:			
User Name:	HILL, ASHTON N		
DTM Description:			
Comments:	spoke to diana who works at po's office. NO INFO GIVEN. she said that they sent in a quarterly amount of 11,180.00 on october. they said they like to send in quarterly prem's instead of yearly. on oct 28th there was a letetr sent to the po stating that the policy was terminated due to insufficient cash value. please research and determine why policy lapsed after payment.		

Begin Date:	2010-11-02	Flags:	4000N0
Begin Time:	16:10:35	DTM Job Name:	
User Id:	JHILLAN	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:	JLIFE	DTM Next Task:	
Type:	POLRES	End Date:	2010-11-02
Status:	ALPHAMATCH	End Time:	16:11:43
Queue:	CSPROC2		
User Name:	HILL, ASHTON N		
DTM Description:			
Comments:			

Begin Date:	2010-11-02	Flags:	9990N0
Begin Time:	16:10:30	DTM Job Name:	
User Id:	JHILLAN	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:	JLIFE	DTM Next Task:	
Type:	PHONE	End Date:	2010-11-02
Status:	PHONE	End Time:	16:10:30

AWD History for Work object key 2010-11-02-16.10.30.748281T01
JLIFE - POLRES - QPASS2 - END - Updateable
[redacted] - 1009208 - - BERNSTEIN - SIMON - 19 -
Social Security Num: [redacted] Policy Number: 1009208
Agent Number: Insured's Last Name: BERNSTEIN
Printed on Tuesday, May 07, 2013 at 1:48:18PM

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Queue: CSPROC
User Name: HILL, ASHTON N
DTM Description:
Comments:

Heritage Union Life Insurance Company
P. O. Box 1147, Jacksonville, IL 62651-1147
Phone 800-825-0003 Fax 803-333-7842

November 09, 2010

SIMON BERNSTEIN
7020 LIONS HEAD
BOCA RATON FL 33496

Insured Name: SIMON BERNSTEIN
Policy Number: 1009208
Correspondence Number: 11036892

Dear SIMON BERNSTEIN:

Thank you for contacting Heritage Union Life Insurance Company. We are writing in response to your inquiry on the above-referenced policy.

This policy is a flexible-premium life insurance contract, which accumulates cash value with interest. A charge is deducted from each premium paid to cover sales and administrative expenses. The remainder of the premium goes into a cash value account.

Your policy will remain in effect as long as you have sufficient cash value to cover your monthly deductions. At the point your cash value was insufficient to meet the monthly cost of insurance deductions due the policy lapsed. The premiums of $11,180.00 received 10/15/2010 was enough to get policy back to positive cash value but only had a cash surrender value $2,333.09. Policy then ran out of value on 10/27/2010. You can pay as much as you wish (up to established federal guidelines) or as little as you wish (not below the minimum). The minimum premium required is the minimum amount you can pay to keep you policy in effect during its no-lapse period outlined in your contract.

If you have any questions, please call the Client Service Center at 800-825-0003, Monday through Friday from 7:30 AM to 4:30 PM Central Standard Time.

Sincerely,

Client Services

AWD History for Work object key 2010-11-12-14.10.33.383281T01
JLIFE - FORMS - PROCESSED - END - Updateable
[redacted] - 1009208 - - BERNSTEIN - SIMON - 19 -
Social Security Num: [redacted] Policy Number: 1009208
Agent Number: Insured's Last Name: BERNSTEIN
Printed on Tuesday, May 07, 2013 at 1:48:52PM

Begin Date:	2010-11-12	Flags:	
Begin Time:	14:11:41	DTM Job Name:	
User Id:	JLYONKA	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:		DTM Next Task:	
Type:		End Date:	2010-11-12
Status:		End Time:	14:11:41
Queue:			
User Name:	LYONS, KERI A		
DTM Description:			
Comments:	FAXED		

Begin Date:	2010-11-12	Flags:	4500N2
Begin Time:	14:11:02	DTM Job Name:	
User Id:	JLYONKA	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:	JLIFE	DTM Next Task:	
Type:	FORMS	End Date:	2010-11-12
Status:	PROCESSED	End Time:	14:11:38
Queue:	END		
User Name:	LYONS, KERI A		
DTM Description:			
Comments:			

Begin Date:	2010-11-12	Flags:	
Begin Time:	14:10:51	DTM Job Name:	
User Id:	JLYONKA	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:		DTM Next Task:	
Type:		End Date:	2010-11-12
Status:		End Time:	14:10:51
Queue:			
User Name:	LYONS, KERI A		
DTM Description:			
Comments:	fax reinst forms 561-988-0833		

Begin Date:	2010-11-12	Flags:	4500N0
Begin Time:	14:10:34	DTM Job Name:	
User Id:	JLYONKA	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:	JLIFE	DTM Next Task:	
Type:	FORMS	End Date:	2010-11-12
Status:	ALPHAMATCH	End Time:	14:11:10
Queue:	CSPROC		

AWD History for Work object key 2010-11-12-14.10.33.383281T01
JLIFE - FORMS - PROCESSED - END - Updateable
[redacted] - 1009208 - - BERNSTEIN - SIMON - 19 -
Social Security Num: [redacted] Policy Number: 1009208
Agent Number: Insured's Last Name: BERNSTEIN
Printed on Tuesday, May 07, 2013 at 1:48:52PM

User Name: LYONS, KERI A
DTM Description:
Comments:

Begin Date:	2010-11-12	Flags:	4500N0
Begin Time:	14:10:33	DTM Job Name:	
User Id:	JLYONKA	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:	JLIFE	DTM Next Task:	
Type:	FORMS	End Date:	2010-11-12
Status:	PHONE	End Time:	14:10:33
Queue:	CSPROC		
User Name:	LYONS, KERI A		

DTM Description:
Comments:

Heritage Union Life Insurance Company
P. O. Box 1147, Jacksonville, IL 62651-1147
Phone 800-825-0003 Fax 803-333-7842

November 12, 2010

SIMON BERNSTEIN
FAX# 561-988-0833

Insured Name: SIMON BERNSTEIN
Policy Number: 1009208
Correspondence Number: 11043261

Dear SIMON BERNSTEIN:

We have received your request to reinstate the above referenced policy. To consider your request, the enclosed forms must be completed for the proposed primary insured and returned to us. In addition, if your policy includes any Riders that you wish to reinstate the enclosed forms must also be completed for any other proposed insured to be covered by the Riders. Upon receipt, we will consider your application for reinstatement under our current underwriting rules and practices. These forms must be received by the Company at the address shown above during the lifetime of the insured, within 31 days from the date of this letter or the timeframe stipulated in your policy provisions, whichever is greater.

- Until the completion of the reinstatement process, your policy will remain terminated.

Completing the reinstatement form is the first step in processing your request. Underwriting may require additional information that includes a statement from your attending physician and/or an examination and blood draw from our paramedical provider. You may be contacted by a Portamedic examiner to make arrangements for the examination.

If you have any questions, please call the Client Service Center at 800-825-0003, Monday through Friday from 7:30 AM to 4:30 PM Central Standard Time.

Sincerely,

Client Services

Enclosure(s): Hippa Notice
Privacy Notice
Reinstatement Form

Authorization for Release of Health Information
to Heritage Union Life Insurance Company
This authorization complies with the HIPAA Privacy Rule.

1009208 _____ ___/___/_____
Policy Number Name of proposed insured/patient (please print) Date of birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical or medically-related facility, federally assisted alcohol or substance abuse program, Veterans Affairs health care facility, or other health care provider or facility that has provided payment, treatment, or services to me or on my behalf or the behalf of me and my minor children who are insured or for whom I am seeking insurance, if any, ("My Providers") to disclose the entire medical record and any other protected health information concerning me or me and my minor children to Heritage Union Life Insurance Company ("the Company") and its agents, employees, and representatives. This includes information on the testing, diagnosis, treatment or prognosis of any physical or mental condition, including, but not limited to, Human Immunodeficiency Virus (HIV) infection and AIDS (Acquired Immune Deficiency Syndrome), sexually transmitted or communicable diseases, mental illness, developmental disabilities, sickle cell anemia, and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes. By my signature below, I acknowledge that any agreements I have made with My Providers to restrict my or my minor children's protected health information do not apply to this Authorization. I further instruct My Providers to release and disclose my/our entire medical records without restriction, if requested under this Authorization.

The Company may use and disclose information received under this Authorization to: 1) underwrite my application for coverage and make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company. I understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

This Authorization shall remain valid for 24 months following the date of my signature. A copy of this Authorization is as valid as the original.

I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to the Company at the address shown on the attached correspondence. A revocation of this Authorization is not effective to the extent that the Company or others have relied on it, or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I understand that if I refuse to sign this Authorization, the Company may not be able to process my application, or, if coverage has been issued, may not be able to make any benefit payments. I have received a copy of this Authorization which I have signed and will retain for my records.

_____

Signature of Proposed Insured/Patient or Legal Representative Date

_____

Description of Legal Representative's Authority or Relationship to Patient

Authorization for Release of Health Information
to Heritage Union Life Insurance Company
This authorization complies with the HIPAA Privacy Rule.

1009208 _____ ___/___/_____
Policy Number Name of proposed insured/patient (please print) Date of birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical or medically-related facility, federally assisted alcohol or substance abuse program, Veterans Affairs health care facility, or other health care provider or facility that has provided payment, treatment, or services to me or on my behalf or the behalf of me and my minor children who are insured or for whom I am seeking insurance, if any, ("My Providers") to disclose the entire medical record and any other protected health information concerning me or me and my minor children to Heritage Union Life Insurance Company ("the Company") and its agents, employees, and representatives. This includes information on the testing, diagnosis, treatment or prognosis of any physical or mental condition, including, but not limited to, Human Immunodeficiency Virus (HIV) infection and AIDS (Acquired Immune Deficiency Syndrome), sexually transmitted or communicable diseases, mental illness, developmental disabilities, sickle cell anemia, and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes. By my signature below, I acknowledge that any agreements I have made with My Providers to restrict my or my minor children's protected health information do not apply to this Authorization. I further instruct My Providers to release and disclose my/our entire medical records without restriction, if requested under this Authorization.

The Company may use and disclose information received under this Authorization to: 1) underwrite my application for coverage and make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company. I understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

This Authorization shall remain valid for 24 months following the date of my signature. A copy of this Authorization is as valid as the original.

I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to the Company at the address shown on the attached correspondence. A revocation of this Authorization is not effective to the extent that the Company or others have relied on it, or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I understand that if I refuse to sign this Authorization, the Company may not be able to process my application, or, if coverage has been issued, may not be able to make any benefit payments. I have received a copy of this Authorization which I have signed and will retain for my records.

_____

Signature of Proposed Insured/Patient or Legal Representative Date

_____

Description of Legal Representative's Authority or Relationship to Patient

OUR PRIVACY POLICY
Required by the federal Gramm-Leach-Bliley Act and state privacy law
(State law will apply if it provides more protection than federal law.)
ANNUITY & LIFE REASSURANCE AMERICA, INC.

We are committed to keeping the non-public personal information ("NPI") we collect confidential and secure. We want to let you know how we protect your privacy. Our Privacy Policy applies to potential, current and former customers.

How do we protect your privacy?

- We restrict access to NPI to our employees who need it for their jobs.
- We use your NPI only as is necessary for us to provide insurance products and services.
- We require nonaffiliates that perform services for us to protect your NPI and not use it for any other purpose.
- We verify that anyone asking for your NPI is entitled to it before we give it.
- We collect your health information only with your written authorization.
- We disclose your NPI only as permitted or required by law.
- We do not disclose your NPI to others for their own marketing purposes.
- We do not reveal your health, character, personal habits or reputation to anyone for marketing purposes.
- We maintain physical, electronic, and procedural safeguards to protect your NPI.

What information do we collect?

We need some NPI to determine if you are eligible for our products. Once a contract is issued, we typically only seek NPI when someone asks for more coverage or submits a claim. Some examples of what we may collect:

- Data you provide on applications (name, address, date of birth, Social Security number, income, and beneficiary).
- Medical information from health care providers obtained with your authorization.
- Information about your policies with us (policy number, coverage, premium, and payment history).
- As you have authorized: credit reports from consumer reporting agencies; driving records from the Bureau of Motor Vehicles; medical records from the Medical Information Bureau. (NPI obtained from insurance support organizations may be kept by them and disclosed to others.)

To whom do we disclose information?

We may share your NPI when you ask or authorize us to do so. Also, the law allows certain disclosures without your authorization. We may share some or all of your NPI with affiliates or nonaffiliates, as permitted or required by law. The law does not allow you to opt out of these disclosures. Examples of who we may share NPI with:

- Nonaffiliates we have hired to help us provide insurance services, such as claims, billing, and customer service vendors and insurance agents; affiliates that help us provide services or audit our operations.
- A consumer reporting agency to detect or prevent fraud.
- A regulatory, legal or government authority, for a compliance audit or under a subpoena or court order.
- Affiliates or nonaffiliates that market our products. These parties may include life and health insurers, insurance agents, and marketing firms. We may share your name, address, product purchased, and policy number for these purposes.

What are your rights?

- You have the right to know what NPI we have collected about you; this does not apply to NPI that relates to an actual or possible claim or civil or criminal action. You may ask us in writing to correct any NPI you believe is not correct.
- You may ask us in writing for a list of those to whom we have disclosed your medical records within the past two years.
- If we wish to disclose your NPI for reasons not allowed by law, we will ask for your written authorization. If you give it to us, you may revoke it at any time. Revocation is subject to the rights of anyone who acted in reliance of your authorization before it was revoked.
- We may change our Privacy Policy from time to time. If we do, we will provide you with all of the legal rights to which you are entitled. This privacy notice supersedes all such prior notices we may have provided to you.

How do you contact us?

If you have questions about this notice, please write to us at: Annuity & Life Reassurance America, Inc., Attn: Legal Department, 1700 Magnavox Way, Fort Wayne, IN 46804. Contact Customer Service for questions about your policy.

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 16 or older • Owner, if other than the Insured • Assignee, if policy assigned • Corporate officer with title, if policy is corporate-owned.

Policy Number	Insured (also called "you")	Insured's Date of Birth

Insured's Address	Insured's Social Security Number*
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

JCK000140

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:		n/a										
b. Second Proposed Insured:												
Complete for Family Plan, Spouse Rider, Other Insured Rider or Children's Term)												
2. 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.

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, nervousness, 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 item(s) that you are referring to, Dates/Duration, Diagnosis, Physician Name and Address, and name of the Health Care Facility.

16. Family History	Age(s) (if living)	Condition of Health *	Age(s) at Death	Cause of Death
Wife or Husband				
Father				
Mother				
Sister(s)				
Brother(s)				

* 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) _____, this _____ Day of

_____, _____.

_____

_____

_____ _____

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) _____, this _____ Day of _____.

_____

_____ _____

Proposed Insured (if age 16 or over) — Spouse (if to be insured) or Second Proposed Insured (if J.W.L.)

_____ _____

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

Telephone Number (day): ( ) _____ (night): ( )

AL-A-01

JCK000142

ANNUITY & LIFE REASSURANCE AMERICA, INC. ("we","us","our")
IMPORTANT NOTICE – *PLEASE READ BOTH SIDES*
NOTICE TO UNITED STATES RESIDENTS UNDER FAIR CREDIT REPORTING ACT

Thank you for choosing us for your insurance program. We would like to explain a part of our underwriting process that is frequently misunderstood.
You are entitled to know that, as part of our routine selection procedure, we may request an investigative consumer report concerning the insurability of each person proposed for coverage. This report would include information as to character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation, obtained through personal interviews with friends, neighbors, and associates of the Proposed Insured. The Proposed Insured may request to be interviewed in connection with this report.

Should you desire additional information about the nature and scope of this report, please make a written request to the Servicing Office, P.O. Box 1147, Jacksonville, Illinois 62651-1147. Please include the name of your agent as well as your own full name, date of birth and return address.

You selected us for excellent financial planning services and quality protection. In order to provide the best possible products on the most favorable basis, it is necessary for us to be somewhat selective in issuing our policies. We sincerely believe that the consumer investigative report is an essential and proper tool to assist us in meeting these mutual objectives.

We will do our best to serve you both now and in the future. Please call us any time at our toll-free number: (800) 825-0003.

NOTICE TO APPLICANT

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree.

IMPORTANT NOTICE – *PLEASE READ BOTH SIDES*
NOTICE REGARDING MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. The Company and 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 a claim for benefits is submitted 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 (medical information will be disclosed only to your attending physician). If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction. If you are a United States resident, your request will be handled in accordance with the procedures set forth in the Fair Credit Reporting Act. The address of the Bureau's information office in the United States is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660. In Canada, the address is 330 University Avenue, Suite 501, Toronto, Ontario M5G 1R7, telephone number (416) 597-0590.

The Company and its reinsurers may also release information in its files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

AWD History for Work object key 2010-11-15-12.26.17.566281T01
JLIFE - FORMS - PROCESSED - END - Updateable
[redacted] - 1009208 - - BERNSTEIN - SIMON - 19 -
Social Security Num: [redacted] Policy Number: 1009208
Agent Number: Insured's Last Name: BERNSTEIN
Printed on Tuesday, May 07, 2013 at 1:49:25PM

Begin Date:	2010-11-15	Flags:	
Begin Time:	13:22:01	DTM Job Name:	
User Id:	JPETESD	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:		DTM Next Task:	
Type:		End Date:	2010-11-15
Status:		End Time:	13:22:01
Queue:			
User Name:	COLE, SHANNON D		

DTM Description:
Comments: MAILED REINSTATEMENT FORM TO PO.

Begin Date:	2010-11-15	Flags:	4500N2
Begin Time:	13:21:35	DTM Job Name:	
User Id:	JPETESD	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:	JLIFE	DTM Next Task:	
Type:	FORMS	End Date:	2010-11-15
Status:	PROCESSED	End Time:	13:21:54
Queue:	END		
User Name:	COLE, SHANNON D		

DTM Description:
Comments:

Begin Date:	2010-11-15	Flags:	
Begin Time:	12:27:44	DTM Job Name:	
User Id:	JMILLH	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:		DTM Next Task:	
Type:		End Date:	2010-11-15
Status:		End Time:	12:27:44
Queue:			
User Name:	MILLER, HEATHER R		

DTM Description:
Comments: *no info given to Diana as I could not locate letter of auth on file.. while I was searching for letter that she claims to have sent in she terminated call*

Begin Date:	2010-11-15	Flags:	
Begin Time:	12:27:14	DTM Job Name:	
User Id:	JMILLH	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:		DTM Next Task:	
Type:		End Date:	2010-11-15

AWD History for Work object key 2010-11-15-12.26.17.566281T01
JLIFE - FORMS - PROCESSED - END - Updateable
[redacted] - 1009208 - - BERNSTEIN - SIMON - 19 -
Social Security Num: [redacted] Policy Number: 1009208
Agent Number: Insured's Last Name: BERNSTEIN
Printed on Tuesday, May 07, 2013 at 1:49:25PM

Status:		End Time:	12:27:14
Queue:			
User Name:	MILLER, HEATHER R		
DTM Description:			
Comments:	PLS FAX REINST FORMS TO DIANA@ 561-988-0833		

Begin Date:	2010-11-15	Flags:	4500NO
Begin Time:	12:26:20	DTM Job Name:	
User Id:	JMILLH	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:	JLIFE	DTM Next Task:	
Type:	FORMS	End Date:	2010-11-15
Status:	ALPHAMATCH	End Time:	12:27:00
Queue:	CSPROC		
User Name:	MILLER, HEATHER R		
DTM Description:			
Comments:			

Begin Date:	2010-11-15	Flags:	4500NO
Begin Time:	12:26:17	DTM Job Name:	
User Id:	JMILLH	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:	JLIFE	DTM Next Task:	
Type:	FORMS	End Date:	2010-11-15
Status:	PHONE	End Time:	12:26:17
Queue:	CSPROC		
User Name:	MILLER, HEATHER R		
DTM Description:			
Comments:			

Heritage Union Life Insurance Company
P. O. Box 1147, Jacksonville, IL 62651-1147
Phone 800-825-0003 Fax 803-333-7842

November 15, 2010

SIMON BERNSTEIN
7020 LIONS HEAD
BOCA RATON FL 33496

Insured Name: SIMON BERNSTEIN
Policy Number: 1009208
Correspondence Number: 11044995

Dear SIMON BERNSTEIN:

We have received your request to reinstate the above referenced policy. To consider your request, the enclosed forms must be completed for the proposed primary insured and returned to us. In addition, if your policy includes any Riders that you wish to reinstate the enclosed forms must also be completed for any other proposed insured to be covered by the Riders. Upon receipt, we will consider your application for reinstatement under our current underwriting rules and practices. These forms must be received by the Company at the address shown above during the lifetime of the insured, within 31 days from the date of this letter or the timeframe stipulated in your policy provisions, whichever is greater.

- Until the completion of the reinstatement process, your policy will remain terminated.

Completing the reinstatement form is the first step in processing your request. Underwriting may require additional information that includes a statement from your attending physician and/or an examination and blood draw from our paramedical provider. You may be contacted by a Portamedic examiner to make arrangements for the examination.

If you have any questions, please call the Client Service Center at 800-825-0003, Monday through Friday from 7:30 AM to 4:30 PM Central Standard Time.

Sincerely,

Client Services

Enclosure(s): Hippa Notice
Privacy Notice
Reinstatement Form

Authorization for Release of Health Information
to Heritage Union Life Insurance Company
This authorization complies with the HIPAA Privacy Rule.

1009208 _____ ___/___/_____
Policy Number Name of proposed insured/patient (please print) Date of birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical or medically-related facility, federally assisted alcohol or substance abuse program, Veterans Affairs health care facility, or other health care provider or facility that has provided payment, treatment, or services to me or on my behalf or the behalf of me and my minor children who are insured or for whom I am seeking insurance, if any, ("My Providers") to disclose the entire medical record and any other protected health information concerning me or me and my minor children to Heritage Union Life Insurance Company ("the Company") and its agents, employees, and representatives. This includes information on the testing, diagnosis, treatment or prognosis of any physical or mental condition, including, but not limited to, Human Immunodeficiency Virus (HIV) infection and AIDS (Acquired Immune Deficiency Syndrome), sexually transmitted or communicable diseases, mental illness, developmental disabilities, sickle cell anemia, and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes. By my signature below, I acknowledge that any agreements I have made with My Providers to restrict my or my minor children's protected health information do not apply to this Authorization. I further instruct My Providers to release and disclose my/our entire medical records without restriction, if requested under this Authorization.

The Company may use and disclose information received under this Authorization to: 1) underwrite my application for coverage and make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company. I understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

This Authorization shall remain valid for 24 months following the date of my signature. A copy of this Authorization is as valid as the original.

I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to the Company at the address shown on the attached correspondence. A revocation of this Authorization is not effective to the extent that the Company or others have relied on it, or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I understand that if I refuse to sign this Authorization, the Company may not be able to process my application, or, if coverage has been issued, may not be able to make any benefit payments. I have received a copy of this Authorization which I have signed and will retain for my records.

_____

Signature of Proposed Insured/Patient or Legal Representative Date

_____

Description of Legal Representative's Authority or Relationship to Patient

Authorization for Release of Health Information
to Heritage Union Life Insurance Company
This authorization complies with the HIPAA Privacy Rule.

1009208 _____ ___/___/_____
Policy Number Name of proposed insured/patient (please print) Date of birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical or medically-related facility, federally assisted alcohol or substance abuse program, Veterans Affairs health care facility, or other health care provider or facility that has provided payment, treatment, or services to me or on my behalf or the behalf of me and my minor children who are insured or for whom I am seeking insurance, if any, ("My Providers") to disclose the entire medical record and any other protected health information concerning me or me and my minor children to Heritage Union Life Insurance Company ("the Company") and its agents, employees, and representatives. This includes information on the testing, diagnosis, treatment or prognosis of any physical or mental condition, including, but not limited to, Human Immunodeficiency Virus (HIV) infection and AIDS (Acquired Immune Deficiency Syndrome), sexually transmitted or communicable diseases, mental illness, developmental disabilities, sickle cell anemia, and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes. By my signature below, I acknowledge that any agreements I have made with My Providers to restrict my or my minor children's protected health information do not apply to this Authorization. I further instruct My Providers to release and disclose my/our entire medical records without restriction, if requested under this Authorization.

The Company may use and disclose information received under this Authorization to: 1) underwrite my application for coverage and make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company. I understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

This Authorization shall remain valid for 24 months following the date of my signature. A copy of this Authorization is as valid as the original.

I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to the Company at the address shown on the attached correspondence. A revocation of this Authorization is not effective to the extent that the Company or others have relied on it, or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I understand that if I refuse to sign this Authorization, the Company may not be able to process my application, or, if coverage has been issued, may not be able to make any benefit payments. I have received a copy of this Authorization which I have signed and will retain for my records.

_____

Signature of Proposed Insured/Patient or Legal Representative Date

_____

Description of Legal Representative's Authority or Relationship to Patient

OUR PRIVACY POLICY
Required by the federal Gramm-Leach-Bliley Act and state privacy law
(State law will apply if it provides more protection than federal law.)
ANNUITY & LIFE REASSURANCE AMERICA, INC.

We are committed to keeping the non-public personal information ("NPI") we collect confidential and secure. We want to let you know how we protect your privacy. Our Privacy Policy applies to potential, current and former customers.

How do we protect your privacy?

- We restrict access to NPI to our employees who need it for their jobs.
- We use your NPI only as is necessary for us to provide insurance products and services.
- We require nonaffiliates that perform services for us to protect your NPI and not use it for any other purpose.
- We verify that anyone asking for your NPI is entitled to it before we give it.
- We collect your health information only with your written authorization.
- We disclose your NPI only as permitted or required by law.
- We do not disclose your NPI to others for their own marketing purposes.
- We do not reveal your health, character, personal habits or reputation to anyone for marketing purposes.
- We maintain physical, electronic, and procedural safeguards to protect your NPI.

What information do we collect?

We need some NPI to determine if you are eligible for our products. Once a contract is issued, we typically only seek NPI when someone asks for more coverage or submits a claim. Some examples of what we may collect:

- Data you provide on applications (name, address, date of birth, Social Security number, income, and beneficiary).
- Medical information from health care providers obtained with your authorization.
- Information about your policies with us (policy number, coverage, premium, and payment history).
- As you have authorized: credit reports from consumer reporting agencies; driving records from the Bureau of Motor Vehicles; medical records from the Medical Information Bureau. (NPI obtained from insurance support organizations may be kept by them and disclosed to others.)

To whom do we disclose information?

We may share your NPI when you ask or authorize us to do so. Also, the law allows certain disclosures without your authorization. We may share some or all of your NPI with affiliates or nonaffiliates, as permitted or required by law. The law does not allow you to opt out of these disclosures. Examples of who we may share NPI with:

- Nonaffiliates we have hired to help us provide insurance services, such as claims, billing, and customer service vendors and insurance agents; affiliates that help us provide services or audit our operations.
- A consumer reporting agency to detect or prevent fraud.
- A regulatory, legal or government authority, for a compliance audit or under a subpoena or court order.
- Affiliates or nonaffiliates that market our products. These parties may include life and health insurers, insurance agents, and marketing firms. We may share your name, address, product purchased, and policy number for these purposes.

What are your rights?

- You have the right to know what NPI we have collected about you; this does not apply to NPI that relates to an actual or possible claim or civil or criminal action. You may ask us in writing to correct any NPI you believe is not correct.
- You may ask us in writing for a list of those to whom we have disclosed your medical records within the past two years.
- If we wish to disclose your NPI for reasons not allowed by law, we will ask for your written authorization. If you give it to us, you may revoke it at any time. Revocation is subject to the rights of anyone who acted in reliance of your authorization before it was revoked.
- We may change our Privacy Policy from time to time. If we do, we will provide you with all of the legal rights to which you are entitled. This privacy notice supersedes all such prior notices we may have provided to you.

How do you contact us?

If you have questions about this notice, please write to us at: Annuity & Life Reassurance America, Inc., Attn: Legal Department, 1700 Magnavox Way, Fort Wayne, IN 46804. Contact Customer Service for questions about your policy.

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 16 or older • Owner, if other than the Insured • Assignee, if policy assigned • Corporate officer with title, if policy is corporate-owned.

Policy Number	Insured (also called "you")	Insured's Date of Birth
Insured's Address		Insured's Social Security Number*
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

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:		n/a										
b. Second Proposed Insured:												
Complete for Family Plan, Spouse Rider, Other Insured Rider or Children's Term)												
2. 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.

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, nervousness, 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 Item(s) that you are referring to, Dates/Duration, Diagnosis, Physician Name and Address, and name of the Health Care Facility.

16. Family History	Age(s) (if living)	Condition of Health *	Age(s) at Death	Cause of Death
Wife or Husband				
Father				
Mother				
Sister(s)				
Brother(s)				

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

AT-A-01

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) _____, this _____ Day of

_____, _____.

_____

_____

_____ _____

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) _____, this _____ Day of _____.

_____.

_____ _____

Proposed Insured (if age 16 or over) — Spouse (if to be insured) or Second Proposed Insured (if J.W.L.)

_____ _____

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

Telephone Number (day): ( ) _____ (night): ( )

AL-A-01

ANNUITY & LIFE REASSURANCE AMERICA, INC. ("we","us","our")
IMPORTANT NOTICE – *PLEASE READ BOTH SIDES*
NOTICE TO UNITED STATES RESIDENTS UNDER FAIR CREDIT REPORTING ACT

Thank you for choosing us for your insurance program. We would like to explain a part of our underwriting process that is frequently misunderstood.
You are entitled to know that, as part of our routine selection procedure, we may request an investigative consumer report concerning the insurability of each person proposed for coverage. This report would include information as to character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation, obtained through personal interviews with friends, neighbors, and associates of the Proposed Insured. The Proposed Insured may request to be interviewed in connection with this report.

Should you desire additional information about the nature and scope of this report, please make a written request to the Servicing Office, P.O. Box 1147, Jacksonville, Illinois 62651-1147. Please include the name of your agent as well as your own full name, date of birth and return address.

You selected us for excellent financial planning services and quality protection. In order to provide the best possible products on the most favorable basis, it is necessary for us to be somewhat selective in issuing our policies. We sincerely believe that the consumer investigative report is an essential and proper tool to assist us in meeting these mutual objectives.

We will do our best to serve you both now and in the future. Please call us any time at our toll-free number: (800) 825-0003.

NOTICE TO APPLICANT

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree.

IMPORTANT NOTICE – *PLEASE READ BOTH SIDES*
NOTICE REGARDING MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. The Company and 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 a claim for benefits is submitted 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 (medical information will be disclosed only to your attending physician). If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction. If you are a United States resident, your request will be handled in accordance with the procedures set forth in the Fair Credit Reporting Act. The address of the Bureau's information office in the United States is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660. In Canada, the address is 330 University Avenue, Suite 501, Toronto, Ontario M5G 1R7, telephone number (416) 597-0590.

The Company and its reinsurers may also release information in its files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

AWD History for Work object key 2010-11-16-12.12.52.495281T01
JLIFE - POLINQUIRY - PROCESSD2 - END - Updateable
[redacted] - 1009208 - - BERNSTEIN - SIMON - 19 -
Social Security Num: [redacted] Policy Number: 1009208
Agent Number: Insured's Last Name: BERNSTEIN
Printed on Tuesday, May 07, 2013 at 1:50:03PM

Begin Date:	2010-11-16	Flags:	
Begin Time:	12:27:38	DTM Job Name:	
User Id:	JKNOXLA	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:		DTM Next Task:	
Type:		End Date:	2010-11-16
Status:		End Time:	12:27:38
Queue:			
User Name:	JESS, LISA A		
DTM Description:			
Comments:	PO CALLED AND WILL BE MAILING LOAN PAYMENT TO US TODAY.		

Begin Date:	2010-11-16	Flags:	9990N2
Begin Time:	12:24:01	DTM Job Name:	
User Id:	JKNOXLA	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:	JLIFE	DTM Next Task:	
Type:	POLINQUIRY	End Date:	2010-11-16
Status:	PROCESSD2	End Time:	12:24:06
Queue:	END		
User Name:	JESS, LISA A		
DTM Description:			
Comments:			

Begin Date:	2010-11-16	Flags:	
Begin Time:	12:23:54	DTM Job Name:	
User Id:	JKNOXLA	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:		DTM Next Task:	
Type:		End Date:	2010-11-16
Status:		End Time:	12:23:54
Queue:			
User Name:	JESS, LISA A		
DTM Description:			
Comments:	FAXED TO DIANA AT 561/988-0833		

Begin Date:	2010-11-16	Flags:	
Begin Time:	12:22:13	DTM Job Name:	
User Id:	JKNOXLA	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:		DTM Next Task:	
Type:		End Date:	2010-11-16
Status:		End Time:	12:22:13
Queue:			

AWD History for Work object key 2010-11-16-12.12.52.495281T01
JLIFE - POLINQUIRY - PROCESSD2 - END - Updateable
[redacted] - 1009208 - - BERNSTEIN - SIMON - 19 -
Social Security Num: [redacted] Policy Number: 1009208
Agent Number: Insured's Last Name: BERNSTEIN
Printed on Tuesday, May 07, 2013 at 1:50:03PM

User Name: JESS, LISA A
DTM Description:
Comments: PLEASE FAX DIANA AT 561/988-0833 THE GRACE NOTICE DATED 8/27

Begin Date:	2010-11-16	Flags:	4000N0
Begin Time:	12:12:55	DTM Job Name:	
User Id:	JKNOXLA	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:	JLIFE	DTM Next Task:	
Type:	POLINQUIRY	End Date:	2010-11-16
Status:	ALPHAMATCH	End Time:	12:22:16
Queue:	CSPROC2		
User Name:	JESS, LISA A		
DTM Description:			
Comments:			

Begin Date:	2010-11-16	Flags:	9990N0
Begin Time:	12:12:52	DTM Job Name:	
User Id:	JKNOXLA	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:	DLIFE	DTM Next Task:	
Type:	PHONE	End Date:	2010-11-16
Status:	PHONE	End Time:	12:12:52
Queue:	CSPROC		
User Name:	JESS, LISA A		
DTM Description:			
Comments:			

Heritage Union Life Insurance Company
P. O. Box 1147, Jacksonville, IL 62651-1147
Phone 800-825-0003 Fax 803-333-7842

November 16, 2010

SIMON BERNSTEIN
7020 LIONS HEAD
BOCA RATON FL 33496

Insured Name: SIMON BERNSTEIN
Policy Number: 1009208
Correspondence Number: 11047109

Dear SIMON BERNSTEIN:

Thank you for contacting Heritage Union Life Insurance Company. We are writing in response to your inquiry on the above-referenced policy.

Following is the Grace Letter dated 8/27/2010.

If you have any questions, please call the Client Service Center at 800-825-0003, Monday through Friday from 7:30 AM to 4:30 PM Central Standard Time.

Sincerely,

Client Services

Enclosure(s): Requested Documents

HERITAGE UNION LIFE INSURANCE COMPANY
P.O. Box 1147, Jacksonville, IL 62651-1147
Phone 800-825-0003 Fax 803-333-7842

AUGUST 27, 2010

Simon Bernstein
7020 Lions Head
Boca Raton FL 33496

RE: Insured: Simon Bernstein
Policy Number: 1009208
Planned Periodic Premium: $34,397.20
Total Amount Required to Continue Coverage: $24,735.16

NOTICE OF POLICY GRACE PERIOD

Dear Simon Bernstein:

Your policy does not have sufficient value to pay the monthly deductions now past due and has entered its grace period. In order to keep your valuable coverage in force, remit your payment so that it is received at the address shown below on or before October 28, 2010 , which is the end of your Grace Period. If payment is not received at the address shown below on or before October 28, 2010, your coverage will terminate effective October 28, 2010 unless your policy has a net cash value and provides for and coverage continues under any of the following: 1) a non-forfeiture option, 2) an option to discontinue premium payments, or 3) an automatic premium loan election. Common non-forfeiture options are the purchase of extended term insurance, the purchase of reduced paid-up insurance or you may surrender your policy for the net cash value. Refer to your policy for time limits and options available.

HERITAGE UNION LIFE INSURANCE COMPANY
PO Box 19099
Newark, NJ 07195-0099

If you are making your Planned Periodic Premium payments when billed, the amount and/or frequency is not sufficient to keep your coverage in force. In order to prevent this from happening in the future, we encourage you to review the terms of your policy and your Policyholder Statement each year to determine if and when an adjustment in your Planned Periodic Premium is necessary.

If this policy should terminate, you may be eligible for reinstatement. The reinstatement of terminated coverage will require evidence of insurability, underwriting approval and payment of all past due premiums during the lifetime of the insured.

If you have any questions, please call the Client Service Center at 800-825-0003, Monday through Friday from 7:30 AM to 4:30 PM Central Standard Time.

Sincerely,

Client Services

V0620100205
//APFLGRPD

AWD History for Work object key 2010-12-13-09.00.00.199281T01
JLIFE - REINST - INCOMPLETE - END - Updateable
[redacted] - 1009208 - - BERNSTEIN - SIMON - 19 -
Social Security Num: [redacted] Policy Number: 1009208
Agent Number: Insured's Last Name: BERNSTEIN
Printed on Tuesday, May 07, 2013 at 1:51:23PM

Begin Date:	2010-12-15	Flags:	
Begin Time:	16:21:03	DTM Job Name:	
User Id:	JSIMMS	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:		DTM Next Task:	
Type:		End Date:	2010-12-15
Status:		End Time:	16:21:03
Queue:			
User Name:	ARNOUDTS, STACY		
DTM Description:			
Comments:	sent forms again...		

Begin Date:	2010-12-14	Flags:	
Begin Time:	14:41:15	DTM Job Name:	
User Id:	JLYONKA	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:		DTM Next Task:	
Type:		End Date:	2010-12-14
Status:		End Time:	14:41:15
Queue:			
User Name:	LYONS, KERI A		
DTM Description:			
Comments:	sent additional info to aof		

Begin Date:	2010-12-14	Flags:	9996N1
Begin Time:	14:41:00	DTM Job Name:	
User Id:	JLYONKA	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:	JLIFE	DTM Next Task:	
Type:	REINST	End Date:	2010-12-14
Status:	INCOMPLETE	End Time:	14:41:03
Queue:	END		
User Name:	LYONS, KERI A		
DTM Description:			
Comments:			

Begin Date:	2010-12-14	Flags:	9990N0
Begin Time:	14:40:55	DTM Job Name:	
User Id:	JLYONKA	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:	JLIFE	DTM Next Task:	
Type:	REINST	End Date:	2010-12-14
Status:	CSPROC	End Time:	14:40:55
Queue:	CSPROC		

AWD History for Work object, key 2010-12-13-09.00.00.199281T01
JLIFE - REINST - INCOMPLETE - END - Updateable
[redacted] - 1009208 - - BERNSTEIN - SIMON - 19 -
Social Security Num: [redacted] Policy Number: 1009208
Agent Number: Insured's Last Name: BERNSTEIN
Printed on Tuesday, May 07, 2013 at 1:51:23PM

User Name: LYONS, KERI A
DTM Description:
Comments:

Begin Date: 2010-12-14
Begin Time: 08:58:03
User Id: INAZAM
Workstation Id:
Business Area:
Type:
Status:
Queue:
User Name: NAZAR, MUDDASAR
DTM Description:
Comments: Tobacco question details missing in part 1, In part 2 details to question 1,2, 3a,3c,4a,5c,8 and complete dr. info missing. Year of signature missing in authorization part 2

Flags:
DTM Job Name:
DTM Return Code:
DTM Task Name:
DTM Next Task:
End Date: 2010-12-14
End Time: 08:58:03

Begin Date: 2010-12-14
Begin Time: 08:50:43
User Id: INAZAM
Workstation Id:
Business Area: JLIFE
Type: REINST
Status: CSPROC
Queue: CSPROC
User Name: NAZAR, MUDDASAR
DTM Description:
Comments:

Flags: 9990N0
DTM Job Name:
DTM Return Code:
DTM Task Name:
DTM Next Task:
End Date: 2010-12-14
End Time: 08:58:19

Begin Date: 2010-12-13
Begin Time: 09:58:45
User Id: IGARGAX
Workstation Id:
Business Area: JLIFE
Type: REINST
Status: ALPHAMATCH
Queue: CSPROC2
User Name: GARG, AMIT X
DTM Description:
Comments:

Flags: 7500N0
DTM Job Name:
DTM Return Code:
DTM Task Name:
DTM Next Task:
End Date: 2010-12-13
End Time: 09:59:23

AWD History for Work object key 2010-12-13-09.00.00.199281T01
JLIFE - REINST - INCOMPLETE - END - Updateable
[redacted] 1009208 - - BERNSTEIN - SIMON - 19 -
Social Security Num: [redacted] Policy Number: 1009208
Agent Number: Insured's Last Name: BERNSTEIN
Printed on Tuesday, May 07, 2013 at 1:51:23PM

Begin Date:	2010-12-13	Flags:	9500N0
Begin Time:	09:00:00	DTM Job Name:	
User Id:	JBAUESK	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:	JLIFE	DTM Next Task:	
Type:	CSGENERIC	End Date:	2010-12-13
Status:	SCANNED	End Time:	09:00:00
Queue:	INDEX		
User Name:	BAUER, SHAWNETTE K		
DTM Description:			
Comments:			

Heritage Union Life Insurance Company
P. O. Box 1147, Jacksonville, IL 62651-1147
Phone 800-825-0003 Fax 803-333-7842

November 15, 2010

SIMON BERNSTEIN
7020 LIONS HEAD
BOCA RATON FL 33496

Insured Name: SIMON BERNSTEIN
Policy Number: 1009208
Correspondence Number: 11044995

Dear SIMON BERNSTEIN:

We have received your request to reinstate the above referenced policy. To consider your request, the enclosed forms must be completed for the proposed primary insured and returned to us. In addition, if your policy includes any Riders that you wish to reinstate the enclosed forms must also be completed for any other proposed insured to be covered by the Riders. Upon receipt, we will consider your application for reinstatement under our current underwriting rules and practices. These forms must be received by the Company at the address shown above during the lifetime of the insured, within 31 days from the date of this letter or the timeframe stipulated in your policy provisions, whichever is greater.

- Until the completion of the reinstatement process, your policy will remain terminated.

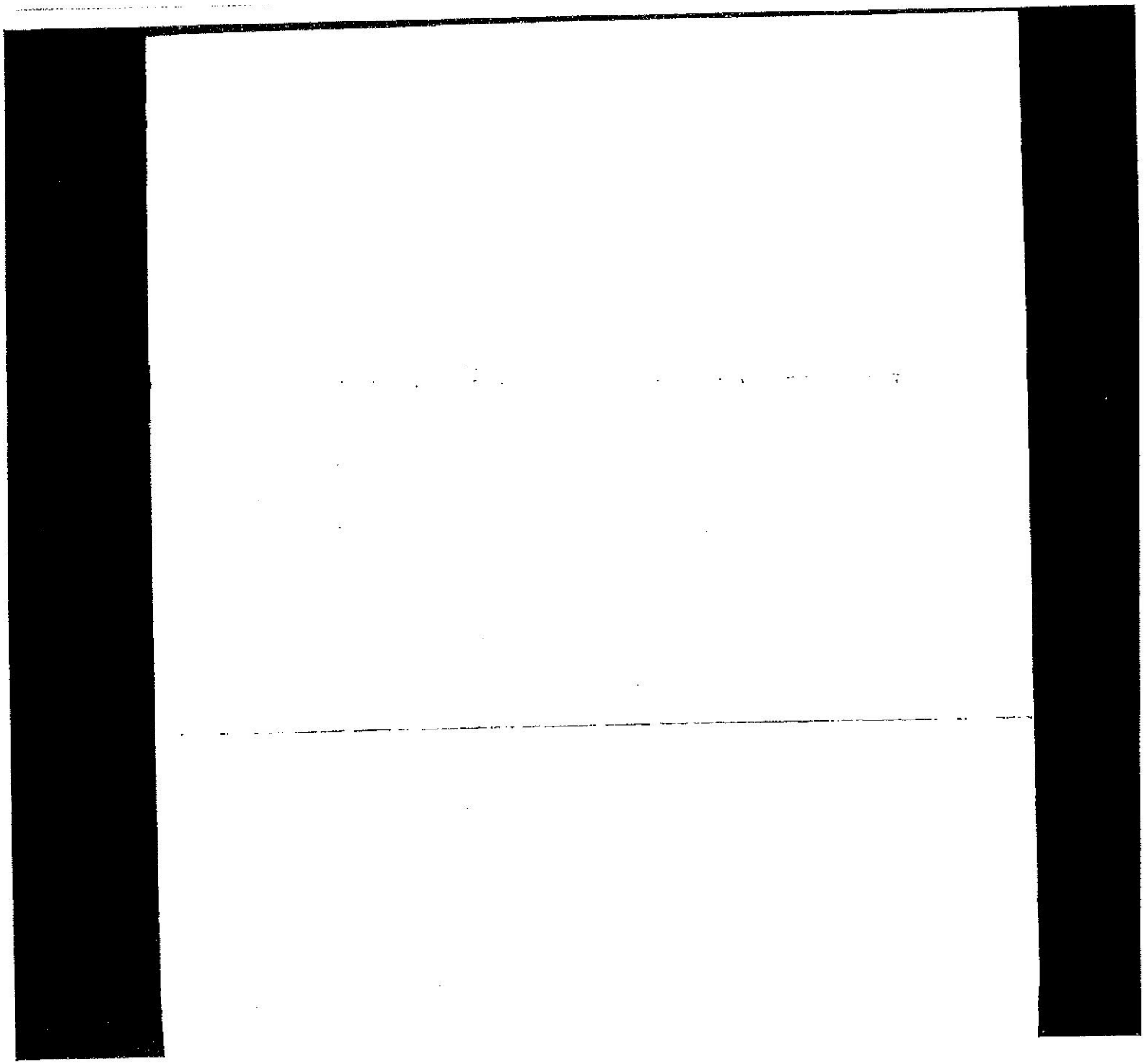
Completing the reinstatement form is the first step in processing your request. Underwriting may require additional information that includes a statement from your attending physician and/or an examination and blood draw from our paramedical provider. You may be contacted by a Portamedic examiner to make arrangements for the examination.

If you have any questions, please call the Client Service Center at 800-825-0003, Monday through Friday from 7:30 AM to 4:30 PM Central Standard Time.

Sincerely,

Client Services

Enclosure(s): Hippa Notice
Privacy Notice
Reinstatement Form



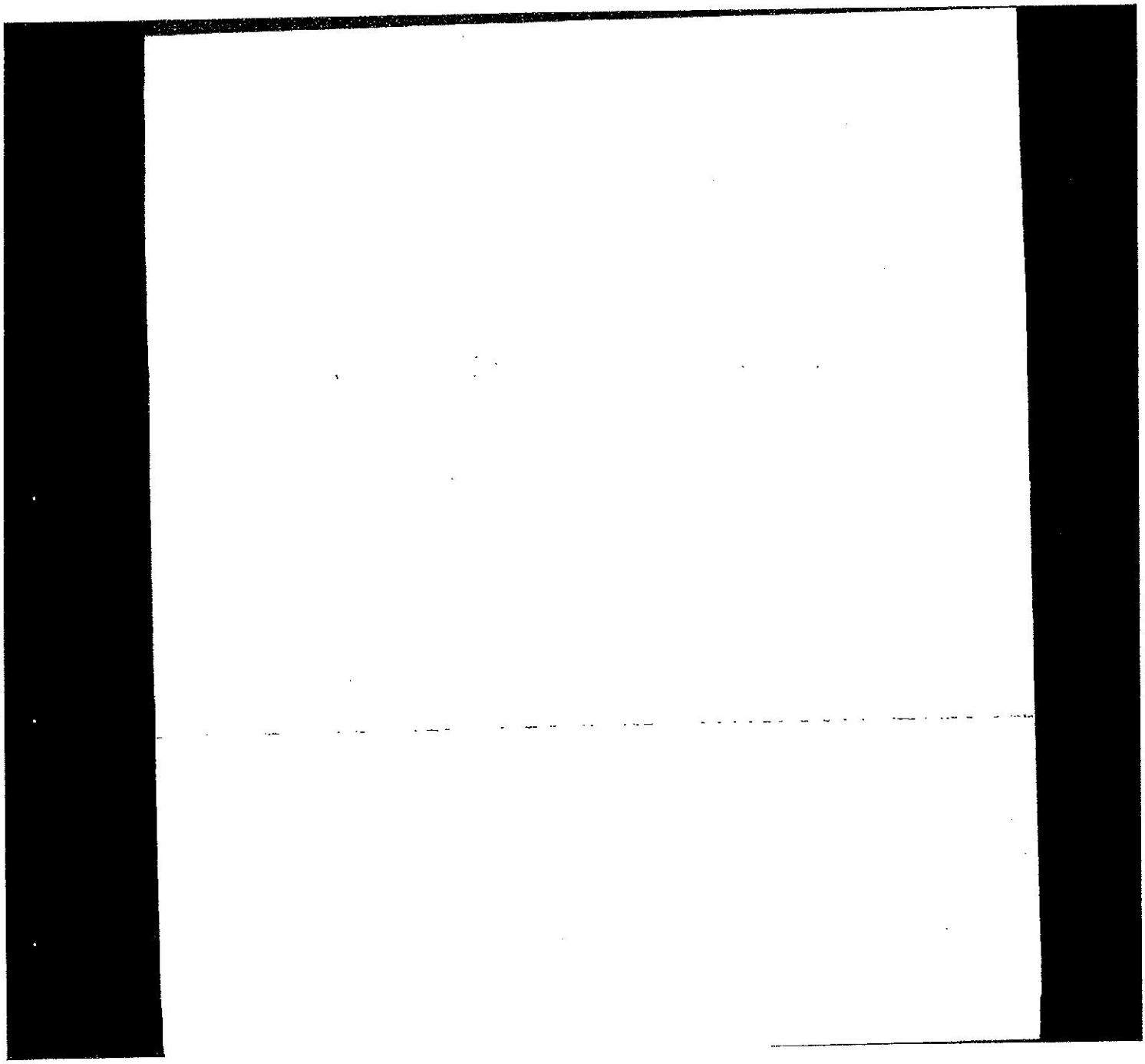
Authorization for Release of Health Information
to Heritage Union Life Insurance Company
This authorization complies with the HIPAA Privacy Rule.

1009208	Simon L Bernstein	12-31-1931
Policy Number	Name of proposed insured/patient (please print)	Date of birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical or medically-related facility, federally assisted alcohol or substance abuse program, Veterans Affairs health care facility, or other health care provider or facility that has provided payment, treatment, or services to me or on my behalf or the behalf of me and my minor children who are insured or for whom I am seeking insurance, if any, ("My Providers") to disclose the entire medical record and any other protected health information concerning me or me and my minor children to Heritage Union Life Insurance Company ("the Company") and its agents, employees, and representatives. This includes information on the testing, diagnosis, treatment or prognosis of any physical or mental condition, including, but not limited to, Human Immunodeficiency Virus (HIV) infection and AIDS (Acquired Immune Deficiency Syndrome), sexually transmitted or communicable diseases, mental illness, developmental disabilities, sickle cell anemia, and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes. By my signature below, I acknowledge that any agreements I have made with My Providers to restrict my or my minor children's protected health information do not apply to this Authorization. I further instruct My Providers to release and disclose my/our entire medical records without restriction, if requested under this Authorization.

The Company may use and disclose information received under this Authorization to: 1) underwrite my application for coverage and make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company. I understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

This Authorization shall remain valid for 24 months following the date of my signature. A copy of this Authorization is as valid as the original.



I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to the Company at the address shown on the attached correspondence. A revocation of this Authorization is not effective to the extent that the Company or others have relied on it, or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I understand that if I refuse to sign this Authorization, the Company may not be able to process my application, or, if coverage has been issued, may not be able to make any benefit payments. I have received a copy of this Authorization which I have signed and will retain for my records.

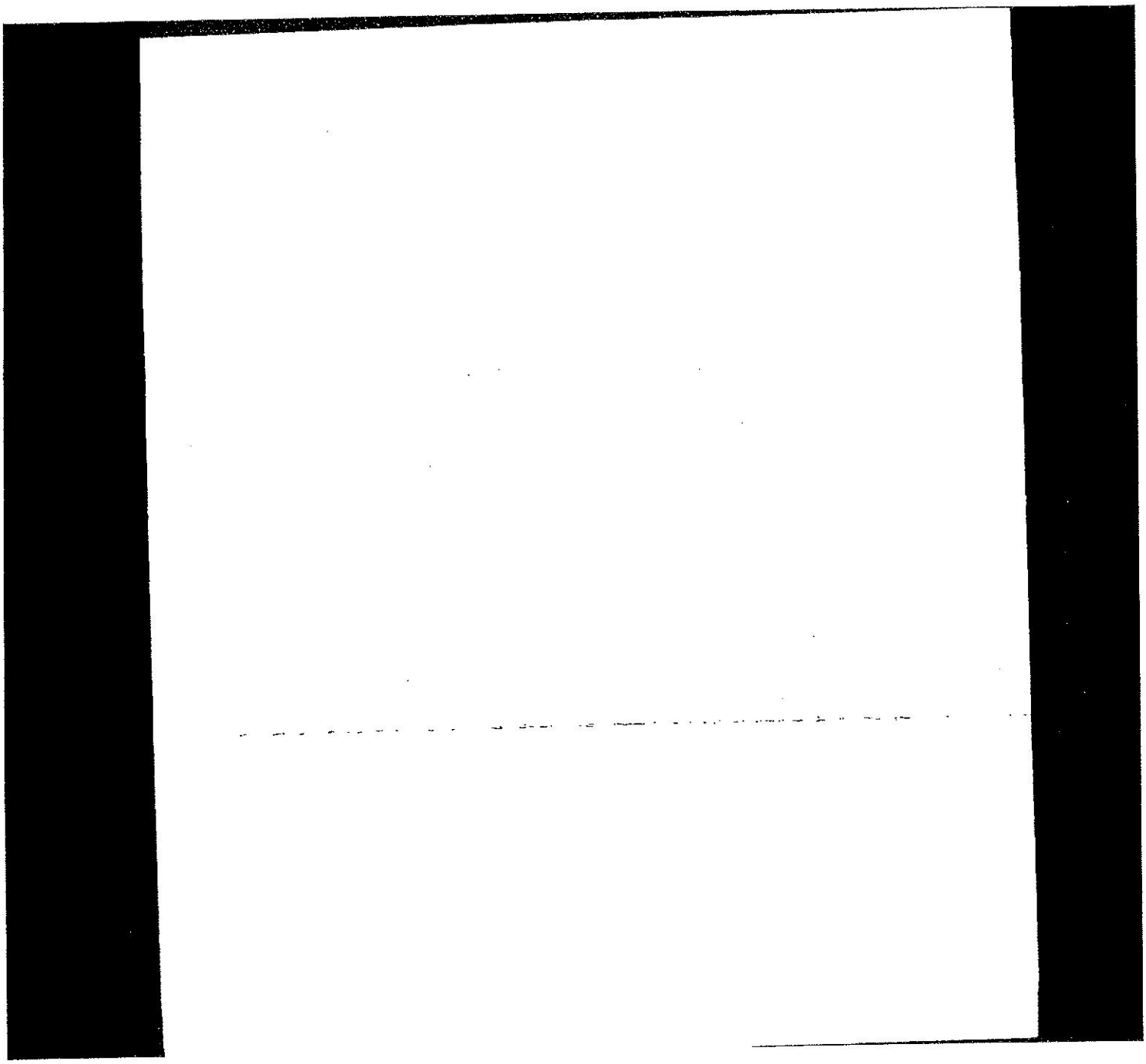
11/30/10

Signature of Proposed Insured/Patient or Legal Representative Date

Description of Legal Representative's Authority or Relationship to Patient

Health Authorization (2.4) **Insured Copy**

JCK000170



2661

Authorization for Release of Health Information
to Heritage Union Life Insurance Company
This authorization complies with the HIPAA Privacy Rule.

1009208 Simon C. Bernstein 12/1/35
Policy Number Name of proposed insured/patient (please print) Date of birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical or medically-related facility, federally assisted alcohol or substance abuse program, Veterans Affairs health care facility, or other health care provider or facility that has provided payment, treatment, or services to me or on my behalf or the behalf of me and my minor children who are insured or for whom I am seeking insurance, if any, ("My Providers") to disclose the entire medical record and any other protected health information concerning me or me and my minor children to Heritage Union Life Insurance Company ("the Company") and its agents, employees, and representatives. This includes information on the testing, diagnosis, treatment or prognosis of any physical or mental condition, including, but not limited to, Human Immunodeficiency Virus (HIV) infection and AIDS (Acquired Immune Deficiency Syndrome), sexually transmitted or communicable diseases, mental illness, developmental disabilities, sickle cell anemia, and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes. By my signature below, I acknowledge that any agreements I have made with My Providers to restrict my or my minor children's protected health information do not apply to this Authorization. I further instruct My Providers to release and disclose my/our entire medical records without restriction, if requested under this Authorization.

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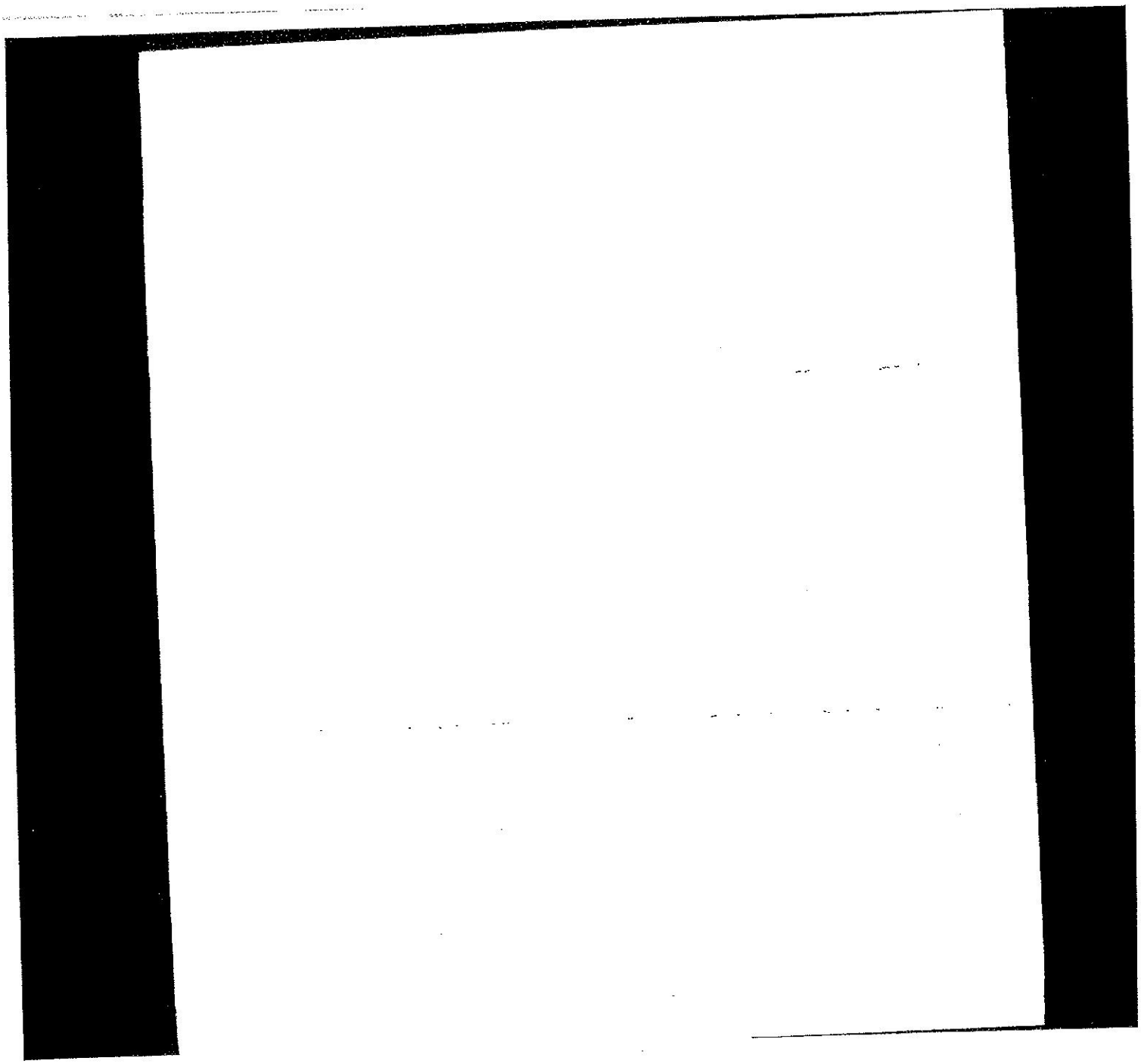

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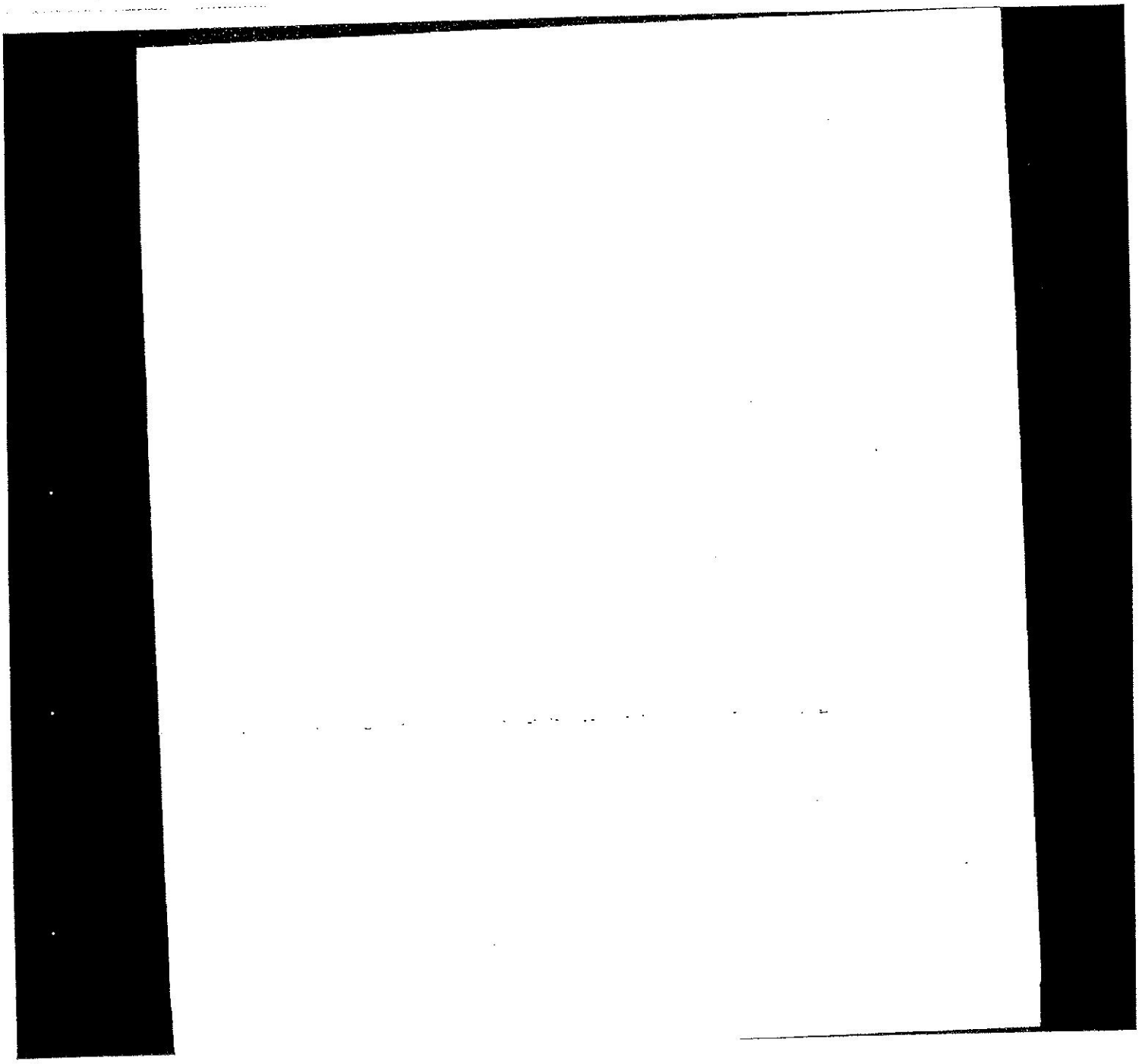
11/30/10

Signature of Proposed Insured/Patient or Legal Representative Date

Description of Legal Representative's Authority or Relationship to Patient

Health Authorization (2.4) **Home Office Copy**



OUR PRIVACY POLICY

Required by the federal Gramm-Leach-Bliley Act and state privacy law
(State law will apply if it provides more protection than federal law.)
ANNUITY & LIFE REASSURANCE AMERICA, INC.

We are committed to keeping the non-public personal information ("NPI") we collect confidential and secure. We want to let you know how we protect your privacy. Our Privacy Policy applies to potential, current and former customers.

How do we protect your privacy?

- We restrict access to NPI to our employees who need it for their jobs.
- We use your NPI only as is necessary for us to provide insurance products and services.
- We require nonaffiliates that perform services for us to protect your NPI and not use it for any other purpose.
- We verify that anyone asking for your NPI is entitled to it before we give it.
- We collect your health information only with your written authorization.
- We disclose your NPI only as permitted or required by law.
- We do not disclose your NPI to others for their own marketing purposes.
- We do not reveal your health, character, personal habits or reputation to anyone for marketing purposes.
- We maintain physical, electronic, and procedural safeguards to protect your NPI.

What information do we collect?

We need some NPI to determine if you are eligible for our products. Once a contract is issued, we typically only seek NPI when someone asks for more coverage or submits a claim. Some examples of what we may collect:

- Data you provide on applications (name, address, date of birth, Social Security number, income, and beneficiary).
- Medical information from health care providers obtained with your authorization.
- Information about your policies with us (policy number, coverage, premium, and payment history).
- As you have authorized: credit reports from consumer reporting agencies; driving records from the Bureau of Motor Vehicles; medical records from the Medical Information Bureau. (NPI obtained from insurance support organizations may be kept by them and disclosed to others.)

To whom do we disclose information?

We may share your NPI when you ask or authorize us to do so. Also, the law allows certain disclosures without your authorization. We may share some or all of your NPI with affiliates or nonaffiliates, as permitted or required by law. The law does not allow you to opt out of these disclosures. Examples of who we may share NPI with:

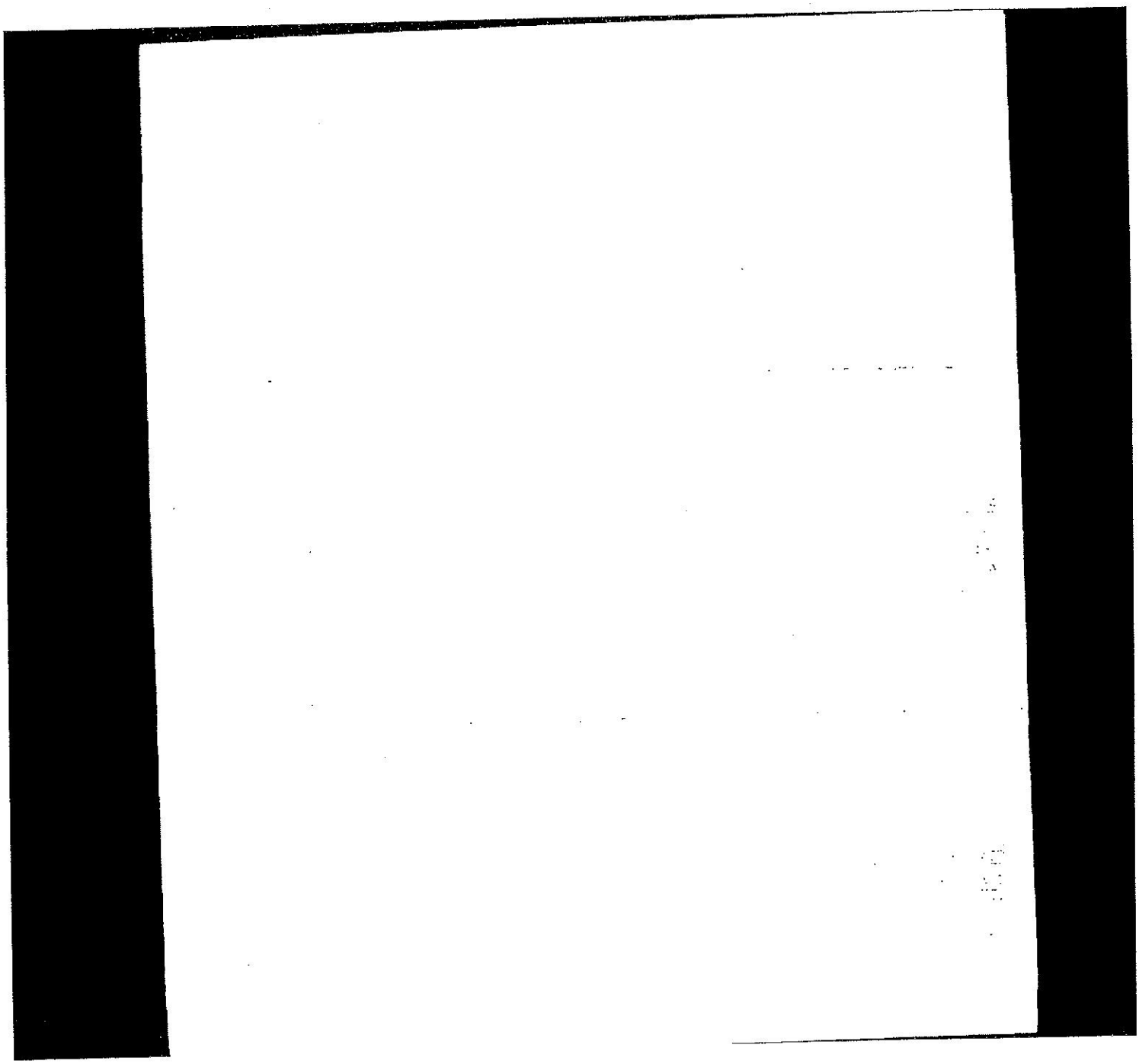
- Nonaffiliates we have hired to help us provide insurance services, such as claims, billing, and customer service vendors and insurance agents; affiliates that help us provide services or audit our operations.
- A consumer reporting agency to detect or prevent fraud.
- A regulatory, legal or government authority, for a compliance audit or under a subpoena or court order.
- Affiliates or nonaffiliates that market our products. These parties may include life and health insurers, insurance agents, and marketing firms. We may share your name, address, product purchased, and policy number for these purposes.

What are your rights?

- You have the right to know what NPI we have collected about you; this does not apply to NPI that relates to an actual or possible claim or civil or criminal action. You may ask us in writing to correct any NPI you believe is not correct.
- You may ask us in writing for a list of those to whom we have disclosed your medical records within the past two years.
- If we wish to disclose your NPI for reasons not allowed by law, we will ask for your written authorization. If you give it to us, you may revoke it at any time. Revocation is subject to the rights of anyone who acted in reliance of your authorization before it was revoked.
- We may change our Privacy Policy from time to time. If we do, we will provide you with all of the legal rights to which you are entitled. This privacy notice supersedes all such prior notices we may have provided to you.

How do you contact us?

If you have questions about this notice, please write to us at: Annuity & Life Reassurance America, Inc., Attn: Legal Department, 1700 Magnavox Way, Fort Wayne, IN 46804. Contact Customer Service for questions about your policy.



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	Insured (also called "you")	Insured's Date of Birth
1009208	Simon Bernstein	12-2-35

Insured's Address: 1020 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

[redacted]

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:		n/a										
b. Second Proposed Insured:												
Complete for Family Plan, Spouse Rider, Other Insured Rider or Children's Term)												
2. a.		Spouse										
b.		Children										
c.												

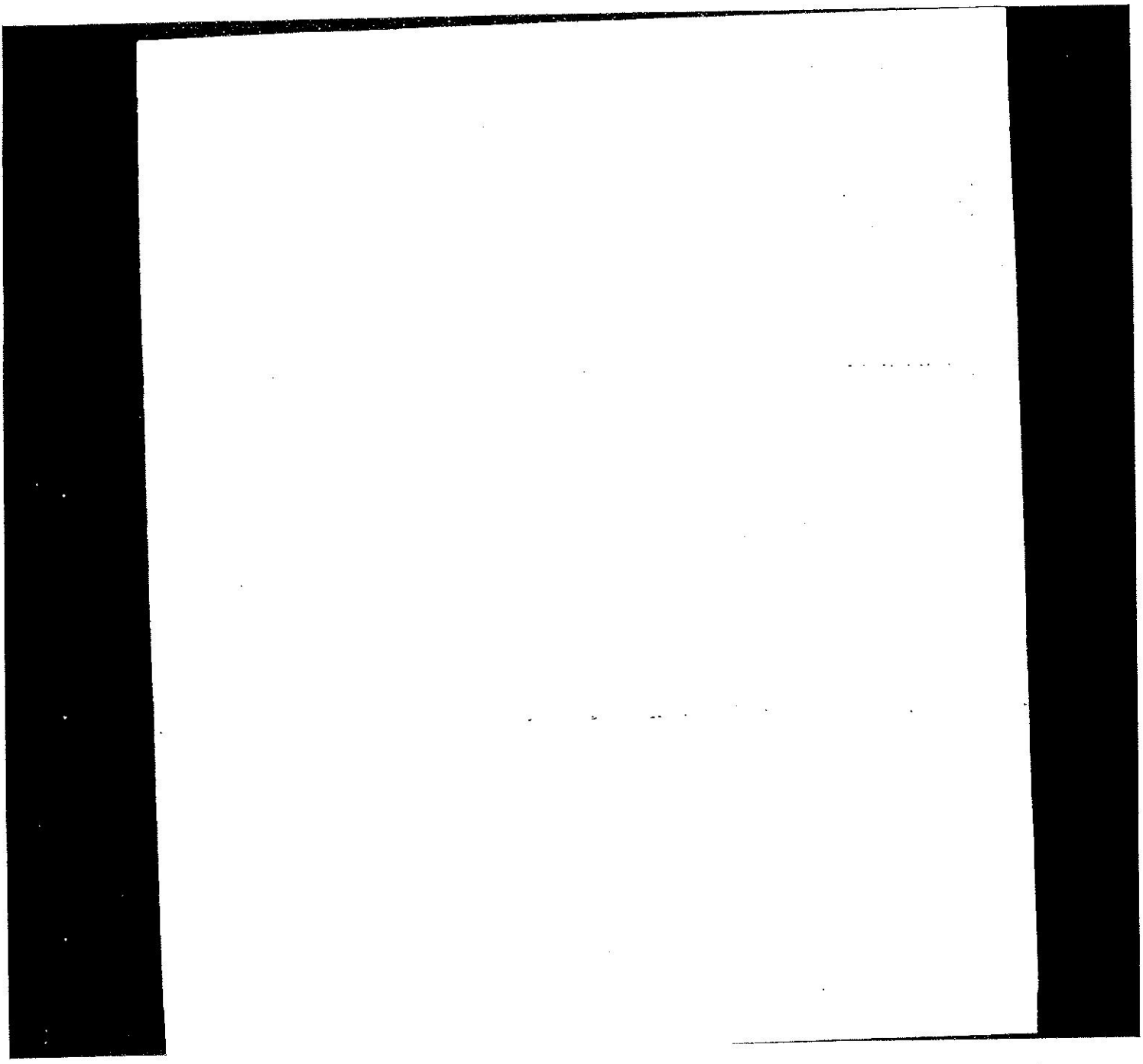
Give details in "Comments" section following the questions for any 'YES' answers to questions 3 through 8 and 10 through 15.

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, nervousness, 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 item(s) that you are referring to, Dates/Duration, Diagnosis, Physician Name and Address, and name of the Health Care Facility.

16. Family History	Age(s) (if living)	Condition of Health *	Age(s) at Death	Cause of Death
Wife or Husband	71	GOOD		
Father			74	HEART
Mother	80	GOOD	88	CANCER
Sister(s)				
Brother(s)				

* 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 the 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

Witness (not related) or Agent

Address

City State Zip

Insured(s), Owner(s), Assignee(s) (Please indicate title)

Address

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

Proposed Insured (if age 16 or over)

Witness (not related) or Agent

Telephone Number (day): ( )

Spouse (if to be insured) or Second Proposed Insured (if J.W.L.)

Owner (if not Proposed Insured) and relationship

(night): ( )

AL-A-01