AWD History for Work object key 2010-09-09-14.26.54.846221T01 JLIFE - MINPREM - PROCESSED - END - Updateable

- 1009208 -- BERNSTEIN - SIMON - 19 -

Social Security Num: Agent Number:

Policy Number: 1009208

2010-09-15

14:42:25

2010-09-10

06:07:18

4000NO

Insured's Last Name: BERNSTEIN Printed on Tuesday, May 07, 2013 at 1:47:50PM ____________

User Id: JWIERTJ DTM Return Code:

Workstation Id:

Business Area:

Type: Status: Queue:

DTM Task Name: DTM Next Task: End Date: End Time:

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

Flags:

DTM Job Name:

DTM Task Name:

DTM Next Task:

End Date:

End Time:

DTM Return Code:

Begin Date:

2010-09-10 Begin Time: 06:07:18 AMGWN User Id:

Workstation Id: Business Area: Type:

Status: Queue:

User Name:

MGWALI, NOMA

2010-09-10

MGWALI, NOMA

06:06:19

AMGWN

DTM Description:

Comments:

kindly verify values.

Begin Date: Begin Time:

User Id: Workstation Id:

Business Area: JLIFE Type: QUOTES ACTUARY ACTUARY

Status: Queue: User Name:

DTM Description: Comments:

Flags:

DTM Job Name: DTM Return Code: DTM Task Name: DTM Next Task:

End Date: End Time:

2010-09-10 06:07:27

Begin Date: 2010-09-09 Begin Time: 14:28:02 **JCOONWR**

User Id: Workstation Id: Business Area:

Type: Status: Queue:

User Name: DTM Description: Flags:

DTM Job Name: DTM Return Code: DTM Task Name: DTM Next Task:

End Date: End Time:

2010-09-09 14:28:02

COONS, WILLIAM RAY

AWD History for Work object key 2010-09-09-14.26.54.846221T01

JLIFE - MINPREM - PROCESSED - END - Updateable
- 1009208 - - BERNSTEIN - SIMON - 19 -

Social Security Num: Agent Number:

Policy Number: 1009208 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 14:26:56

4000NO

Begin Time: User Id: Workstation Id: Business Area:

JCOONWR JLIFE QUOTES

Flags: DTM Job Name: DTM Return Code: DTM Task Name: DTM Next Task:

Type: Status: Queue:

ALPHAMATCH CSPROC2

End Date: End Time:

2010-09-09 14:28:04

User Name:

COONS, WILLIAM RAY

DTM Description:

Comments:

Begin Date: Begin Time: User Id: 2010-09-09 14:26:54 JCOONWR

Flags: DTM Job Name: DTM Return Code:

Workstation Id: Business Area:

JLIFE PHONE PHONE CSPROC DTM Task Name: DTM Next Task: End Date: End Time:

2010-09-09 14:26:54

JCK000124

999010

Queue:

Type: Status:

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 - 1009208 - BERNSTEIN - SIMON - 19 -Policy Number: 1009208

Social Security Num: Agent Number:

Insured's Last Name: BERNSTEIN Printed on Tuesday, May 07, 2013 at 1:48:18PM

DTM Job Name:

DTM Return Code:

DTM Task Name:

DTM Next Task:

End Date:

End Time:

Flags:

DTM Job Name:

DTM Task Name: DTM Next Task:

End Date:

End Time:

DTM Return Code:

Flags:

Begin Date: Begin Time:

User Id:

Workstation Id: Business Area:

Type: Status:

Queue: User Name:

DTM Description: Comments:

2010-11-10 09:02:49

JSIMOJJ JLIFE POLRES

QPASS2 END SIMONS, JINA J

Begin Date:

Begin Time: User Id:

Workstation Id: Business Area:

Type: Status: Oueue: User Name:

DTM Description: Comments:

Begin Date:

Begin Time:

User Id:

2010-11-09

10:56:21 ACARRLX

JLIFE POLRES QPASS CSQC

CARR, LIEZEL

Flags:

DTM Job Name:

DTM Return Code:

DTM Task Name:

DTM Next Task:

End Date:

End Time:

2010-11-09 10:04:05

AKOBOF

Workstation Id: Business Area: Type:

Status: Oueue: User Name:

DTM Description:

Comments:

Begin Date:

KOBO, FLORINE

Letter mailed to PO

Begin Time: User Id:

Workstation Id: Business Area:

Type: Status: 2010-11-09 09:54:34 AKOBOF

STILL POLRES PROCESSD3

9990Y2

Flags: DTM Job Name: DTM Return Code: DTM Task Name: DTM Next Task:

End Date: End Time:

2010-11-09 10:04:14

2010-11-10 09:02:56

9990Y2

2010-11-09

2010-11-09

10:04:05

9990N0

AWD History for Work object key 2010-11-02-16.10.30.748281T01

JLIFE - FOLRES - QPASS2 - END - Updateable
- 1009208 - BERNSTEIN - SIMON - 19 Policy Number: 1009208

Flags:

DTM Job Name:

DTM Task Name:

DTM Next Task:

DTM Job Name: DTM Return Code:

DTM Task Name:

DTM Next Task:

End Date:

End Time:

End Date:

End Time:

Flags:

DTM Return Code:

Social Security Num:

Insured's Last Name: BERNSTEIN Agent Number:

Printed on Tuesday, May 07, 2013 at 1:48:18PM

Queue:

CSQC2

User Name:

KOBO, FLORINE

DTM Description:

Comments:

Begin Date:

Begin Time: User Id:

Workstation Id:

Business Area:

Type: Status:

User Name:

DTM Description:

Queue:

AKOBOF SALIE, MARIAM

2010-11-09

03:47:37

ASALIM

JLIFE

POLRES

JHICKC

POLRES

CSPROC2

CSPROC2

CSPROC2

Comments:

2010-11-08 Begin Date: Begin Time: 15:46:24

User Id: Workstation Id:

Business Area: Type: Status:

Oueue: User Name:

DTM Description:

Comments:

Begin Date:

Begin Time: User Id:

Workstation Id: Business Area:

Type: Status:

Queue: User Name: DTM Description:

Comments:

2010-11-05

BONJEAN, CORTNEY

10:08:22 JWIERTJ

JLIFE POLRES

CS1 CSPROC

WIERSMA, TONY J

Flags:

DTM Job Name: DTM Return Code: DTM Task Name:

DTM Next Task: End Date:

2010-11-05 10:08:27 End Time:

9990N0

2010-11-09

03:47:37

9990N0

2010-11-08

15:46:27

9990N0

JCK000127

AWD History for Work object key 2010-11-02-16.10.30.748281T01

JLIFE - POLRES - OPASS2 - END - Updateable - 1009208 - BERNSTEIN - SIMON - 19 - BERNSTEIN - SIMON - 19

Social Security Num: Agent Number:

Policy Number: 1009208

Insured's Last Name: BERNSTEIN

Printed on Tuesday, May 07, 2013 at 1:48:18PM

0 Begin Date:

Begin Time: User Id:

Workstation Id: Business Area:

Type: Status: Oueue:

User Name:

DTM Description: Comments:

Flags: 2010-11-05 10:08:19

DTM Job Name: DTM Return Code: DTM Task Name: DTM Next Task:

End Date: End Time:

2010-11-05 10:08:19

2010-11-04

10:20:49

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: Begin Time:

2010-11-04 10:20:49 User Id: ASALIM

Workstation Id: Business Area: Type: Status: Queue:

JWIERTJ

SALIE, MARIAM

WIERSMA, TONY J

DTM Description:

User Name: 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?

Flags:

DTM Job Name:

DTM Task Name:

DTM Next Task:

End Date:

End Time:

DTM Return Code:

Begin Date: Begin Time:

User Id: Workstation Id:

Business Area: Type: Status:

Queue: User Name: DTM Description: Comments:

2010-11-04 10:18:59

ASALIM JLIFE

POLRES ACTUARY ACTUARY SALIE, MARIAM

4000N0 Flags:

DTM Job Name: DTM Return Code: DTM Task Name:

DTM Next Task: End Date:

2010-11-04 10:20:58 End Time:

4000NO Flags:

Begin Time: User Id: Workstation Id:

Begin Date:

2010-11-04 04:10:19 ASALIM

DTM Job Name: DTM Return Code: DTM Task Name:

AWD History for Work object key 2010-11-02-16.10.30.748281T01

JLIFE - POLRES - QPASS2 - END - Updateable - BERNSTEIN - SIMON - 19 1009208 -

Social Security Num:

Policy Number: 1009208

Agent Number:

Insured's Last Name: BERNSTEIN

Printed on Tuesday, May 07, 2013 at 1:48:18PM

Business Area:

JLIFE

DTM Next Task:

Type: Status: POLRES ALPHAMATCH ASALIM SALIE, MARIAM End Date: End Time:

2010-11-04 04:10:19

Oueue: User Name:

DTM Description: Comments:

Begin Date:

Begin Time: User Id:

2010-11-02 16:13:31 JHILLAN

Workstation Id:

Business Area: Type: Status:

DTM Job Name: DTM Return Code: DTM Task Name: DTM Next Task: End Date:

End Time:

Flags:

2010-11-02 16:13:31

Queue: User Name:

DTM Description: Comments:

HILL, ASHTON N

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.

> 4000NO

Begin Date: Begin Time:

Business Area:

16:10:35 User Id: Workstation Id:

JHILLAN

JLIFE POLRES ALPHAMATCH

2010-11-02

CSPROC2

HILL, ASHTON N

User Name: DTM Description:

Comments:

Type:

Status:

Queue:

Flags:

DTM Job Name: DTM Return Code: DTM Task Name:

DTM Next Task: End Date: End Time:

2010-11-02 16:11:43

Begin Date:

Begin Time: User Id: Workstation Id:

Business Area: Type: Status:

2010-11-02 16:10:30 JHILLAN

PHONE PHONE Flags:

DTM Job Name: DTM Return Code: DTM Task Name: DTM Next Task:

End Date: End Time:

2010-11-02 16:10:30

9990NO

AWD History for Work object key 2010-11-02-16.10.30.748281T01

JLIFE - POLRES - QPASS2 - END - Updateable

1009208 - BERNSTEIN - SIMON - 19 Policy Num: Policy Number: 1009208

Social Security Num: Agent Number:

Insured's Last Name: BERNSTEIN

Printed on Tuesday, May 07, 2013 at 1:48:18PM

Queue:

CSPROC

HILL, ASHTON N

User Name: 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

- 1009208 - - BERNSTEIN - SIMON - 19 -

Social Security Num:

Policy Number: 1009208

Insured's Last Name: BERNSTEIN Agent Number:

Printed on Tuesday, May 07, 2013 at 1:48:52PM

Begin Date: Begin Time:

User Id:

Workstation Id:

Business Area: Type:

Status: Queue:

User Name: LYONS, KERI A

DTM Description:

Comments:

FAXED

2010-11-12 14:11:41

JLYONKA

Begin Date: Begin Time:

2010-11-12 14:11:02 JLYONKA

JLTFE

FORMS

PROCESSED END

User Id: Workstation Id: Business Area:

Type: Status:

Queue: User Name:

DTM Description:

Comments:

2010-11-12

LYONS, KERI A

Begin Date: Begin Time: User Id: JLYONKA

Workstation Id: Business Area:

Type: Status: Queue:

User Name: DTM Description:

LYONS, KERI A

Comments:

fax reinst forms 561-988-0833

Begin Date: Begin Time:

User Id: Workstation Id: Business Area:

Туре: Status: Queue:

2010-11-12 14:10:34 JLYONKA

JLIFE FORMS ALPHAMATCH CSPROC

Flags:

DTM Job Name: DTM Return Code: DTM Task Name: DTM Next Task:

End Date: End Time: 2010-11-12 14:11:10

Flags:

Flags: DTM Job Name: DTM Return Code: DTM Task Name: DTM Next Task:

DTM Job Name: DTM Return Code:

DTM Task Name: DTM Next Task:

End Date: End Time:

Flags:

DTM Job Name:

DTM Return Code:

DTM Task Name:

DTM Next Task:

End Date:

End Time:

End Date: End Time:

2010-11-12 14:11:41

2010-11-12

2010-11-12

14:10:51

4500NO

14:11:38

AWD History for Work object key 2010-11-12-14.10.33.383281T01

JLIFE - FORMS - PROCESSED - END - Updateable
1009208 - - BERNSTEIN - SIMON - 19 -

Social Security Num:

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: Begin Time:

2010-11-12 14:10:33

4500NO Flags:

User Id: Workstation Id: JLYONKA

Plags:
DTM Job Name:
DTM Return Code:
DTM Task Name:
DTM Next Task:
End Date:
End Time:

Business Area:

JLIFE FORMS PHONE

Type: Status: CSPROC

2010-11-12 14:10:33

Queue: User Name: LYONS, KERI A

DTM Description: Comments:

JCK000133

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	Date of birth
	(please print)	

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

Health Authorization (2.4)

Insured Copy

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	Date of birth
	(please print)	

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

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?

the state of the state of the state of

- 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.

01/08 Privacy Notice

Annuity & Life Reassurance America, Inc. Home Office: Hartford, CT 06103 ("the Company") POLICYOWNER PLAN CHANGE/ REINSTATEMENT REQUEST PART 1

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

INSTRUCTIONS: • Check [] for service de Servicing Office • For Change of Benefic SIGNATURE REQUIREMENTS: • Insured	iary, complete separate form, , If age 16 or older • Owner,					
 Corporate officer with little, if policy is corpolicy Number 	orate-owned. 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	er		 		Agent's	Phone Number
Servicing Agent's Name	Agency Code				Agent C	ode .
"Will not process without valid insured's Social Return all Items to: ☐ Owner ☐ General Age	Security Number and Owner's ney (Other (specify)	Social Sec	curity or Tax I	dentification (Number.	
☐ TRADITIONAL ☐ UNIVERSAL LIFE						
Old Plan: Old Benefit Am		New			lew Benefit A	
If converting part of a term policy or term life ri	der, is the balance to be retain	ed or dropp	ed? ☐ Re	tain S	☐ Dr	ορ
Death Benefit Option (Universal Life ONLY): [seclare the O	riginal Policy	Contract has	been lost or destroyed.
Benefits:	Currently on Policy (Check Answer)	Ādā	Delete	Increase	Decrease	New Amount
Accidental Death	☐ Yes ☐ No					\$ <u> </u>
Waiver of Premium (or COLIFUL)	☐ Yes ☐ No			-,□		\$
Monthly Disability Benefit (UL ONLY)	☐ Yes ☐ No		Ö			5
Guaranteed Purchase Option	Yes No .					
Riders:	•					ž.
Spouse's Level Term Rider	☐ Yes ☐ No					\$
Children's Term Rider	☐ Yes ☐ No					2
Primary Insured Term Rider	☐ Yes ☐ No					5
Other Insured Term Rider	☐ Yes ☐ No					\$
Other Riders (specify):						
	☐ Yes ☐ No					\$
	☐ Yes ☐ No					5
	☐ Yes ☐ No				. 🗆 .	5
2 II was an laborat product?	☐ Yes ☐ No If "YES", v	what form o	f tobacco do .	you use? 🔲	Cigarettes [] Cigars [] Fipe [] Smokeless
Do you currently use any tobacco product?				ich you last u		
Have you ever used any tobacco product? BILLING INSTRUCTIONS: MODE:AnnualQuarte	<u> </u>			Direct L		
New Planned Periodic Premium: \$		· An	nount Enclos	ed; \$	·	· · · · · · · · · · · · · · · · · · ·
SPECIAL INSTRUCTIONS:					· 	
,						
			. 			
						

(Print first name, middle i	moker Select No		Relationship To Proposed Insured		e of Birth Day Y		Age Nearest Birthday	State of Birth	Sex		leight Inches	. Waiph! Now Yr. a
1. a. Proposed		Occupation	nta	WISTALL)	1						T	
insured:										-	 	<u> </u>
 b. Second Proposed Insured: 		0 100		<u> </u>			<u> </u>	<u> </u>	<u> </u>		1	<u> </u>
Complete for Family Pt	an, Spouse Rider, Other Ir	isured Rider or Chi	ldren's Tem)	1	·-·			7	1	· -		г
2. a. ·			Spause					-				ļļ
b.			Children				<u> </u>		ļ		ļ	ļ
C.				<u> </u>			<u> </u>	<u>t </u>	1	i	<u> </u>	<u> </u>
Give delails în "Comm	rents* section following the	questions for any	"YES" answers	to quest	ions 3 t	hrou	gh 8 and 10) through	7 75.			
Within the past 10	years, has any person pro	posed for coverage	9:									[mv - m
a. Been examin	ed by or consulted a physi	cian or other practi	tioner?									☐Yes ☐
b. Been under o	observation or treatment in	a hospital or any o	ther form of he	alth care	acility	'						OYes O
c. Had an X-ray	, electrocardiogram, blood	tast, urine or other	laboratory les	is?								Yes Ot
4. Within the past 10	years, has any person pro	posed for coverage	2;	1.00				alad ad		- ac 1		-Byes-Br
	years, has any person pro- nellts or compensation for	sickness or Injury,	or had life or d	sábility it	isuranc	6 (110	одива, геје	rea, not	lettewe	u, ui is	35080	☐Yes ☐1
as a substant	e or treatment for, or been	arrested for or bee	n addicted to.	the use o	of alcoho	ol or	drugs?					☐Yes ☐N
b. Sought advict	ase of the reproductive org	ans, genital organ	s, breasts, or a	ny ampu	tation o	r bod	dily infirmily	, hernia	or ruplur	e,		□Yes □N
harmonholds	or vadeose veios?											
d. Been advised	to have any diagnostic te	st, hospitalization,	or surgery which	h was no	ot comp	ietec	17 					☐Yes ☐1
5. Within the past 10	years, has any persons pr	oposed for coverag	e had or been	treated f	or:							☐Yes ☐N
a. Any disease o	or disorder of the eyes, ea	rs, nose, throat, or	thyrold gland?									☐Yes ☐N
b. Any deformity	or disorder of the back, s	pine, muscles, bon	es or joints?									☐Yes ☐N
	eart murraur, high blood p	essure, or any other	er disease or d	isorder o	f the he	art,	circulatory s	ystem, t	ologa or	ptood		□Yes □N
vessels?	ndigestion, or other diseas	a of the stomach	intestines, gall	bladder.	liver, pa	ıncre	as spleen.	or enlar	ged lym	ph gla	nds?	☐Yes ☐N
d. Pepuculcar,	asthma, pleudsy, or any o	that dispass of the	chest or lung									☐Yes ☐N
e. Tuberculosis,	blood or sugar in urine, u	diel disease of the	or disease of the	ne kidney	s. blade	ler o	r prostate?					☐Yes ☐A
o. Severe beada	blood or sugar in urine, u iches, fainting spells, dizzi or disorder of the brain or	ness, vertigo, sync	ope, epilepsy,	nervousr	ess, pa	ralys	ls, mental	disorder,	depress	sion, o	rany	□Yes □N
b Pharmais or	other lever, diabetes, syp	nilis, pout, arthritis,	gotter, cancer,	tumor a	r disord	er of	the lymph	nodes?			}	□Yes □N
) A	spections instiment or a	ny iliness allment	abnormality, o	injury no	ot ment	one	i above will	rin the p	ast 10 y	ears?		☐Yes ☐N
6. Within the past 7 ye	ars: To the best of your kr	owledge, has any p	person proposi aled Complex	ed for co (ARC)?	verage l	nad (of been told	by a me	edical pr	ofessio	onal, -	□Yes □N
7. Is any person prop	osed for coverage now pre	gnant7 (If "YES",)	provide the chi	d's expe	cted du	e da	te in "Co <i>mn</i>	rents")				☐Yes ☐N
ls any person dinn	nsed for coverage now uni	der medical treatme	ent or taking ar	ly prescri	iption di	ugs	?					☐Yes ☐N
To the best of your	knowledge, are all person	s proposed for cov	erage now in g	ood heal	th7 (if	NO"	, provide de	talls in "	Comme	715")		☐Yes ☐N
Mas any person pri	posed for coverage any la	itention to travel or	reside outside	the Unit	ed,State	es or	Canada?					□Yes □N
14. Has any nerson no	oposed for coverage withir	the past two years	lown as a pil	ot, stude	nt pilot d	or cre	ew member	or Inten	d to do s	sa?		□Yes □N
12 Has any person on	oposed for coverage enga	ged in, or intend to	engage in, und	lerwater	diving, i	าลกฎ	gliding or p	arachul	ing?		1	☐Yes ☐N
0.11	energy for coverage ands	and in printend to	engage in, cor	npelitive	racing o	of an	y kind?					☐Yes ☐N
I Una antinomana are	propert for coverage had a	driver's license Su	spended or rev	rokea, or	peen c	onvio	cted in the l	ast 3 yea	ers of a r	novin	7	□Yes □N
violation or of drivin	g while impaired, intexical apposed for coverage ever-	ed, or under the mi	Metice of mind	a ui aico	10:7							□Yes □N
												r
Plaaso list Question Nur	nber and item(s) that you ar	e referring to, Dates	/Duration, Diag	nosis, Ph	ysiclan I	√arm∈	a and Addre	ss, and n	ame of t	ne Hea	aith Care	racinty,
								. .				
	:										 -	
6. Family History	Age(s) (if living)	Condition of Healt	h * Age(s) at Deat	h		Cause o	l Death			<u>not</u> ansv Good,* gi	
Vife or Husband											saco, gi etalis abi	
ather										1		
lother]		
Sister(s)									., ,	1		

AGREEMENT AND SIGNATURE FOR PARTS | & || (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.

		named to the second sec	20	*		
Witness (not related) or Agent		Insured(s),	Owner(s), Assign	ee(s) (Please ii	ndicate title) · · ·
Address			Address			-
City	State	Zlp	City	····	State	Zip
r pri i	uthorize(s) any licensed phy	antion Bureau or Other of	ier, hospita nanization.	d, clinic, or othe institution or ce	rson, machas any	records or
facility, insurance or knowledge of time of reinsurers, any such authorization shall b	uthorize(s) any licensed phy ompany, the Medical Inform or my health or the health o h information. A photostatic be valid for two and one hal	vician, medical practition nation Bureau or other org fany family dependent a copy of this authorization f years from the date I sig	ner, hospita ganization, pplying for a shall be a yn this app	al, clinic, or othe institution or pe insurance, to gi as valid as the o lication.	rson, machas any ve to the Company riginal. I agree tha	, or its t this
facility, insurance or knowledge of time of reinsurers, any such authorization shall b	uthorize(s) any licensed phy ompany, the Medical Inform or my health or the health o	vician, medical practition nation Bureau or other org fany family dependent a copy of this authorization f years from the date I sig	ner, hospita ganization, pplying for a shall be a yn this app	al, clinic, or othe institution or pe insurance, to gi as valid as the o lication.	rson, machas any ve to the Company riginal. I agree tha	, or its t this
facility, insurance or knowledge of time of reinsurers, any such authorization shall b	onthorize(s) any licensed phy company, the Medical Inform or my health or the health o h information. A photostatic be valid for two and one hali	vician, medical practition atton Bureau or other or fany family dependent a copy of this authorization fyears from the date I sign.	er, hospitaganization, ganization, pplying for a shall be a gri this app this	al, clinic, or othe institution or pe insurance, to gi as valid as the olication. Day of	rson, machas any ve to the Company riginal. I agree tha	t this
facility, insurance of knowledge of the c reinsurers, any such authorization shall b Dated at (City and S	on the rise of the second of t	rsician, medical practition atton Bureau or other or family dependent a copy of this authorization f years from the date I sign.	ner, hospitaganization, pplying for a shall be a grithis app this	al, clinic, or othe institution or per insurance, to git as valid as the orbitation. Day of	rson, mar has any ve to the Company riginal. I agree tha	t this

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 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) 597-0598.

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

Flags:

JLIFE - FORMS - PROCESSED - END - Updateable - 1009208 - - BERNSTEIN - SIMON - 19

Social Security Num:

Policy Number: 1009208

Agent Number:

Insured's Last Name: BERNSTEIN

Printed on Tuesday, May 07, 2013 at 1:49:25PM . £31=33=51=51=51=4====32##=3==6=#3#=3

Begin Date: Begin Time:

Business Area:

User Id:

2010-11-15 13:22:01

JPETESD Workstation Id:

DTM Job Name: D'IM Return Code: DTM Task Name:

DTM Next Task: End Date: End Time:

DTM Return Code:

DTM Task Name:

DTM Next Task:

End Date:

End Time:

Flags:

DTM Job Name:

DTM Return Code:

DTM Task Name:

DTM Next Task:

End Date:

End Time:

2010-11-15 13:22:01

4500N2

2010-11-15

2010-11-15

12:27:44

13:21:54

Type: Status:

Oueue:

COLE, SHANNON D User Name:

DTM Description: Comments:

MAILED REINSTATEMENT FORM TO PO.

Begin Date:

Begin Time:

13:21:35 JPETESD

User Id: Workstation Id:

Business Area: Type:

Status: Queue: User Name:

DTM Description:

Flags: 2010-11-15 DTM Job Name:

JLIFE

FORMS PROCESSED END

COLE, SHANNON D

Comments:

2010-11-15

Begin Date: 12:27:44 Begin Time: JMILLH User Id:

Workstation Id: Business Area: Type:

Status: Queue: User Name:

DTM Description: Comments:

MILLER, HEATHER R

*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: Begin Time:

User Id: Workstation Id: Business Area:

Type:

2010-11-15

JMILLH

12:27:14

DTM Job Name: DTM Return Code: DTM Task Name: DTM Next Task:

Flags:

End Date:

2010-11-15

AWD History for Work object key 2010-11-15-12.26.17.566281T01

JLIFE - FORMS - PROCESSED - END - Updateable

- 1009208 - - BERNSTEIN - SIMON - 19 -

Social Security Num:

Policy Number: 1009208

Insured's Last Name: BERNSTEIN Agent Number:

Printed on Tuesday, May 07, 2013 at 1:49:25PM

Status:

End Time:

12:27:14

4500N0

Queue: User Name:

MILLER, HEATHER R

DTM Description:

Comments:

PLS FAX REINST FORMS TO DIANA@ 561-988-0833

Begin Date: Begin Time:

User Id:

2010-11-15 12:26:20

JMILLH JLIFE

ALPHAMATCH

2010-11-15

12:26:17

FORMS

CSPROC

Business Area: Type: Status:

Workstation Id:

Queue: User Name:

MILLER, HEATHER R

DTM Description:

Flags:

DTM Job Name: DTM Return Code:

DTM Task Name: DTM Next Task:

End Date: 2010-11-15 End Time:

12:27:00

Comments:

Begin Date: Begin Time:

User Id:

Workstation Id: Business Area: FORMS Type:

Status: Oueue:

User Name: DTM Description: Comments:

JMILLH JLIFE

PHONE CSPROC

MILLER, HEATHER R

4500NO Flags:

DTM Job Name:
DTM Return Code:
DTM Task Name:
DTM Next Task:

End Date: End Time: 2010-11-15 12:26:17

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	Date of birth
	(please print)	

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 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 Represen	tative Date
Description of Legal Representative's Authority or Relat	ionship to Patient
	8
Health Authorization (2.4)	Insured Copy

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	Date of birth
	(please print)	

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 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.

01/08 Privacy Notice

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

REINSTATEMENT REQUEST PART 1

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

INSTRUCTIONS: • Check [for service de Servicing Office • For Change of Benefit SIGNATURE REQUIREMENTS: • Insurec • Corporate officer with title, if policy is con	clary, complete separate form. Liff age 16 or older • Owner,					signed
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 Numb	er				Agent's F	Phone Number
Servicing Agent's Name	Agency Code				Agent Co	de .
*Will not process without valid insured's Social Return all items to: Owner General Age	Security Number and Owner's ancy Diher (specify)	Social Sec	urity or Tax lo	entification N	umber.	
☐ TRADITIONAL ☐ UNIVERSAL LIFE						
Old Plan: Old Benefit An		New			ew Benefit Ar	mount; \$
If converting part of a term policy or term life of	ider, is the balance to be retaine	ed or dropp	ed7 🗌 Ret	ain \$	☐ Dro	φ
Death Benefit Option (Universal Life ONLY):	Theyel Thoreasing		eclare the Or	iginal Policy (Contract has	been lost or destroyed.
Death Berleit Ohnor (Claverse) the Children	Currently on Policy			Constitution of		
Benefits:	(Check Answer)	Add	Delete	Increase		New Amount
Accidental Death	☐ Yes ☐ No					\$ _.
Waiver of Premium (or COLIFUL)	☐ Yes ☐ No			`.□.		\$
Monthly Disability Benefit (UL ONLY)	☐ Yes ☐ No					\$
Guaranteed Purchase Option	☐ Yes ☐ No ·					
Riders:					383	,
Spouse's Level Term Rider	☐ Yes ☐ No					\$
Children's Term Rider	☐ Yes ☐ No					2
Primary Insured Term Rider	☐ Yes ☐ No					5
Other Insured Term Rider	☐ Yes ☐ No					S
Other Riders (specify):						
	☐ Yes ☐ No					\$
	☐ Yes ☐ No					\$
	☐ Yes ☐ No				. 🗆 ·	\$
	,	to to one	Flabacca da y	(a)1 (sea 2 []	Classettes [7]	Clgers 🗌 Pipe 🔲 Smokeless
Do you currently use any lobacco product?				ch you last us		
Have you ever used any tobacco product?	Yes No I I "YES", w	Aliai Mas ai	e cale of min	on you had do	,	
BILLING INSTRUCTIONS: MODE: Annual Semi-Annual Government Allotment	terly Monthly Non-bill	BILLING	TYPE:	Olrect □Li	st bill P	4C
New Planned Periodic Premium: \$		· An	rount Enclose	ed: \$	- , ,,,, ,,,,	
SPECIAL INSTRUCTIONS:						
				 ,	<u> </u>	
	(1997-1977) (1997-1977) (1997-1977) (1997-1977) (1997-1977) (1997-1977) (1997-1977) (1997-1977) (1997-1977) (1					

Preferred Non-St			Relationship To Proposed	Da	ite of B	irth	Age Nearest	Slate of		F	leight	.W	eight
(Print first name, middle i	nulai, and iast name)	Occupation	Insured			Year	Blrthday	Birth	5ex	Fee	Inches	Now	Yr. ag
1. a. Proposed			n/a]	4 3000000	
Insured; b. Second]			
Proposed insured: Complete for Family Pla	Danie Gidas Olha	classend Didge or Ch	Ildren's Term)		J	L.,	.L		1	1		J	<u>. </u>
	m, apouse Muer, Oure	i madicu rader de de	Spouse	T	Ţ	I		[T]	T	{	T
2. a			Children				1	1	1	1	1		1
b.			 			1	1	1		1		 	
c. Give details in "Comm	nate" saction following	the attestions for any	'YES' answers	to ques	tions	3 lhrou	gh 8 and 10) through	15.	4	<i></i>	<u> </u>	
3. Within the past 10	vears has any nerson	proposed for coverag	e:			305-0	**************						is .
J. Pano avamina	ed by or consulted a pl	vs/cian or other pract	itioner?							120		□Yes	: 🗆 N
b Poor under o	bservation or treatmen	in a hospital or any o	ther form of he	aith car	e facil	lly?						☐Yes	: DN
s. Und as V sav	electrocardiogram, blo	or test urine or othe	r laboratory tes	ts?								□Yes	I DNo
/ Milhim Name and 10	mare has any nerson	conceed for coverag	e:									-□Xas	No Child
a Received ben	efits or compensation t	or sickness or Injury.	or had life or di	sąbility l	nsura	nce mo	odified, reje	cled, not	renewe	d, or is	ssued	□Yes	: FING
ar a substand	Cysin back			100000000000000000000000000000000000000	2001 70 0	3 0227 3		·					
 b. Sought advice 	e or treatment for, or be	en arrested for or bea	en addicted to,	the use	or aice	onol or	arugs?	haroia	or ruchia	ъ	·	☐Yes	
c. Had any disea	ase of the reproductive or varicose veins?	organs, genital organ	s, breasts, or a	пуапца	ata not	101000	any tenterincy	, 31c/11ld v)	~,		□Yes	□Nt
d Been advised	to have any diagnostic	test, hospitalization,	or surgery which	h was n	ot cor	npletec	17					☐Yes	□No
5. Within the past 10	vears has any nersons	proposed for coverage	ge had or been	treated	tor.							□Yes	□No
5. Within the pase to	or disorder of the eyes,	ears, nose, throat, or	thyrold gland?									□Yes	DNo
h Anut deformille	or disorder of the back	snine muscles, bor	es or joints?									□Yes	□No
c. Chest pain, he	eart murmur, high blood	pressure, or any oth	er disease or d	isorder	of the	heart,	circulatory s	ystem, b	lood or	plood		□Yes	□No
vessels?	ndigestion, or other dis-	ages of the stomach	Intestines, gall	bladder	liver.	pancre	es, spieen,	or enlar	ged lym	ph gla	nds?	□Yes	□No
d. Peptic ulcar, ii	asthma, pleurisy, or an	u other disease of the	chest or lune?									□Yes	□No
e. Tuberculosis,	blood or sugar in urine	y outer disease or oth	er disease of It	e kidne	vs. bla	dder o	r prostate?	.,				□Yes	·
n Severe beada	ches, faintino spells, di	zziness, vertigo, sync	ope, epilepsy,	iervous	ness,	paralys	is, mental i	lisorder,	depress	dan, o	гапу	□Yes	
other disease	or disorder of the brain other fever, diabetes, s	or nervous system?	mailar cancer	himor r	ac disp	rder of	the lymob	nodes?				□Yes	TINO
h. Rheumatic or	other lever, clabeles, s perations, treatment, o	ypinis, god, aranis,	abnormally of	loiury n	ot me	offoner	d above will	in the o	ast 10 v	ears?		☐Yes	
a Within the part 7 up	es. To the hest of your	knowledge, has any	person proposi	ed for co	vetag	e had	or been told	by a me	dical pri	ofessio	onat, -	□Yes	
he or she had: an Im 7. Is any person propo	mune deficiency disord	er, AIUS or AIUS-Re	ared Complex	d's expe	cted	due da	te in "Comm	nents")				□Yes	□N□
7. Is any person propo	sed for coverage now	pregnanti (n. 125.	ent or taking ac	v presci	riplion	drugs	7					□Yes	
Is any person propose. To the best of your	sed for coverage now	onder medical treatil	ent or texting of	nnd bea	1167 (IF "NO"	nrovide de	tails in "	Comme	nts'il		Yes	
9. To the best of your	knowledge, are all pers	ons proposed for cuv	erage now mrg	the Uni	led St	ates or	Canada?			,		□Yes	
10. Has any person pro	posed for coverage an	y Intention to travel of	- Nove ne a nik	at stude	nt nile	or cu	ew member	orlalen	t to do s	n2		□Yes	
11. Has any person pro	posed for coverage wil	hin the past two year	s flown as a pm	leauster	dlying	hann	olidion or a	arachuli	na 7			Yes	
12. Has any person pro	posed for coverage en	gaged in, or intend to	engage in, unc	nna lithys	cacin	n of an	a Maria or h	- I usi rati				□Yes	
13. Has any person pro 14. Has any person pro	posed for coverage en	gaged in, or intend to	engage in, con	nked p	been	CONVIC	ted in the !	ast 3 vea	rs of a r	novino			
violation or of driving	a while impaired, intoxi	cated, or under the in	mence of drug-	s or alco	hol?							□Yes	
15. Has any person pro													
Please list Question Num	nber and item(s) that you	are referring to, Dates	s/Duration, Diag	nosis, Pl	nysicla	n Namı	e and Addre	ss, and n	ame of t	he Hei	alth Care	Facility.	
. 4											···-		
16. Family History	Age(s) (if living)	Condition of Healt	h* Age(s) al Dea	th]		Cause o	Death			not ansv		
Wife or Husband											Good," gi etalls ab		
Father						·				┤ "	CACAMO CATA	- 1 - 1	
Mother						~~~~				j			
Sister(s)								100]			

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, the same conditions and exceptions as provided in the policy with respect to the incorrestability thereof, it is oncertain that unless otherwise provided, the rainstatement of a policy reinstates interests of any assignees, beneficiaries or owners. The 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 uisability 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.

	ge and that no proceedings		this	Day of		
Dated at (City and S	itate)		, 1195	, ou, u.		
	*			*		*
	7	-2 1			70 15	
						A-7
				•		
Witness (not related)	or Agent		insured(s),	Owner(s), Assignee(s)	(Please Indicale ti	le) · ·
Address			Address	······································		
		Zip	City	S	late	Zip
City	State	5000 F M	•	~		
	A	UTHORIZATION	FOR PART II	I clinic or other medi	cal or medically relat	ed
The undersigned au	thorize(s) any licensed phys mpany, the Medical Informa r my health or the health of	illon Bureau or oin	er organization. ent applying for	insurance, to give to t s valid as the original	he Company, or its	or
knowledge of me or reinsurers, any such	Information, A photostatic of a valid for two and one half	veers from the dat	6 i aidu nua abbi	Lauon,		9
knowledge of me or reinsurers, any such	Information, A photostatic of a valid for two and one half	veers from the dat	6 i aidu nua abbi	Lauon,	<u> </u>	ě.
knowledge of me or reinsurers, any such	Information A photostatic (veers from the dat	6 i aidu nua abbi	Lauon,		
knowledge of me or reinsurers, any such authorization shall be Dated at (City and Si	Information, A photostatic of a valid for two and one half	years from the dat	e i sign ans appi	Lauon,		W.L.)
knowledge of me or reinsurers, any such authorization shall be Dated at (City and Si	information, A photostatic of a valid for two and one half tate)	years from the dat	spouse (if to	Day of	roposed Insured (If J.)	W.L.)

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 quilty 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) 597-0596.

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

Flags:

DTM Job Name:

DTM Return Code:

Social Security Num: Agent Number:

to the matter and the second of the second s

- 1009208 - - BERNSTEIN - SIMON - 19 -Policy Number: 1009208

Insured's Last Name: BERNSTEIN Printed on Tuesday, May 07, 2013 at 1:50:03PM

Begin Date:

2010-11-16 Begin Time: JKNOXLA User Id:

Workstation Id: Business Area:

Type: Status: Oueue:

User Name: DTM Description:

Comments:

12:27:38

DTM Task Name: DTM Next Task: 2010-11-16 End Date: 12:27:38 End Time:

PO CALLED AND WILL BE MAILING LOAN PAYMENT TO US TODAY.

Begin Date: Begin Time: User Id:

Type:

Status:

Queue:

Workstation Id:

Business Area:

2010-11-16 12:24:01 JKNOXLA

JESS, LISA A

JLIFE POLINQUIRY PROCESSD2

JESS, LISA A

2010-11-16

12:23:54

JKNOXLA

END

User Name: DTM Description:

Comments:

Begin Date: Begin Time:

User Id: Workstation Id: Business Area:

Type: Status: Queue:

User Name:

DTM Description:

Comments:

JESS, LISA A FAXED TO DIANA AT 561/988-0833

2010-11-16

12:22:13 JKNOXLA

Workstation Id: Business Area: Type: Status: Oueue:

Begin Date: Begin Time:

User Id:

Flags: DTM Job Name: DTM Return Code: DTM Task Name:

DTM Next Task: End Date:

2010-11-16 End Time: 12:24:06

Flags:

DTM Job Name: DTM Return Code: DTM Task Name: DTM Next Task:

2010-11-16 End Date: End Time: 12:23:54

9990N2

Flags:

DTM Job Name: DTM Return Code: DTM Task Name: DTM Next Task:

End Date: End Time:

2010-11-16 12:22:13

Social Security Num:

Agent Number:

Printed on Tuesday, May 07, 2013 at 1:50:03PM

User Name:

JESS, LISA A

Butter of the State of the State of State of State of State of the State of State of

DTM Description:

Comments:

PLEASE FAX DIANA AT 561/988-0833 THE GRACE NOTICE DATED 8/27

Begin Date: Begin Time: 2010-11-16 12:12:55

4000NO

User Id:

JKNOXLA

Flags: DTM Job Name: DTM Return Code:

Workstation Id: Business Area:

JLIFE POLINQUIRY ALPHAMATCH DTM Task Name: DTM Next Task:

Type: Status: Queue:

CSPROC2

End Date: 2010-11-16

User Name:

Comments:

JESS, LISA A

End Time: 12:22:16

DTM Description:

Flags:

9990NO

Begin Date: Begin Time: User Id:

2010-11-16 12:12:52 JKNOXLA

DTM Job Name: DTM Return Code: DTM Task Name: DTM Next Task:

Workstation Id: Business Area: Type:

DLIFE PHONE PHONE CSPROC JESS, LISA A

2010-11-16 End Date: 12:12:52 End Time:

User Name: DTM Description:

Comments:

Status:

Queue:

Heritage Union Life Insurance Company

THE RESIDENCE OF THE PROPERTY OF THE PROPERTY

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.

Re: Insured: Simon Bernstein

A STATE OF THE STA

Policy Number: 1009208 Page 2

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

AND THE STATE OF T

AWD History for Work object key 2010-12-13-09.00.00.199281T01 JLIFE - REINST - INCOMPLETE - END - Updateable - 1009208 - - BERNSTEIN - SIMON - 19 -

Social Security Num:

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: User Id:

16:21:03 **JSIMMS**

DTM Job Name: DTM Return Code:

Workstation Id: Business Area:

DTM Task Name: DTM Next Task:

Type:

End Date: End Time:

2010-12 16:21:03 2010-12-15

Status: Queue:

ARNOUDTS, STACY

User Name: DTM Description:

Comments:

sent forms again...

Begin Date:

2010-12-14

Flags:

Begin Time: User Id:

14:41:15 JI.YONKA

DTM Job Name: DTM Return Code: DTM Task Name:

Workstation Id: Business Area: Type:

DTM Next Task: End Date: End Time:

2010-12-14 14:41:15

Status: Queue: User Name:

LYONS, KERI A

DTM Description:

Comments:

sent additional info to aof

Begin Date:

2010-12-14 14:41:00

JLIFE

9996N1 Flags:

Begin Time: User Id:

JLYONKA

DTM Job Name: DTM Return Code:

Workstation Id:

DTM Task Name:

Business Area: Type:

DTM Next Task: End Date:

REINST INCOMPLETE Status: END

2010-12-14 14:41:03 End Time:

Queue: User Name:

LYONS, KERI A

DTM Description:

Comments:

9990NO

Begin Date: Begin Time: User Id:

2010-12-14 14:40:55 JLYONKA

Flags: DTM Job Name: DTM Return Code:

Workstation Id: Business Area:

DTM Task Name: DTM Next Task: End Date:

End Time:

Type: Status: Queue:

REINST CSPROC CSPROC

JLIFE

2010-12-14 14:40:55

AND THE PROPERTY OF THE PROPER

AWD History for Work object, key 2010-12-13-09.00.00.199281T01

JLIFE - REINST - INCOMPLETE - END - Updateable - 1009208 - - BERNSTEIN - SIMON - 19 -

Social Security Num: Agent Number:

Policy Number: 1009208

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: Begin Time: User Id:

2010-12-14 08:58:03 INAZAM

Flags: DTM Job Name: DTM Return Code: DTM Task Name:

Workstation Id: Business Area:

Type:

DTM Next Task: End Date: End Time:

Status: Queue:

User Name: DTM Description: Comments:

NAZAR, MUDDASAR

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

Begin Date:

2010-12-14 08:50:43

Flags:

9990N0

2010-12-14

08:58:03

Begin Time: User Id:

INAZAM

DTM Job Name: DTM Return Code: DTM Task Name:

Workstation Id: Business Area:

JLIFE REINST CSPROC

DTM Next Task: End Date: 2010-12-14 End Time: 08:58:19

Type: Status: Oueue:

CSPROC NAZAR, MUDDASAR

User Name: DTM Description:

Comments:

7500NO

Begin Date: Begin Time: User Id:

2010-12-13 09:58:45

Flags: DTM Job Name:

IGARGAX

DTM Return Code: DTM Task Name: DTM Next Task:

Workstation Id: Business Area: Type:

JLIFE REINST ALPHAMATCH CSPROC2 GARG, AMIT X

End Date: 2010-12-13 End Time: 09:59:23

Status: Queue: User Name:

DTM Description:

Comments:

AWD History for Work object key 2010-12-13-09.00.00.199281T01

JLIFE - REINST - INCOMPLETE - END - Updateable

1009208 - - BERNSTEIN - SIMON - 19 -

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

9500NO

Begin Time: User Id:

09:00:00 JBAUESK

Flags: DTM Job Name:

Workstation Id:

DIM Return Code: DTM Task Name: DTM Next Task:

Business Area:

JLIFE

Type:

CSGENERIC SCANNED

End Date:

Status:

INDEX

2010-12-13 09:00:00 End Time:

Queue: User Name:

BAUER, SHAWNETTE K

D'IM Description: Comments:

JCK000165

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.

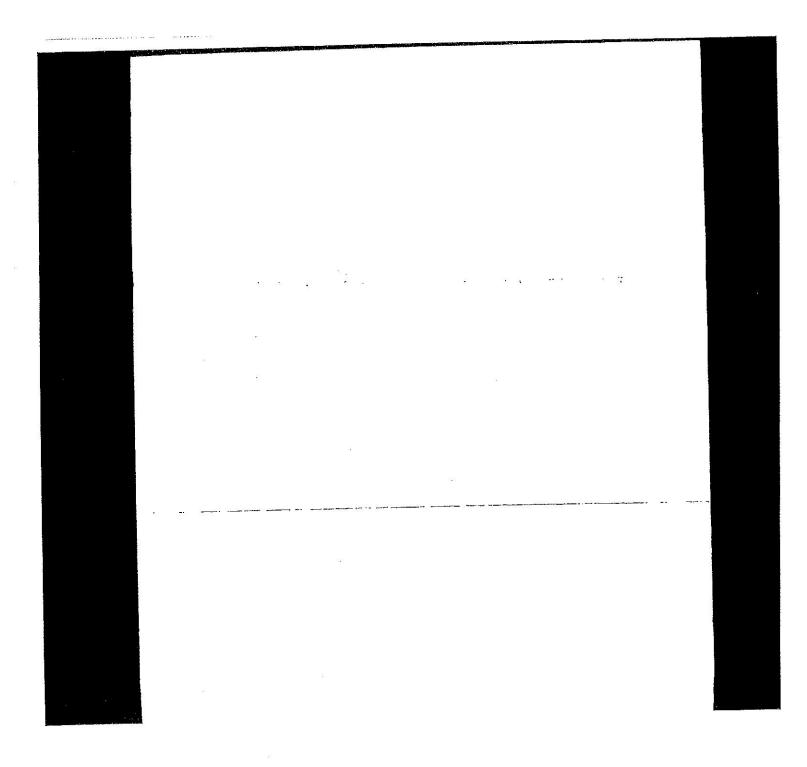
Sincerely,

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

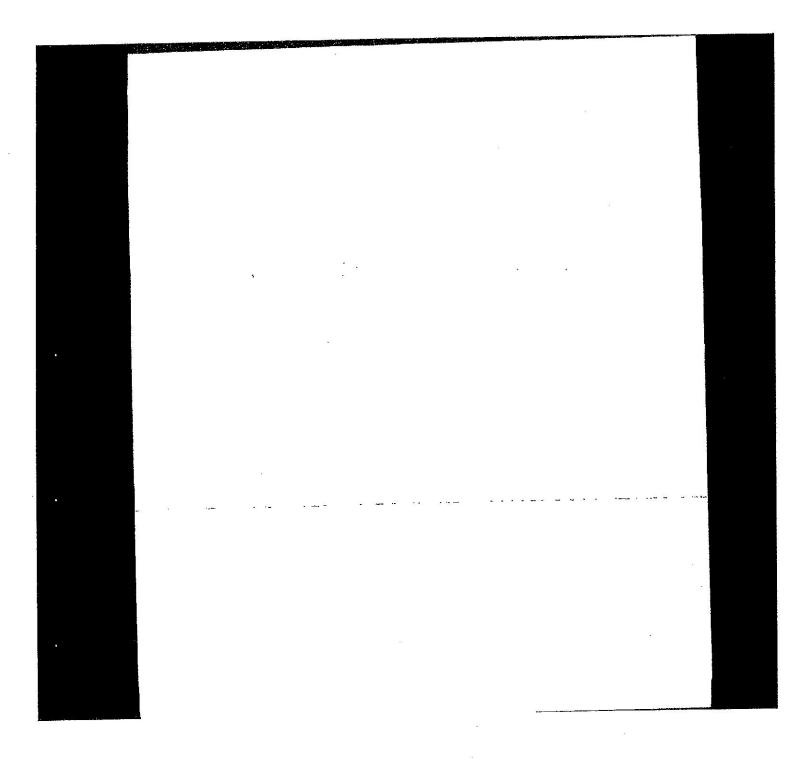
Date of birth

(please print)

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.



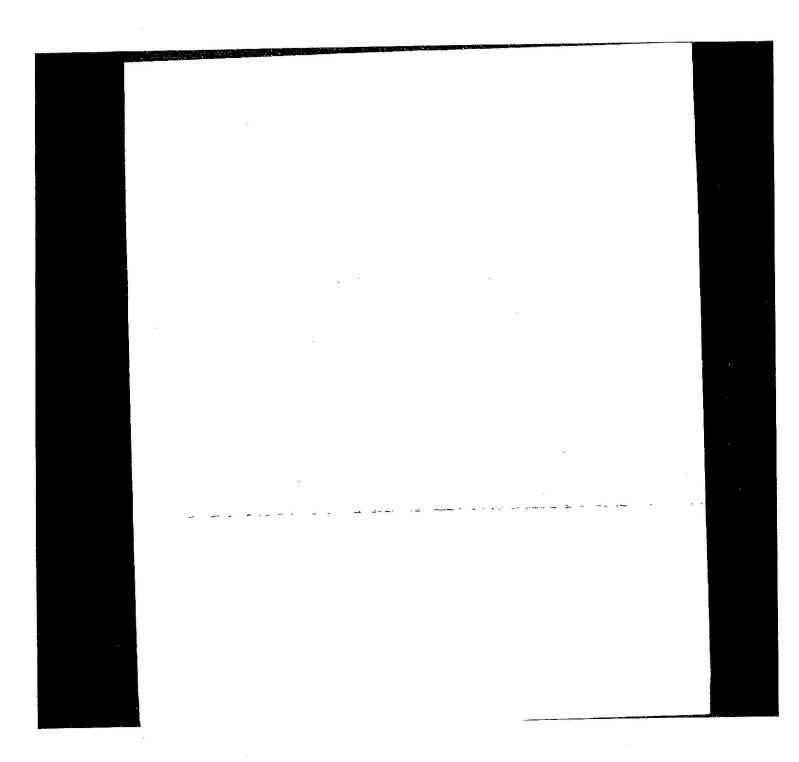
I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to the Company at the address above. correspondence. A revocation of this Authorization is not effective to the extent that the Company or others have relied on it, or to the extent that 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

Description of Legal Representative's Authority or Relationship to Patient

Health Authorization (2.4)

Insured Copy



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

1009208

Simon C. BRANSTEIN

Date of birth

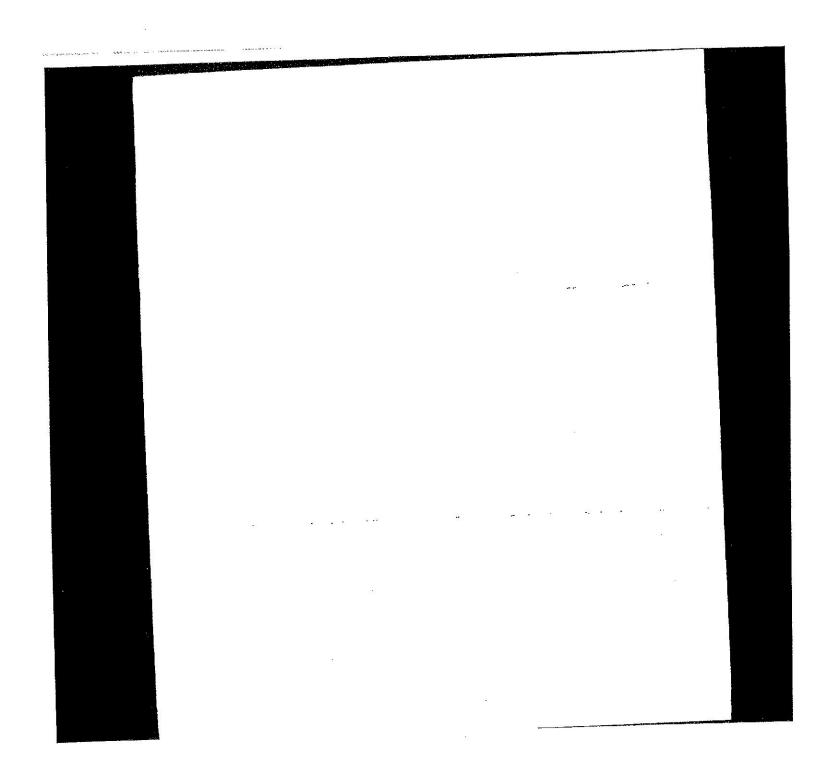
Policy Number

Name of proposed insured/patient (please print)

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.



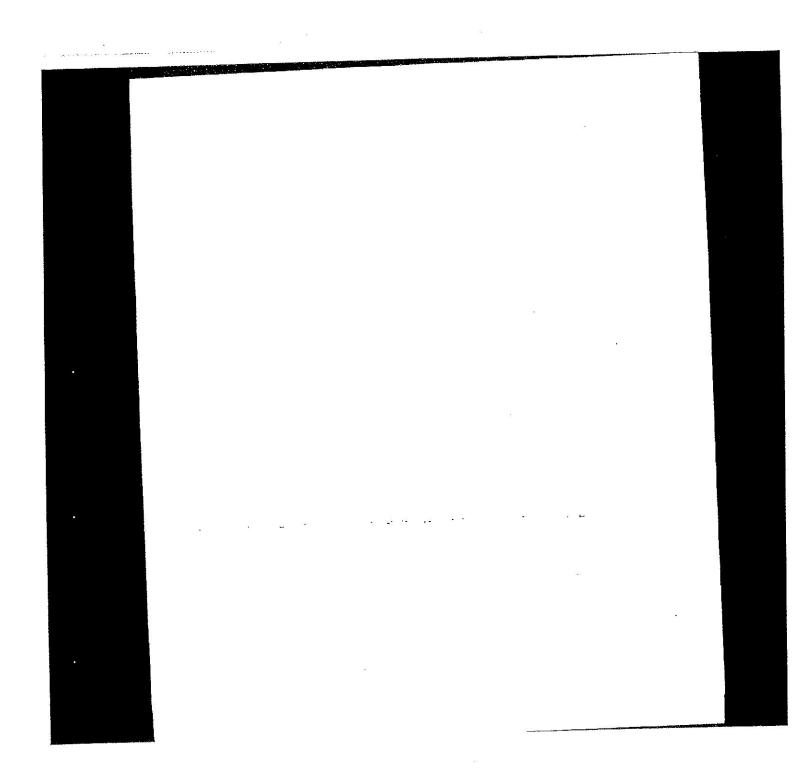
I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to the Company at the address of correspondence. A revocation of this Authorization is not effective to the extent that the Company or others have relied on it, or to the extent that the 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

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 consumer reporting agency to detect or prevent traud.

 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?

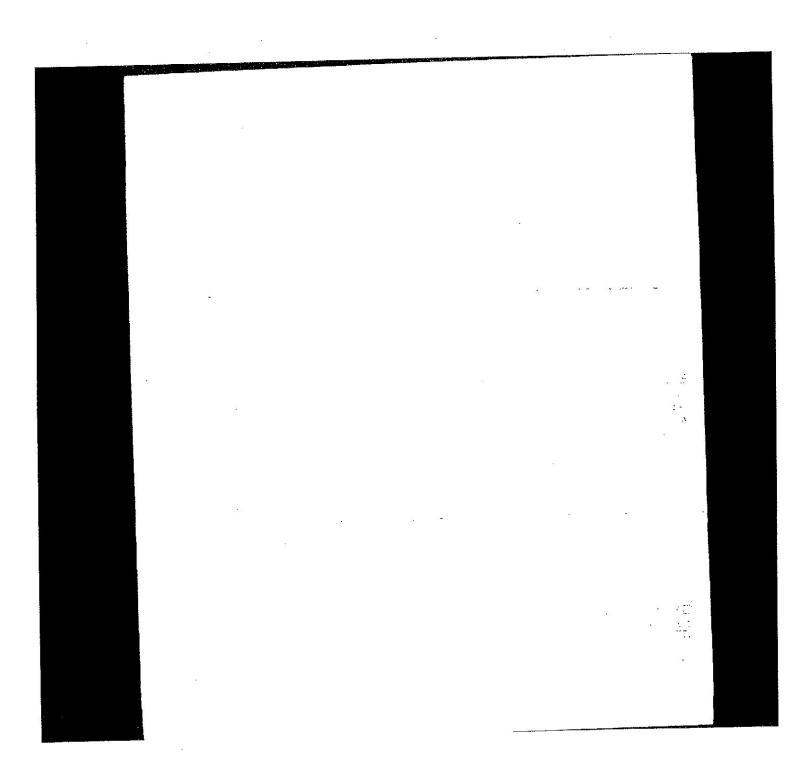
- You have the right to know what NPI we have collected about you; this does not apply to NPI that relates to an actual or possible claim or civil or criminal action. You may ask us in writing to correct any NPI you believe is not correct.
- You may ask us in writing for a list of those to whom we have 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., Atin: Legal Department, 1700 Magnavox Way, Fort Wayne, IN 46804. Contact Customer Service for questions about your policy.

01/08 Privacy Notice

でいる



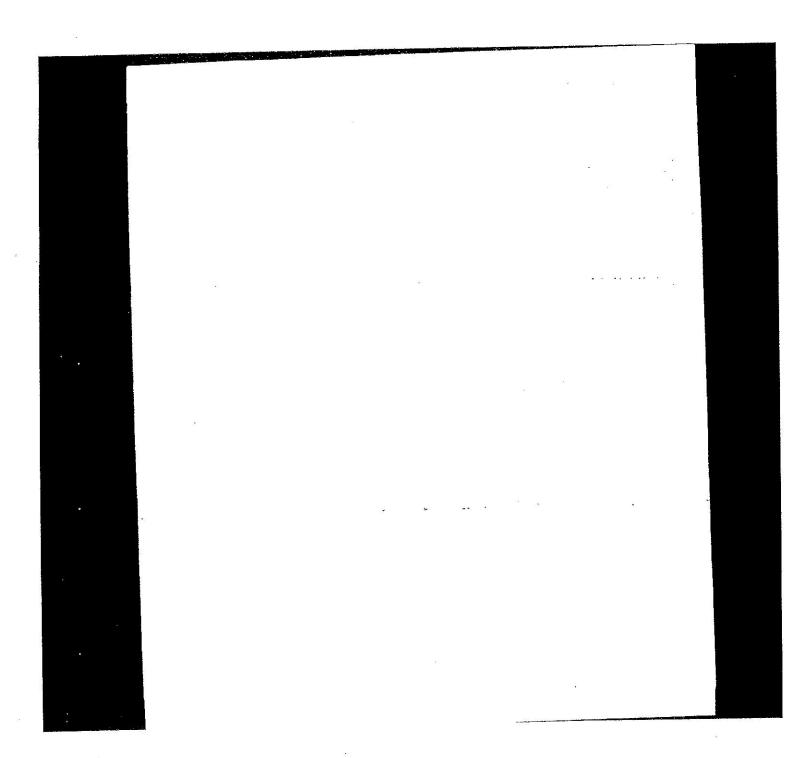
Annuity & Life Reassurance America, Inc. Home Office: Hartford, CT 06103 ("the Company") POLICYOWNER PLAN CHANGE/ REINSTATEMENT REQUEST PART 1

Service Bureau: 1x -P.O. Box 1147 Jacksonville, IL 62651 (800) 825-0003

INSTRUCTIONS: • Check [] for service de Servicing Office • For Change of Benefic SIGNATURE REQUIREMENTS: • Insured	sired • Indicate to what addr- iary, complete separate form, , if age 15 or older • Owner,							
 Corporate officer with title, if policy is corp lolicy Number 	orate-owned. Insured (also called _xou')	1steir				Insured's Date of Birth		
nsured's Address	Simon Ber	CACOLO			Insured's	Social Security Number		
June or Assignee					Owner's	Social Security Number .		
2750.00 (27 (27 (27 (27 (27 (27 (27 (<u> </u>				Phone Humber		
Swner or Assignee Address and Phone Number	!f			0	Agensy	- Impe Holitoei		
Servicing Agent's Name	Agancy Coda				Agent Co	ode .		
Will not process without valid insured's Social Return all Items to: Owner General Age	Security Number and Owner's ncy Other (specify)	Social Se	curity or Tax I	dentification N	lumber.			
TRADITIONAL UNIVERSAL LIFE								
Old Plan; Old Benefil Am		Name and Addition	Plan		New Benefit Amount: \$			
If converting part of a term policy or term life if	der, is the balance to be retain	ed or drop	ped7 Re	lain \$	☐ Dro	·		
Death Benefil Option (Universal Ula ONLY); {			declare the O	riginal Policy	Contract has	been lost or destroyed		
Benefils:	Currently on Policy (Check Answer)	Add	Delete	Increase	Decrease	Invoint well		
Accidental Death	Yes No					<u>.</u>		
Waiver of Premium (or GOI If UL)	☐ Yes ☐ No			· 🗆				
Monthly Disability Benefit (UL ONLY)	☐ Yes ☐ No		\Box	a,		<u> </u>		
Guaranteed Purchase Option	☐ Yes ☐ No							
Riders:								
Spousa's Level Term Ridar	Yes No			□ .		£		
Children's Term Rider	☐ Yes ☐ No					1		
Primary Insured Term Rider	☐ Yes ☐ No					¥		
Other Insured Term Rider	☐ Yea ☐ No							
Other Riders (specify);			_					
	C Yes C No					<u> </u>		
	☐ Yes ☐ No					3		
	☐ Yes ☐ No				<u> </u>	<u> </u>		
Do you currently use any tobacco product?			of tobacco do :			Cigars Pipe Smokeless		
Have you ever used any tobacco product?	1							
BILLING INSTRUCTIONS: MODE: Annual Semi-Annual Ouart Government Albiment	erly Monthly Non-bill	BILLING	S TYPE:	Oirect □Li	ist bill 🔲 🛭 🖰 🖰	AC		
ew Planned Periodic Premium: \$ Amount Enclosed: \$								
SPECIAL INSTRUCTIONS:								
				<u>.</u>		· · · · · · · · · · · · · · · · · · ·		
· · · · · · · · · · · · · · · · · · ·								
4L-A-01								

ites lions fran Lance Simon Benestain 78.5.51

PARTI APPLIC	ATION FOR [] In	crease \$25,000 ar	less TRe	instate	ment		ıdd Rider	ar Beni	efit			13 13 13 13 13 13 13 13 13 13 13 13 13 1	÷		
Preferred Non-S	moker Select i	lon-Smaker [Lieuw doug	ersion	Po	olicy i	thinder =		·						
(Paol first name, middle i	kullal, and last name)	Occupation	Relationship To Proposed Insured	Qa dinent	e of Bir Oay	<u>т</u> } Үезг	Age Nearest Birthday				Now	ioh(Yr. ago			
1. a. Proposed			rda.												
hsured: b. Second															
	lan, Spouse Rider, Other	Innuend Bidas os Chi	deen's Team	l —							L				
	ian, spoose moer, Coler	2/130/80 7/700/ 0/ 0/	Spouse												
2. a. b.			Children									600000000000000000000000000000000000000			
			, , , , , , , , , , , , , , , , , , , ,									70.000 000			
Cine delaits in "Comp	nents" section following t	he questions for any	YES' answers	to ques	tions 3	throu	gh 8 and 10	lhrough	15.						
2 Wilhin the past 10	veaes, has any person p	roposed for coverage	<u>:</u>							Vennonno					
3. Within the past 10 years, has any person proposed for coverage: a. Bean examined by or consulted a physician or other practitioner?											e)Yes				
h Reen under s	observation or treatment	n a hospital or any o	ther form of he	alth care	racib)	γ?						☐Yes			
r Had an X-ray	, electrocardiogram, bloc	x) test, wine or other	laboratory test	137								@Yes			
	CI . MINI -10	and for reverse	· · · · · · · · · · · · · · · · · · ·						·			©×es	-CM의-		
a. Received bei	nellis or compensation to	r sickness or Injury, o	or had life or di	sability l	nsuran	ce ma	dified, rejec	led, not	renewer	, or to	SURG	Elics	□No		
	dard dele?											[]Yes	(ZMO		
b. Sought advice	ce or Irealment for, or bee rase of the reproductive of	construction of the	hreasts, or a	ny ampu	dation	or bod	lity Infirmity.	hemia	r ruplur	e.		☐Yes			
d Been advised	to have any diagnostic i	esi, hospitalization, o	or antidery muje	h was n	ot com	pleted	?					☐Yes	-		
5. Within the past 10	years, has any persons i	proposed for coverag	a had or been	treated t	lor.							☐YE5			
a. Any disease or disorder of the eyes, ears, nose, throat, or thyroid gland?										Yes					
		I	er or idials?									□Yes			
c. Chest pain, heart marmur, high blood pressure, or any other disease or disorder of the heart, dramatory system, doct or the									ETY 83	□No.					
vessels?	Indianction or other dise	are of the sigmach.	intestines, gall	bladder.	liver, j	pancre	as, spiese,	or entary	ed lym	nh gis	nda?	□Yes	EW ₀		
vesatis? d. Popilic ulder, indigestion, or other disease of the stornach, intestines, gall bladder, liver, pancreas, splean, or enlarged lymph glands? e. Tuberculosis, astima, pleurisy, or any other disease of the chest or lung?									☐Yes	□No.					
									OYes	EMO					
 Albumin, pus Severe head; 	, blood or sugar in unne. sches, fainling spells, dix	ziness, verligo, sync	ope, apilepsy.	neryous	ness, p	aralys	la, mental d	sorder,	depress	ion, o	rany	□Yes	PNo		
												☐Yes	EJKO		
h, Rhoumalic or	other fever, diabetes, sy	philis, gout, arthrips,	gotter, cancer,	aurika o	- USG	tioned	La bour will	in the or	at 10 v	2017		☐Yes			
 Any surgical of 	operations, treatment, or ears: To the best of your	any iliness, airment	abnormality, of	n lar co	verage	had	r been lold	by a me	tical on	fessk	not.	TYes			
												_			
7 Is any person fitting	osed for coverage now 0	romant? [II "YES . I	окомов ста сти	in a sylve	cted d	ua dat	e in "Comm	enis7				□Y99			
C	mend for coverage new II	orier medical treatme	nt or taking an	iy presa	i nough	unigs:						(3)Xes			
2 Z- th- hard plant	korusindon ata ali nersr	ns proposed for cov	erage now in 9	ood heal	m? D	NO.	binaige pe	lails in 10	Comman	137		∐Yes			
40 11	paced for roverage any	intention in travel of	reside outside	the Unit	ed. Sta	tes or	Canaday					☐Yas			
44 Vot any name on or	consed for coverage with	In the past two years	flown as a pile	ot, stude	ut buo	OL ELE	w member	or Intend	to do s	a 7		Yes			
17 Has any nerson of	enosed for coverage unit	aged in, or intend to	engage in, und	erwater	diving,	nang	Briging of b	arachulir	ng?			☐Yes			
11. Has any person proposed for coverage engaged in, or intend to engage in, underwater diving, hang gliding or parachuting? 13. Has any person proposed for coverage engaged in, or intend to engage in, competitive racing of any kind?									☐Yes	_/					
13. Has any person proposed for coverage had a driver's license auspended or revoked, or been convicted in the last 3 years of a moving left, Has any person proposed for coverage had a driver's license auspended or revoked, or been convicted in the last 3 years of a moving delation or of driving white impaired, Intoxicated, or under the influence of drugs or alcohol?								'	□Yes						
15. Has any person proposed for coverage ever been convicted of a felony?								□Yes	ENO						
	mber and item(s) that you			nosis, Ph	ysidar 	1 Name	and Addin	is, and n	arne of U	ne He	alth Care	Facility.			
					7			Derth		1					
16. Family History	Age(s) (il living)	Condition of Health	h Age(s	1 at Deal	in		Cause o	Deam		7 ~	<u>nol</u> ans Good, g	va			
Wife of Husband	 '\ 	& AIR		7			Leave			1 0	etails ab	ove.			
Father Violher				4		- 18	'8			4					
Sister(s)	80	Sam		9			RIBAT	rea							



AGREEMENT AND SIGNATURE FOR PARTS 1 & 11 (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 luther the 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 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 assigness, beneficiaries or owners, unless otherwise provided, the reinstatement of a policy reinstates interests of any assigness, 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 tha

changed only to the e	xtent provided.	1	a sample lad butha	Company and arrest for myself.	(nuceelves)
The undersigned for	inest(s) matem transactions	s or sukace and and	In colonia indemnih	Company and agree for myself, y and hold the Company harmle seet warrant(s) that all persons	ss from any
heirs, beneficiarias ar	id all others claiming under	the above policy	to release, indeprining	essly warrant(s) that all persons of them.	signing
tiability incurred becau	use of completing the above	transactions. In	e ditoeraigned oxpre	ofthere	
below are of legal age	and that no ofgcaegings in	pandable, are i	periony against any	22 Day of NOV	•
		A KATAN	this	Day of July	
Oated at (City and Sta				•	
2010					
0	-				
11	······································				
				a contract of the contract of	
100		 .			
1				er(s) Assignee(s) (Please ind	-1- 40-1
Witness (not related) o	Agent		insured(s), Owner	r(s), Assignee(s) (Please inc	icale one)
(Titalicas (Siar) and ory		9800		400	
Address			Address		12
Michael			100000		
City	State	Ziρ	City	State	Zip
City			TOD DABT II		
	· AD	THORIZATION	POR PART II	-to as other medical as medical	v related
The undersigned auth	orize(s) any Reensed physic	ian, medical prac	colloner, nospital, chi	nic, or other medical or medical tution or person, that has any re	cords or
facility, insurance com	pany, the Medical Informati	ou Brisan ot our	er organization, bisk	tution or person, that has any re	or Rs
knowledge of me or i	my health or the health of ar	ny family depend	ent applying to a su	rance, to give to the Company, lid as the original, I agree that	his
authorization shall be	valid for two and one half ye	ars from the date			
Dated at (City and Sta			this 30 !	Day of NOV	
Dated at (City and Sta	ie)	·			
					
1 in	garages of the		** (! la ha !	naured) or Second Proposed insure	d (it J.W.L.)
Proposed Insured (if ag	g 16 of over)		Spouse in more	Hatried) or adventil a toposide in acco	
- Taban				posed Insured) and relationship	
Witness (not related) or	Agent		Owner (it not Più	bazed trizateo) and resemplarish	
Telephone Number Ida			(night): ()	· ·	
relepache Number Jus	7 1 1 1				

AL-A-01