

Heritage Union Life Insurance Company

P. O. Box 1147, Jacksonville, IL 62651-1147

Phone 800-825-0003 Fax 803-333-7842

Visit us at www.insurance-servicing.com

September 05, 2012

SIMON BERNSTEIN
7020 LIONS HEAD
BOCA RATON FL 33496

Insured Name: SIMON BERNSTEIN
Policy Number: 1009208
Correspondence Number: 11643235

Dear SIMON BERNSTEIN:

Thank you for contacting Heritage Union Life Insurance Company. As requested, an Illustration Form is enclosed. Please complete and sign this form and return to our office.

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): Illustrations Request

JCK000408

Heritage Union Life Insurance Company

800-825-0003

I am requesting an Illustration/Reprojection for policy number 1009208, insuring the life of SIMON BERNSTEIN .

Name and Phone of contact in the event we have questions

Universal Life Policy

- Current death benefit and premiums
 - Minimum premiums to endow at maturity
 - Minimum premiums to carry to maturity
 - Other specific request
-
-
-

We provide one illustration request, with up to three re-proposal scenarios per policy per year at no charge. Any additional requests require \$25.00 fee prior to running the illustration.

I have enclosed a check or money order payable to Heritage Union Life Insurance Company for:

<input type="checkbox"/> First request per year	Free
<input type="checkbox"/> Additional requests	\$25.00 each
TOTAL	\$ _____

Please allow 7-14 business days from the date of receipt in our office for processing.
Thank you.

Please return illustration to:

Name:	_____
Address:	_____ _____
Fax:	_____
Phone:	_____ _____

Policy Owner Signature

Date

AWD History for Work object key 2012-09-20-17.16.00.812221T01

JLIFE - POLRES - QPASS2 - END - Updateable

1009208 - - BERNSTEIN - SIMON - 19 -
Social Security Num: [REDACTED] Policy Number: 1009208

Agent Number: [REDACTED]

Insured's Last Name: BERNSTEIN

Printed on Tuesday, May 07, 2013 at 2:54:53PM

0000=

Begin Date: 2012-10-03 Flags: 9990N0
Begin Time: 13:42:06 DTM Job Name:
User Id: JRUSSBS DTM Return Code:
Workstation Id: DTM Task Name:
Business Area: JLIFE DTM Next Task:
Type: POLRES End Date: 2012-10-03
Status: QPASS2 End Time: 13:42:10
Queue: END
User Name: RUSSWINKEL, BARB S
DTM Description:
Comments:

Begin Date: 2012-09-27 Flags: 9990Y2
Begin Time: 05:12:41 DTM Job Name:
User Id: AMULDCX DTM Return Code:
Workstation Id: DTM Task Name:
Business Area: JLIFE DTM Next Task:
Type: POLRES End Date: 2012-09-27
Status: QPASS End Time: 05:12:53
Queue: CSQC
User Name: MULDER, CORA X
DTM Description:
Comments:

Begin Date: 2012-09-26 Flags:
Begin Time: 09:38:29 DTM Job Name:
User Id: ASOLOA DTM Return Code:
Workstation Id: DTM Task Name:
Business Area: DTM Next Task:
Type: End Date: 2012-09-26
Status: End Time: 09:38:29
Queue:
User Name: SOLOMONS, AVRIL
DTM Description:
Comments: as per notepad - Diana Banks authorized

Begin Date: 2012-09-26 Flags:
Begin Time: 09:26:17 DTM Job Name:
User Id: ASOLOA DTM Return Code:
Workstation Id: DTM Task Name:
Business Area: DTM Next Task:
Type: End Date: 2012-09-26
Status: End Time: 09:26:17

JCK000410

AWD History for Work object key 2012-09-20-17.16.00.812221T01

JLIFE - POLRES - QPASS2 - END - Updateable

1009208 - - BERNSTEIN - SIMON - 19 -

Social Security Num: [REDACTED]

Policy Number: 1009208

Agent Number: [REDACTED]

Insured's Last Name: BERNSTEIN

Printed on Tuesday, May 07, 2013 at 2:54:53PM

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Queue:
User Name: SOLOMONS, AVRIL
DTM Description:
Comments: reviewed 5 files attached, no trust docs
prev polres, see lett dtd 05/11/2012

Begin Date: 2012-09-26 Flags: 9990Y2
Begin Time: 09:10:07 DTM Job Name:
User Id: ASOLOA DTM Return Code:
Workstation Id: DTM Task Name:
Business Area: JLIFE DTM Next Task:
Type: POLRES End Date: 2012-09-26
Status: PROCESSD3 End Time: 09:39:09
Queue: CSQC2
User Name: SOLOMONS, AVRIL
DTM Description:
Comments:

Begin Date: 2012-09-24 Flags: 4000N0
Begin Time: 17:51:09 DTM Job Name:
User Id: IVERMNX DTM Return Code:
Workstation Id: DTM Task Name:
Business Area: JLIFE DTM Next Task:
Type: POLRES End Date: 2012-09-24
Status: ALPHAMATCH End Time: 17:53:43
Queue: CSPROC2
User Name: VERMA, NAVEEN X
DTM Description:
Comments:

Begin Date: 2012-09-21 Flags: 9990N0
Begin Time: 05:45:24 DTM Job Name:
User Id: IHASHS DTM Return Code:
Workstation Id: DTM Task Name:
Business Area: JLIFE DTM Next Task:
Type: POLCERT End Date: 2012-09-21
Status: ALPHAMATC2 End Time: 05:45:48
Queue: CSPROC
User Name: HASHMI, SADIYA
DTM Description:
Comments:

JCK000411

AWD History for Work object key 2012-09-20-17.16.00.812221T01

JLIFE - POLRES - QPASS2 - END - Updateable

- 1009208 - - BERNSTEIN - SIMON - 19 -
Social Security Num: [REDACTED] Policy Number: 1009208

Agent Number:

Insured's Last Name: BERNSTEIN

Printed on Tuesday, May 07, 2013 at 2:54:53PM

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Begin Date:	2012-09-20	Flags:	9900N0
Begin Time:	17:16:00	DTM Job Name:	
User Id:	FAXSRVR	DTM Return Code:	
Workstation Id:		DTM Task Name:	
Business Area:	JLIFE	DTM Next Task:	
Type:	FAX	End Date:	2012-09-20
Status:	FAXED	End Time:	17:16:00
Queue:	INDEX		
User Name:	Fax Server UserId, BATCH		
DTM Description:			
Comments:			

September 20, 2012

Heritage Insurance Company
Fax: 803-333-7842

Policy number: 1009208

To Whom It May Concern:

I previously requested a copy of the Simon Bernstein Irrevocable Insurance Trust dated June 21, 1995 which is the beneficiary of the above referenced policy. I received a response via fax with documents but the requested Trust was not included.

Please fax a copy of the Trust to Robert Spallina at 561.997.7308.

Please feel free to call me with any questions at 561.239.2986.

Thank you,



Diana Banks

Heritage Union Life Insurance Company

PO Box 1147, Jacksonville, IL 62651-1147

Phone 800-825-0003 Fax 803-333-7842

Visit us at www.insurance-servicing.com

September 26, 2012

SIMON BERNSTEIN
7020 LIONS HEAD
BOCA RATON, FL 33496

Insured Name: SIMON BERNSTEIN
Policy Number: 1009208
Correspondence Number: 09755734

Dear Policyowner:

Thank you for contacting Heritage Union Life Insurance Company. We appreciate your business and welcome the opportunity to be of service.

This letter is in response to your recent inquiry regarding the above-referenced policy. Please be advised that according to our records, we do not have any trust documents on file.

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

JLIFE - ADDCHGB - RIPPED - END - Updateable
- 1009208 - - - - 19 -

Social Security Num:
Agent Number:

Policy Number: 1009208

Insured's Last Name:

Printed on Tuesday, May 07, 2013 at 3:09:37PM

Begin Date: 2012-12-08 Flags:
Begin Time: 13:00:48 DTM Job Name:
User Id: AWDICYCLE DTM Return Code:
Workstation Id: DTM Task Name:
Business Area: DTM Next Task:
Type: End Date: 2012-12-08
Status: End Time: 13:00:48
Queue:
User Name:
DTM Description: Batch Station & User, BATCH
Comments: NCOA file address update.
 OLD Address: 7020 LIONS HEAD BOCA RATON, FL 33496
 NEW Address: 880 BERKELEY ST BOCA RATON, FL 33487-2450

Begin Date: 2012-12-08 Flags: 9990N0
Begin Time: 13:00:48 DTM Job Name:
User Id: AWDICYCLE DTM Return Code:
Workstation Id: DTM Task Name:
Business Area: JLIFE DTM Next Task:
Type: ADDCHGB End Date: 2012-12-08
Status: RIPPED End Time: 13:00:48
Queue: END
User Name:
DTM Description: Batch Station & User, BATCH
Comments:

**Policy Number
1009208**

File Docs 1



Capitol Bankers Life

1 OF APPLICATION TO

CAPITOL BANKERS LIFE INSURANCE COMPANY
Home Office: Minneapolis, Minnesota
Administrative Office: 735 North Water St. P.O. Box 2016
Milwaukee, Wisconsin 53201 (414) 277-9998

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

1009208

PERSONS TO BE INSURED (Print First Name, Middle Initial, Last Name) Sex Age Birthdate State of Birth Ht. Build Wt. Social Security Number
PROPOSED INSURED SIMON BERNSTEIN M 12/3/35 MICH
SPOUSE (if to be insured or Payor)
DEPENDENT CHILDREN IF TO BE INSURED
Residence Address 620 N. SHERIDAN RD. Employer S.B. LEXINGTON, INC.
City GLENCOE State ILL. Zip 60022 Business Address 9933 LAWLER
County Telephone No. Occupation EXECUTIVE
Proposed insured will be owner of policy unless otherwise indicated.
Owner's Name First Arlington National Bank, Trustee Social Security Number
Mailing Address Of S.B. Lexington, Inc. Employee Death Benefit Trust
Relationship to Proposed Insured

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

LIFE INSURANCE OR ANNUITY APPLIED FOR:

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

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

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

Table with 4 columns: Name of Company, Coverage (Life), Amount of Acc. Death, Year of Issue. Row 1: INTER-OCEAN, 1,000,000, 80

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

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

Remarks/Amendments PLEASE SEND PREMIUM NOTICES TO: * S.B. Lexington, Inc. Employee Death Benefit Plan, c/o National Service Association 9933 Lawler Suite 210 Skokie, Illinois 60077

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

ACKNOWLEDGEMENT AND AUTHORIZATION

I hereby acknowledge receipt of a notice titled "Notice to Applicants for Insurance" respecting the filing and distribution of medical information concerning myself and receipt of a notice respecting the Fair Credit Reporting Act. Public Law 91-508. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person that has any records or knowledge of me or my health to give to the Capitol Bankers Life Insurance Company or its reinsurers any such information. A photographic copy of this authorization shall be as valid as the original.

Is there a replacement involved in this transaction? Yes No
Signed at CHICAGO, ILLINOIS City State
Signature of Proposed Insured
Date 3/2/82

- 9.a. Name and address of personal physician? _____
 (If none, so state)
- b. Date, reason and who last consulted the above? _____
- c. What treatment was given or medication prescribed? _____

To the best of your knowledge and belief has any person proposed to be insured:

Give details in the space below for any question answered YES. Include the NAME and ADDRESS of the attending practitioner.

- | | Yes | No |
|--|--------------------------|--------------------------|
| 10. Ever had any indication or disorder or diagnosis, or treatment of: | | |
| a. The lungs or respiratory system including hayfever or other allergies, asthma, bronchitis, tuberculosis or emphysema? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. The heart or circulatory system including high blood pressure, heart attack, heart murmur, or chest pain, irregular heartbeat or varicose veins or phlebitis? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. The digestive system including ulcer, gastritis, intestinal disorders, colitis, gall bladder, hemorrhoids, disorder of the pancreas, liver or spleen? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. The nervous system, including epilepsy, convulsions, headaches, paralysis, mental disorders, nervousness, or psychiatric treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. The genitourinary system including any kidney disorder, kidney stones, cystitis, prostatitis, or bladder infections? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Diabetes or sugar in the urine, thyroid or other glandular disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. The muscular or skeletal system including arthritis, gout, rheumatism, any back or spine disorders or treatment of muscle disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Cancer, tumor, cyst, or growth of any kind? | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Eyes or ears including impaired sight or hearing? | <input type="checkbox"/> | <input type="checkbox"/> |
| j. If Applicable: Any disorder of the generative organs including irregular menstruation? | <input type="checkbox"/> | <input type="checkbox"/> |
| Any complications of pregnancy? | <input type="checkbox"/> | <input type="checkbox"/> |
| Any existing pregnancies? | <input type="checkbox"/> | <input type="checkbox"/> |
| If "yes," how many months? | | |
| 11. Ever had surgery or has surgery ever been recommended? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Had an electrocardiogram, chest x-ray, or blood study of any kind in the past five years? If yes, give name of physician completing test and results. | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Currently taking medication or medical treatment of any type? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Ever been treated for alcoholism or drug addiction or ever a member of Alcoholics Anonymous? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Been deferred or discharged from military service for physical or mental reasons? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Made claim for or received disability payment for an injury or sickness? | <input type="checkbox"/> | <input type="checkbox"/> |

I REPRESENT THAT the statements and answers in Part I, together with those in Part II, (Medical Examination if needed) in connection with this application, are full, complete and true to the best of my knowledge and belief and it is agreed that all such statements and answers shall form the basis for and be a part of the proposed contract of insurance.

Signed at _____
 City State Date

Agent _____ Proposed Insured _____

AGENT'S REPORT

Pay commissions to:

- _____ % Agent's # _____
- _____ % Agent's # _____
- _____ % Agent's # _____
- _____ % Agent's # _____

Examination arrangements:

- Doctor _____
- Will examine Applicant on _____ 19____
- Doctor's phone number is _____

HOME OFFICE USE ONLY

To identify special markets, check box.

- RLR
- IRA
- Pension
- Business Case: Buy-Sell,
- Estate Analysis
- Sec. 79



Capitol Bankers Life

PART I OF APPLICATION TO

CAPITOL BANKERS LIFE INSURANCE COMPANY
Home Office: Minneapolis, Minnesota
Administrative Office: 735 North Water St. P.O. Box 2016
Milwaukee, Wisconsin 53201 (414) 277-9998

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

PERSONS TO BE INSURED (Print First Name, Middle Initial, Last Name) Sex Age Birthdate State of Birth Build Ht. Wt. Social Security Number
PROPOSED INSURED Simon Bernstein M 12/13/35 Mich 57 180
SPOUSE (if to be insured or Payor)
DEPENDENT CHILDREN IF TO BE INSURED
Residence Address 620 SHERIDAN DR. Employer S.B. LEXINGTON, INC.
City Glenview, State IL Zip Business Address 9933 LAWLER SUITE 210
County Telephone No. Occupation SKOKIE, ILL. CHAIRMAN OF BOARD
Proposed insured will be owner of policy unless otherwise indicated.
Owner's Name First Arlington National Bank Trustee of S.B. Social Security Number
Mailing Address Lexington, Inc. Employee Death Benefit Trust
Relationship to Proposed Insured

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

LIFE INSURANCE OR ANNUITY APPLIED FOR:

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

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

Table with 4 columns: Name of Company, Coverage (Life), Amount of Acc. Death, Year of Issue

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

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

Remarks/Amendments S.B. Lexington, Inc. Employee Death Benefit Plan
c/o National Service Assoc.
Please send list billing to: 9933 Lawler, Suite 210
Skokie, Ill. 60077

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

ACKNOWLEDGEMENT AND AUTHORIZATION

I hereby acknowledge receipt of a notice titled "Notice to Applicants for Insurance" respecting the filing and distribution of medical information concerning myself and receipt of a notice respecting the Fair Credit Reporting Act, Public Law 91-508. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person that has any records or knowledge of me or my health to give to the Capitol Bankers Life Insurance Company or its insurers any such information. A photographic copy of this authorization shall be as valid as the original.

Is there a replacement involved in this transaction? Yes No
Signed at Chicago, Illinois
Signature of Proposed Insured
Signature of Applicant

NON-MEDICAL QUESTIONS (CONTINUATION OF PART I) This section must be completed for persons not required to complete Part II (Medical Examination)

9.a. Name and address of personal physician? Dr. Hubert Allen
 (If none, so state) Highland Park, Ill.
 b. Date, reason and who last consulted the above? 1980 Annual physical
 c. What treatment was given or medication prescribed? 1980 Annual physical

To the best of your knowledge and belief has any person proposed-to-be-insured: _____

Give details in the space below for any question answered YES. Include the NAME and ADDRESS of the attending practitioner.

- 10. Ever had any indication of disorder or diagnosis, or treatment of:
 - a. The lungs or respiratory system including hayfever or other allergies, asthma, bronchitis, tuberculosis or emphysema? Yes No
 - b. The heart or circulatory system including high blood pressure, heart attack, heart murmur, or chest pain, irregular heartbeat or varicose veins or phlebitis? Yes No
 - c. The digestive system including ulcer, gastritis, intestinal disorders, colitis, gall bladder, hemorrhoids, disorder of the pancreas, liver or spleen? Yes No
 - d. The nervous system, including epilepsy, convulsions, headaches, paralysis, mental disorders, nervousness, or psychiatric treatment? Yes No
 - e. The genitourinary system including any kidney disorder, kidney stones, cystitis, prostatitis, or bladder infections? Yes No
 - f. Diabetes or sugar in the urine, thyroid or other glandular disorder? Yes No
 - g. The muscular or skeletal system including arthritis, gout, rheumatism, any back or spine disorders or treatment of muscle disorder? Yes No
 - h. Cancer, tumor, cyst, or growth of any kind? Yes No
 - i. Eyes or ears including impaired sight or hearing? Yes No
 - j. If Applicable, Any disorder of the generative organs including irregular menstruation? Yes No
 Any complications of pregnancy? Yes No
 Any existing pregnancies? Yes No
 If "yes," how many months? _____
- 11. Ever had surgery or has surgery ever been recommended? Yes No
- 12. Had an electrocardiogram, chest x-ray, or blood study of any kind in the past five years? If yes, give name of physician completing test and results. Yes No
- 13. Currently taking medication or medical treatment of any type? Yes No
- 14. Ever been treated for alcoholism or drug addiction or ever a member of Alcoholics Anonymous? Yes No
- 15. Been deferred or discharged from military service for physical or mental reasons? Yes No
- 16. Made claim for or received disability payment for an injury or sickness? Yes No

Tonsillectomy - 1940
 Allergic Asthma
 Hayfever
 DR. ALLEN
 BRICANYL T1
 LAST TAKEN 9-7-82
 CHOLECYSTECTOMY - 1961
 DR. COHN
 WEISS MEM. HOSPITAL
 CHICAGO, ILL.
 HERNIORRHAPHY - 1967
 SKOKIE VALLEY HOSPITAL
 SKOKIE, ILLINOIS
 ANNUAL PHYSICAL - 1980
 DR. ALLEN
 EKG, X-RAY, ETC.
 Defered Because of
 GALLBLADDER Disease

I REPRESENT THAT the statements and answers in Part I, together with those in Part II, (Medical Examination if needed) in connection with this application, are full, complete and true to the best of my knowledge and belief and it is agreed that all such statements and answers shall form the basis for and be a part of the proposed contract of insurance.

Signed at Chicago, Ill. 10/12/80
 City State Date
Richard W. White Agent [Signature] Proposed Insured

AGENT'S REPORT

Pay commissions to:

_____% Agent's # _____
 _____% Agent's # _____
 _____% Agent's # _____
 _____% Agent's # _____

Examination arrangements:

Doctor _____
 Will examine Applicant on _____ 19____
 Doctor's phone number is _____

HOME OFFICE USE ONLY

To identify special markets, check box.

- RLR Business Case: Buy-Sell, Sec. 79
- IRA Keyman Estate Analysis
- Pension HR-10

06

PART II OF APPLICATION TO:

Capitol Bankers Life

CAPITOL BANKERS LIFE INSURANCE COMPANY
Home Office: Minneapolis, Minnesota
Administrative Office: 735 North Water St. P.O. Box 2016
Milwaukee, Wisconsin 53201 (414) 277-9998

PROPOSED INSURED:

BEANSTON SIMON L
Last Name First Name Middle Initial

Date of Birth 12 2 35
Mo. Day Year

Male Female

- 1. a. Name and address of your personal physician? DR. HERBERT ALLEN, HIGHLAND PARK, ILL.
b. Date and reason last consulted? 1980 - ANNUAL PHYSICAL
c. What treatment was given or medication prescribed? NONE

- 2. Have you ever been treated for or ever had any known indication of:
a. Disorder of eyes, ears, nose, or throat?
b. Dizziness, fainting, convulsions, headache, speech defect, paralysis or stroke, mental or nervous disorder?
c. Shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis, allergies, hayfever, or chronic respiratory disorder?
d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels?
e. Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion, or other disorder of the stomach, intestines, liver or gallbladder?
f. Sugar, albumin, blood or pus in urine, venereal disease, stone or other disorder of kidney, bladder, prostate or reproductive organs?
g. Diabetes, thyroid or other endocrine disorders?
h. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, including the spine, back, or joints?
i. Deformity, lameness or amputation?
j. Disorder of skin, lymph glands, cyst, tumor or cancer?
k. Allergies, anemia or other disorder of the blood?
l. Excessive use of alcohol, tobacco, or any habit-forming drugs?
3. Are you now under observation or taking treatment?
4. Have you had any change in weight in the past year?
5. Other than above, have you within the past 5 years:
a. Had any mental or physical disorder not listed above?
b. Had a checkup, consultation, illness, injury, surgery?
c. Been a patient in a hospital, clinic, sanitarium, or other medical facility?
d. Had electrocardiogram, X-ray, blood sugar, basal metabolism, other diagnostic test?
e. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed?
6. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition?
7. Have you ever requested or received a pension, benefits, or payment because of an injury, sickness or disability?
8. Family History: Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide?

DETAILS of "Yes" answers. (IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS: Include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities.)

- 2a - TONSILLECTOMY - 1940
2c - ALLERGIC ASTHMA
HAYFEVER
DR. ALLEN (CALL 14)
BRIANLYL TID
LAST TAKEN 9-7-82
2e - CHOLECYSTECTOMY - 1961
DR. COHN
WEISS MEM. HOSPITAL
CHICAGO, ILLINOIS
2c - HERNIORRHAPHY - 1967
SKOKIE VALLEY HOSPITAL
SKOKIE, ILLINOIS
5618 - ANNUAL PHYSICAL - 1980
DR. ALLEN (CALL 14)
EKG, URINE, BLOOD TESTS
6 - DEFERRED BECAUSE OF
GALLBLADDER DISEASE
8 - HEART ATTACK - MOTHER
FATHER.

Table with columns: Name, Age if Living?, Cause of Death?, Age at Death?. Rows for Father (CORONARY, 47), Mother (CORONARY, 72), Brothers and Sisters (No. Living: 2, No. Dead: 0).

- 9. If Applicable:
a. Have you ever had any disorder of menstruation, pregnancy, or of the reproductive organs or breasts?
b. To the best of your knowledge and belief are you now pregnant?

I HEREBY DECLARE that, to the best of my knowledge and belief, the statements and answers in Part II of this Application are full, complete, and true. These statements and answers are to be considered as the basis for any insurance written hereon.

Signature of Witness: James H. Hurm, M.D.
Signed at: (City & State) CHICAGO, ILLINOIS

Signature of PROPOSED INSURED
Date: 9-8-1982

AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person that has any records or knowledge of me or my health to give to the Capitol Bankers Life Insurance Company or its reinsurers any such information.

A photographic copy of this authorization shall be as valid as the original.

WITNESS: James H. Hurm, M.D.

SIGNATURE OF PROPOSED INSURED OR APPLICANT

PART III - PHYSICIAN'S EXAMINATION REPORT

PROPOSED INSURED: BERNARD, SIMON L
 Last Name First Name Middle Initial Date of Birth 12 - 2 - 35
 Mo. Day Year

10a. Height (In Shoes) <u>5</u> ft. <u>7 1/2</u> in.	Weight (Clothed) <u>180</u> lbs.	Chest (Full Inspiration) <u>40</u> in.	Chest (Forced Expiration) <u>38 1/2</u> in.	Abdomen, at Umbilicus <u>36 1/2</u> in.
---	-------------------------------------	---	--	--

Details of "Yes" answers. (Identify item.)

b. Did you weigh? Yes No Did you measure? Yes No
 c. Is appearance unhealthy or older than stated age? Yes No

11. Blood Pressure (Record ALL readings)

Systolic		<u>124</u>		
Diastolic	4th phase			
	5th phase	<u>82</u>		
12. Pulse:				
Rate	At Rest	After Exercise	3 Minutes Later	
	<u>80</u>	<u>120</u>	<u>84</u>	
Irregularities per min.	<u>0</u>	<u>0</u>	<u>0</u>	

13. Heart: Is there any:

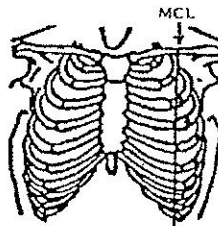
Enlargement Yes No Dyspnea Yes No
 Murmur(s) Yes No Edema Yes No
 (describe below - if more than one, describe separately)

Location

--	--

- Constant
- Inconstant
- Transmitted
- Localized
- Systolic
- Presystolic
- Diastolic
- Soft (Gr. 1-2)
- Mod. (Gr. 3-4)
- Loud (Gr. 5-6)

Indicate:
 Apex by X
 Murmur area by O
 Point of greatest intensity by O
 Transmission by †



For comments and your impression?

14. Is there on examination any abnormality of the following:
 (Circle applicable items and give details.)

- | | Yes | No |
|--|-------------------------------------|-------------------------------------|
| (a) Eyes, ears, nose, mouth, pharynx? _____
(if vision or hearing markedly impaired, indicate degree and correction.) | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| (b) Skin (incl. scars); lymph nodes; varicose veins or peripheral arteries? _____ | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| (c) Nervous system (include reflexes, gait, paralysis)? _____ | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| (d) Respiratory system? _____ | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| (e) Abdomen (include scars)? _____ | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| (f) Genitourinary system (include prostate)? _____ | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| (g) Endocrine system (include thyroid and breasts)? _____ | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| (h) Musculoskeletal system (include spine, joints, amputations, deformities)? _____ | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

15. (a) Are there any hernias? Yes No (b) Any hemorrhoids? Yes No

16. Are you aware of additional medical history? Yes No
 [A confidential report may be sent to the Medical Director]

Urinalysis: Specific Gravity 1.016 Albumin NEG. Sugar NEG.
 Is specimen being sent to Home Office? Yes No

Send Specimen to Home Office if: life insurance application is \$50,000 or more, age 60 or over, or with history or finding of albumin or sugar, or history or any urinary tract disease or blood pressure 140/90 or over.

Date: 9-8-52 Time: 9 A.M. City: CHENRO State: ILL

Signature of Medical Examiner: [Signature] M.D.

CAPITOL BANKERS
LIFE INSURANCE COMPANY

COPY

December 31, 2001

Simon Bernstein
7020 Lions Head
Boca Raton FL 33496

Re: Policy Number: 1009208
Insured: Simon Bernstein

Dear Simon Bernstein:

We are required by your state of residence to provide you, the policy/certificate owner, with annual notification of your right to designate an individual as a secondary addressee for receipt of possible lapse notices for this life insurance policy or certificate. You will continue to receive annual notification, even if this right has already been elected and a secondary addressee has been named.

If elected, the secondary addressee will receive these notices, if any, in all years following the policy/certificate owner or insured reaching age 64. If you wish to exercise this right, please complete the enclosed form and return it to us in the enclosed envelope.

While we are obligated to provide the secondary addressee with notification of a pending lapse if you so elect, we are restricted from providing anyone other than the policyowner any further details.

We are proud to be your insurance company and thank you for being our customer.

Capitol Bankers Life Insurance Company

1275 SANDUSKY ROAD JACKSONVILLE, FL 32250-1155 PHONE 1-800-825-0003 FAX 217-245-1922

JCK000423

CAPITOL BANKERS
LIFE INSURANCE COMPANY

COPY

OWNER INFORMATION AND SECONDARY ADDRESSEE
1009208

(Please print or type)

Policy Number _____

Name of Insured _____

Name of Owner _____

Birthdate of Owner _____

The Owner may designate a Secondary Addressee. After the policy has been in force for at least 1 year, and either the Insured or the Owner is at least age 65, any notification required at the end of the contractual grace period will also be sent to this Secondary Addressee.

SECONDARY ADDRESSEE (Optional)

Name _____

Street Address _____

City _____ State _____ Zip Code _____

Signature of Owner(s) _____

ANNTH

1275 SANDUSKY ROAD JACKSONVILLE, FL 32250-1155 PHONE 1-800-825-0003 FAX 217-245-1922

JCK000424

CAPITOL BANKERS LIFE INSURANCE COMPANY

ANNUAL REPORT

Policyowner:	Insured:	SIMON BERNSTEIN
	Policy No.:	1009208
	Plan:	CURRENT VALUE LIFE
	Premium Mode:	QUARTERLY
	Each Payment:	\$17,857.30

SIMON BERNSTEIN
7920 LIONS HEAD
BOCA RATON FL 33496

STATEMENT OF POLICY COSTS AND BENEFITS FOR CURRENT YEAR AND NEXT YEAR

	Current Policy Year Ending Dec 27, 2001	Projection For Next Policy Year Ending Dec 27, 2002
CURRENT RATE BASIS INTEREST	6.00%	5.00*
SUM INSURED	\$1,689,070.00	\$1,689,070.00
POLICY PREMIUMS:		
BASE POLICY	\$69,212.60	\$71,429.20
RIDERS	\$0.00	\$0.00
CASH VALUE:		
INCREASE	38,963.49	41,736.19
TOTAL	202,660.61	244,396.80
POLICY LOANS	0.00	0.00
CURRENT VARIABLE LOANS	115,478.25	

The figures shown above assume (a) that all premiums are paid when due; (b) that there are no policy loan transactions (except as shown); and (c) that the Renewal Option is not changed.

Your minimum level renewal premium for the next policy year under our Current Rate Basis (Option A) is \$17857.30. You may change your Renewal Option to pay a higher premium under the Guaranteed Rate Basis (Option B), and build higher cash value. These premium amounts are based on your current premium mode.

If you have any questions concerning your policy or your Annual Report, please call us at the toll-free number listed below, or contact your agent.

PO BOX 1147 JACKSONVILLE IL 62651-1147 PHONE 800-825-0003 FAX 217-245-1922

JCK000425

CAPITOL BANKERS
LIFE INSURANCE COMPANY

FAX NUMBER 217-245-1922

DATE: *Aug 1, 2001*

SENDER: *Stephan W. Vetter / Client Services*

RECEIVER: *Scott Hewitt / STP Enterprise*

Number of Pages *2*

COMMENTS:

*Following is the information you
requested.*

1275 SANDUSKY ROAD JACKSONVILLE, IL 62650 PHONE 800-825-0003 FAX 217-245-1922

JCK000426

File

**CAPITOL BANKERS
LIFE INSURANCE COMPANY**

July 26, 2001

SIMON BERNSTEIN
7020 LIONS HEAD
BOCA RATON FL 33496

Re: Policy No. 1009208

Dear Mr. Bernstein:

Thank you for contacting Capitol Bankers Life Insurance Company. It is a pleasure to be of assistance.

We have received your request for information on the above-referenced policy. The death benefit is \$1,689,070.00 and the cash surrender value as of 26 July 2001 is approximately \$53,329.30. The loan amount including the interest is \$115,478.25.

If you should have further questions, please call us at 800/825-0003.

Sincerely,

Stephanie Vetter
Client Services

1275 SANDUSKY ROAD JACKSONVILLE, IL 62650 PHONE 800-825-0003 FAX 217-245-1922

JCK000427

62D2,1009208 ; . AS-OF LAST MVP BERNSTEIN, SIMON

M-47 12/03/35

* NOTES

AGE RTE IS CEASE	FACE/UN	MONTHLY	SUS-STAT-ENT-ASN/O-MEC-RE-LAST MVP-ACT
(01)--CVLOA	-0611-04500-3-2-CVL-0A-		NO 22 ZC NO /0 N 0 06/27/01 N
M-47 N 82 12-41	1689,070	3,016.09	PLAN- CVLOA
STATUS - PREMIUM PAYING			DIR-Q 17303.15
			BILLING ON SCHED
			VALUE 164765.06
			RISK 1515405.44
			SPAMT 1689070.00
			LOAN 115478.25
			SUSP .00

OPTION INCLUDES CV
REQ MAT **/**/**
BILLED TO 09/27/01
ISSUE 12/27/82
LAST FIN 07/25/01
LAST BILL 05/29/01
LAST ACCT 07/25/01
LAST OTHR 11/02/00

Scott Pruett of STP Enterprises wants a letter with the death benefit, loaned amount w/the interest, and the cash value faxed to him at 312-819-0773.

s vetter

CK620 DISPLAY COMPLETE

07/26/01 L183
CICSPJAX19

62D1,1009208 ; . AS-OF LAST MVP BERNSTEIN, SIMON
* NOTES

M-47 12/03/35

IST-IL RST-FL AREA-33496 COV-LAP-SP-BILL	SUS-STAT-ENT-ASN/O-MEC-RE-LAST MVP-ACT
UL SS NBR [REDACTED] NO 18 2	NO 22 ZC NO /0 N 0 06/27/01 N
INSURED SIMON BERNSTEIN	PLAN- CVLOA OPTION INCLUDES CV
7 7020 LIONS HEAD	DIR-Q 17303.15 REQ MAT **/**/**
BOCA RATON FL 33496	BILLING ON SCHED BILLED TO 09/27/01
	VALUE 164765.06 ISSUE 12/27/82
OWN(01) SIMON BERNSTEIN	RISK 1515405.44 LAST FIN 07/25/01
7020 LIONS HEAD	SPAMT 1689070.00 LAST BILL 05/29/01
BOCA RATON FL 33496	LOAN 115478.25 LAST ACCT 07/25/01
	SUSP .00 LAST OTHR 11/02/00

PAYOR SIMON BERNSTEIN
7020 LIONS HEAD
BOCA RATON FL 33496

AGT-0000735032-CAPITOL BANKERS LIF R
GA-- NONE.
CK620 DISPLAY COMPLETE

07/26/01 LIB3
CICSPJAX19

INTER

OFFICE

MEMO

To: Michelle Brant
From: Janet Warrick
Subject: Apply money as premium payment
Date: 7-26-2001
Company/Region: Capitol Bankers

POLICY NUMBER: 1009208
INSURED: Simon Bernstein
AMOUNT: 34,606.30
MONEY INS SUSPENSE ACCT # 2412600
ERROR REGISTER DATE N/A

Please apply the \$34,606.30 in account 2412600 as 2 quarterly premium payments of \$17,303.15 for the 2nd and 3rd quarter of this year for policy number 1009208.

Thanks
Janet

U102,1009208 ; ACTION PROCESS;

AS OF 04/04/01

AP0599 - REQUEST REQUIRED HISTORICAL INFORMATION TO BE ACCESSED
REQUEST DATE = 04/04/01 HISTORY DATE = 05/27/01

ULRSTH
ULRSTH
ULLN00

AP0412 - POLICY LOAN QUOTATION REQUEST

REQUEST TYPE = NET

CURRENT CV \$91,223.58 PROCEEDS

\$17303.15

LOAN INTEREST RATE = 6.542%

CURRENT LOAN \$79,402.24 ADV INT

\$869.66

REQUEST AMT = \$17303.15

MIN BALANCE \$5,410.36 MAX LOAN

\$85813.22

COST-BASIS \$869,282.77

CPH FUND

VALUE

REQUEST AMT

REQUEST

1 FIXED1

\$91,223.58

\$18,172.81

JUL 25 2001

AP0011 - TRANSACTION CONTINUED

07/25/01 L496
CICSPJAX19

U102,1009208 ; ACTION PROCESS;

AS OF 06/23/01

AP0599 - REQUEST REQUIRED HISTORICAL INFORMATION TO BE ACCESSED
REQUEST DATE = 06/23/01 HISTORY DATE = 05/27/01

ULRSTH
ULRSTH
ULLN00

AP0412 - POLICY LOAN QUOTATION REQUEST

REQUEST TYPE = NET CURRENT CV \$69,798.34 PROCEEDS \$17303.15
LOAN INTEREST RATE = 6.542% CURRENT LOAN \$97,575.05 ADV INT \$600.05
REQUEST AMT = \$17303.15 MIN BALANCE \$5,423.74 MAX LOAN \$64374.60
COST-BASIS \$869,282.77

JUL 25 2001

CPH FUND	VALUE	REQUEST AMT	REQUEST
1 FIXED1	\$69,798.34	\$17,903.20	

AP0011 - TRANSACTION CONTINUED

07/25/01 L496
CICSPJAX19

* The owner wanted APL done to pay premium. Requested were rec'd in Billing Department & never given to us to process on system. I processed a loan for 2 quarterly payments as of 4-4-2001 & 6-23-2001. I will have treasury apply the money to pay premium.

JUL 25 2001

JANET WARRICK
CLIENT SERVICES

U102,1009208 ; ACTION PROCESS;

AS OF 07/25/01

AP0412 - POLICY LOAN QUOTATION REQUEST

REQUEST TYPE = NET	CURRENT CV	\$86,069.03	PROCEEDS	U LLN00
LOAN INTEREST RATE = 6.542%	CURRENT LOAN	\$79,402.24	ADV INT	\$17303.15
REQUEST AMT = \$17303.15	MIN BALANCE	\$5,430.58	MAX LOAN	\$494.44
	COST-BASIS	\$869,282.77		\$80638.45

CPH FUND	VALUE	REQUEST AMT	REQUEST
1 FIXED1	\$86,069.03	\$17,797.59	

Reversed

*needed to use different
as of date.*

AP0011 - TRANSACTION CONTINUED

07/25/01 L496
CICSPJAX19

,1009208 ; AS-OF 07/25/01;. BERNSTEIN, SIMON

M-47 12/03/35

NEW MONEY INTEREST RATE	6.000%	INVESTMENT METHOD	POLICY YEAR PORT
TOTAL CASH VALUE	165,487.51	SUS-STAT-ENT-ASN/O-MEC-RE-LAST MVP-ACT	
LOANED AMOUNT	97,575.05	NO 22 ZC NO /0 N 0 06/27/01 I	
SURRENDER VALUE	70,804.22	PLAN- CVLOA	OPTION INCLUDES CV
COI REFUND	181.02	DIR-Q 17303.15	REQ MAT **/**/**
MAXIMUM LOAN AVAILABLE	62,481.94	BILLING ON SCHED	BILLED TO 09/27/01
LOAN PAYOFF	94,864.31	VALUE 164733.28	ISSUE 12/27/82
NET AMT AT RISK (INS)	1,515,421.02	RISK 1515437.16	LAST FIN 06/27/01
SPECIFIED AMOUNT (INS)	1,689,070.00	SPAMT 1689070.00	LAST BILL 05/29/01
OTHER INSURANCE	.00	LOAN 79402.24	LAST ACCT 06/27/01
DEATH BENEFIT	1,689,070.00	SUSP .00	LAST OTHR 11/02/00
INTEREST CREDITED	21,728.17	INTEREST EARNED AT GIR	16,392.10
PREMIUMS PAID	869,282.77	WITHDRAWALS	.00
COST BASIS	869,282.77		

AP0599 - REQUEST REQUIRED HISTORICAL INFORMATION TO BE ACCESSED
 REQUEST DATE = 07/25/01 HISTORY DATE = 05/27/01

ULRSTH
 ULRSTH

AP0010 - REQUESTED TRANSACTION SUCCESSFULLY COMPLETED

07/25/01 L496
 CICSPJAX19

U102,1009208	;	!		OPTIONAL OVERRIDES	!
XLOAD= ?	;		!	Y - OVERRIDE STANDARD PREMIUM LOAD	!
XLOADAMT= ?		;	!	PREMIUM LOAD OVERRIDE AMOUNT - OR ZERO	!
XCOMM= ?	;		!	Y - OVERRIDE STANDARD COMMISSIONS	!
XCOMMAMT= ?		;	!	COMMISSION OVERRIDE AMOUNT - OR ZERO	!
XCHG= ?	;		!	Y - OVERRIDE STANDARD CHARGE	!
XCHGAMT= ?		;	!	CHARGE OVERRIDE AMOUNT - OR ZERO	!
XPREMTAX= ?	;		!	Y - OVERRIDE PREMIUM TAX CALCUATION	!
XMVA= ?	;		!	Y - OVERRIDE MARKET VALUE ADJUSTMENT CALC	!
SUPPCHK= Y	;		!	Y - OVERRIDE DISBURSEMENT CHECK	!
SCREEN= ?	;	.			

! 20 ACCEPTED - ENTER MORE DATA, ".", OR QUIT!

CICSPJAX19

,1009208	;	AS-OF 07/25/01;	BERNSTEIN, SIMON	M-47 12/03/35
NEW MONEY INTEREST RATE	6.000%	INVESTMENT METHOD	POLICY YEAR PORT	
TOTAL CASH VALUE	165,471.27	SUS-STAT-ENT-ASN/O-MEC-RE-LAST MVP-ACT		
LOANED AMOUNT	79,402.24	NO 22 ZC NO /0	N 0 06/27/01	N
SURRENDER VALUE	88,455.93	PLAN- CVL0A	OPTION INCLUDES CV	
COI REFUND	181.02	DIR-Q 17303.15	REQ MAT **/**/**	
MAXIMUM LOAN AVAILABLE	80,638.45	BILLING ON SCHED	BILLED TO 09/27/01	
LOAN PAYOFF	77,196.36	VALUE 164733.28	ISSUE 12/27/82	
NET AMT AT RISK (INS)	1,515,437.16	RISK 1515437.16	LAST FIN 06/27/01	
SPECIFIED AMOUNT (INS)	1,689,070.00	SPAMT 1689070.00	LAST BILL 05/29/01	
OTHER INSURANCE	.00	LOAN 79402.24	LAST ACCT 06/27/01	
DEATH BENEFIT	1,689,070.00	SUSP .00	LAST OTHR 11/02/00	
INTEREST CREDITED	21,712.01	INTEREST EARNED AT GIR	16,391.94	
PREMIUMS PAID	869,282.77	WITHDRAWALS	.00	
COST BASIS	869,282.77			

AP0010 - REQUESTED TRANSACTION SUCCESSFULLY COMPLETED

07/25/01 L496
CICSPJAX19

62D1,1009208 ; . AS-OF LAST MVP BERNSTEIN, SIMON

M-47 12/03/35

* NOTES

IST-IL RST-FL AREA-33496 COV-LAP-SP-BILL SUS-STAT-ENT-ASN/O-MEC-RE-LAST MVP-ACT
UL SS NBR [REDACTED] NO 18 2 NO 22 ZC NO /0 N 0 06/27/01 N

INSURED SIMON BERNSTEIN
7020 LIONS HEAD
BOCA RATON FL 33496

PLAN- CVLOA OPTION INCLUDES CV
DIR-Q 17303.15 REQ MAT **/**/**
BILLING ON SCHED BILLED TO 09/27/01
VALUE 164733.28 ISSUE 12/27/82
RISK 1515437.16 LAST FIN 06/27/01
SPAMT 1689070.00 LAST BILL 05/29/01
LOAN 79402.24 LAST ACCT 06/27/01
SUSP .00 LAST OTHR 11/02/00

OWN(01) SIMON BERNSTEIN
7020 LIONS HEAD
BOCA RATON FL 33496

PAYOR SIMON BERNSTEIN
7020 LIONS HEAD
BOCA RATON FL 33496

AGT-0000735032-CAPITOL BANKERS LIF R
GA-- NONE.
CK620 DISPLAY COMPLETE

07/25/01 L496
CICSPJAX19

PLEASE RETURN THIS PORTION WITH YOUR PAYMENT

1009208	BERNSTEIN, SIMON	06-27-01	3 MONTH PREMIUM	17,303.15
07-29-01			AMOUNT DUE	17,303.15

SIMON BERNSTEIN
7020 LIONS HEAD
BOCA RATON FL 33496

DEPOSIT
JUL 23 2001

BILLING CENTER

193130303932303840404006270103017303150121001730315000000004

INDICATE ADDRESS CHANGE ABOVE

CAPITOL BANK
P.O. BOX 4174
SPRINGFIELD, IL

Please Pay
by A/P (for 2/27/11)
and send me
an audit
Thank you
Samm Benster

PLEASE RETURN THIS PORTION WITH YOUR PAYMENT

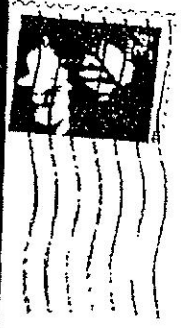
1009208	BERNSTEIN, SIMON	03-27-01	3 MONTH PREMIUM	17,303.15
04-28-01			AMOUNT DUE	17,303.15

SIMON BERNSTEIN
7020 LIONS HEAD
BOCA RATON FL 33496

RECEIVED
JUL 23 '01
BILLING SERVICE

173130303932303840404003270103017303150111801730315000000002

INDICATE ADDRESS CHANGE ABOVE



RECEIVED
WEST POINT
PM
JUL 28 2001

BILLING DEPT.

RECEIVED

JUL 20 2001

TREASURY DEPT.

62702-4174



From

Name --

Address



To help us serve you better, please:

- enclose the return portion of the premium notice
- make sure the address appears in the window
- write your policy number on your check or money order
- sign and date your check

THANK YOU!

We appreciate your business.



S.B. Lexington, Inc.

600 WEST JACKSON BLVD • SUITE 800 • CHICAGO, IL 60661 • (312) 693-0044

561 477 9090
2602 FFL 195

SIMON L. BERNSTEIN
CHAIRMAN

4/4/01

To Whom it May Concern

Please pay my next premium by
APL on Policy # 1009208
this is a Capital Bankers Policy.

Thank you

RECEIVED
APR - 9 2001
BILLING DEPT.

INSURANCE COUNSLORS WITH (IN-TEG-RI-TY)



S.B. Lexington, Inc.

STATIONER & PRINTER
1017 W. WASHINGTON ST.,
MILWAUKEE, WIS. 53233
Phone: 442-2222



Capital Bankers Ins Co.
1275 SANDUSKY RD.
JACKSONVILLE, ILL 62650

att: Bellini
62650+153



INTER

OFFICE

MEMO

To: Treasury
From: Janet Warrick
Subject: Apply money as premium
Date: 01-05-2001
Company/Region: Capitol Bankers

POLICY NUMBER: 1009208
INSURED: Simon Bernstein
AMOUNT: \$ 17,303.15
MONEY INS SUSPENSE ACCT # 2412600
ERROR REGISTER DATE N/A

Could you please apply the \$17,303.15 in account 2412600 as premium payment to policy 1009208 per the owners request.

Thanks
Janet Warrick

Please call if you have any questions.

Best regards,

**CAPITOL BANKERS
LIFE INSURANCE COMPANY**

file

18 June 2001

SIMON BERNSTEIN
7020 LIONS HEAD
BOCA RATON FL 33496

Re: Policy No. 1009208

Dear Mr. Bernstein:

Thank you for contacting Capitol Bankers Life Insurance Company. It is a pleasure to be of assistance.

We have received your request for information on the above-referenced policy. Our records indicate as of 14 June 2001 the loan balance is approximately \$79,402.24 and the loan payoff is \$76,612.87. The loan payoff is good for ten days.

The cash surrender value as of 14 June 2001 is approximately \$91,588.87.

Thank you for the opportunity to serve you. If we may be of further service, please call us at 800/825-0003.

Sincerely,

Stephanie Vetter
Client Services

Enclosure

1275 SANDUSKY ROAD JACKSONVILLE, IL 62650 PHONE 800/825-0003 FAX 217/245-1922

JCK000446

**CAPITOL BANKERS
LIFE INSURANCE COMPANY**

FAX NUMBER 217-245-1922

DATE: 6-18-01

SENDER: Stephanie Vetter/Client Services

RECEIVER: Gamela Owens/STP Enterprises

Number of Pages 2

COMMENTS:

Following is the policy information
you requested

Thanks

1275 SANDUSKY ROAD JACKSONVILLE, IL 62650 PHONE 800-825-0003 FAX 217-245-1922

JCK000447

62D1,1009208 ; . AS-OF LAST MVP BERNSTEIN, SIMON M-47 12/03/35
* NOTES

IST-IL RST-FL AREA-33496 COV-LAP-SP-BILL	SUS-STAT-ENT-ASN/O-MEC-RE-LAST MVP-ACT
UL SS NBR [REDACTED] NO 18 2	NO 22 ZC NO /0 N 0 05/27/01 N
INSURED SIMON BERNSTEIN	PLAN- CVLOA OPTION INCLUDES CV
7020 LIONS HEAD	DIR-Q 17303.15 REQ MAT **/**/**
BOCA RATON FL 33496	BILLING ON SCHED BILLED TO 09/27/01
	VALUE 166637.45 ISSUE 12/27/82
OWN(01) SIMON BERNSTEIN	RISK 1513536.38 LAST FIN 05/29/01
7020 LIONS HEAD	SPAMT 1689070.00 LAST BILL 05/29/01
BOCA RATON FL 33496	LOAN 79402.24 LAST ACCT 05/29/01
	SUSP .00 LAST OTHR 11/02/00

PAYOR SIMON BERNSTEIN
7020 LIONS HEAD
BOCA RATON FL 33496

AGT-0000735032-CAPITOL BANKERS LIF R
GA-- NONE.
CK620 DISPLAY COMPLETE

06/14/01 L682
CICSPJAX19

6/14/01

Please fax loan bal, loan payoff + CSV as
of June 14, 2001 to Jamila Owens at STP
Enterprises (agent's office) at 312-819-0773.

Lorie CAFFERY
SERVICES

JUN 15 2001

JCK000448

STP ENTERPRISES, INC.
303 EAST WACKER
SUITE 210
CHICAGO, IL 60601
PH 312 819 7474
FAX 312 819 0773

facsimile transmittal

To: STEPHANIE VETTER Fax: 217 245 1922
From: SCOTT PRUETT Date: 5/24/01
Re: 1009208 SIMON BERNSTEIN Pages: 1
CC:

Urgent For Review Please Comment Please Reply Please Recycle

THANK YOU FOR THE 5/15/01 FAX ON POLICY 1009208 SIMON BERNSTEIN. PLEASE
FAX US THE CURRENT OUTSTANDING LOAN AMOUNT ON THIS POLICY. THANK
YOU.

*already faxed to
Scott Pruett*

5/30/01

*Stephanie
Vetter*

May 25 2001
11:25:20 AM

**CAPITOL BANKERS
LIFE INSURANCE COMPANY**

May 15, 2001

SIMON BERNSTEIN
7020 LIONS HEAD
BOCA RATON FL 33496

Re: Policy No. 1009208

Dear Mr. Simon:

Thank you for contacting Capitol Bankers Life Insurance Company. It is a pleasure to be of assistance.

We have received your request for information on the above referenced policy. The current face amount on your policy is \$1,689,070.00. The loan interest is 6.542%.

If you should have further questions, please call us at 800-825-0003.

Sincerely,



Stephanie Vetter
Client Services

1275 SANDUSKY ROAD JACKSONVILLE, IL 62650 PHONE 800-825-0003 FAX 217-245-1922

JCK000450

**CAPITOL BANKERS
LIFE INSURANCE COMPANY**

FAX NUMBER 217-245-1922

DATE: 5-15-01

SENDER: Stephanie Vetter

RECEIVER: STP Enterprises / Jamillia Owens

Number of Pages (including this page) 2

COMMENTS:

Policy information on Policy Number 1009208

1275 SANDUSKY ROAD JACKSONVILLE, IL 62650 PHONE 800-825-0003 FAX 217-245-1922

JCK000451