Nationwide® Financial
Fixed Life Insurance Application Packet
California

Regular Mail:

Nationwide Life Insurance Company
P.O. Box 182835
Columbus, Ohio 43218-2835

Express Mail:

Nationwide Financial Life Operations
RR1-04-D4
5100 Rings Road
Dublin, Ohio 43017-1522

Have questions? We're here to help!

Sales and Service Center
1-866-678-LIFE (5433)

If you are using these forms more than 60 days from the print date, please check with your Nationwide representative to ensure this is the most current form packet, or go to www.nationwide.com

FLE-0100 CA-AD

Nationwide®
On Your Side

Investments Retirement Insurance

LIFE APPLICATION INSTRUCTIONS

On Your Side®

Submitting Application

Obtaining Supplemental Forms

NOTE: There are some supplemental forms that may need to be submitted with the application and required forms if certain conditions apply (i.e. special risk questionnaires such as Hazardous Avocation, Foreign Supplement, Aviation, Drug, Alcohol, etc). These supplemental forms can be obtained by contacting our application **HELP-LINE** at 866-678-LIFE (5433) or by accessing our web-site at www.nationwide.com.

What to send:

Submit:	Provide:	Retain:
☐ Copy of signed application to Nationwide. ☐ State required forms to Nationwide.	☐ Copy of application to the Client.	☐ Permanently retain the originally signed and dated paperwork for your files for future reference.

Where to send:

***FOR THE FASTEST SERVICE USE FAX.**
Fax Number:
1-888-677-7393

Regular Mail:
Nationwide Life Insurance Company
P.O. Box 182835
Columbus, OH 43218-2835

Express Mail:
Nationwide Financial Life Operations
RR1-04-D4
5100 Rings Road
Dublin, OH 43017-1522

Available Products
Indicate plan name being applied for in the Life Insurance Plan section of the application

INIVIDUAL VARIABLE UNIVERSAL LIFE:
- Nationwide YourLife® Accumulation VUL
- Nationwide YourLife® Protection VUL
- Nationwide YourLife® Survivorship VUL

WHOLE LIFE:
- Nationwide YourLife® 20-pay WL
- Nationwide YourLife® WL 100

UNIVERSAL LIFE:
- Nationwide YourLife® Current Assumption UL
- Nationwide YourLife® No-Lapse Guarantee UL
- Nationwide YourLife® No-Lapse Guarantee SULII

TERM LIFE:
- Nationwide YourLife® 10-year Term
- Nationwide YourLife® 20-year Term
- Nationwide YourLife® 30-year Term

Completing the Application

In the event Supplemental Coverage has been elected, please complete:
- Part C, Section 8 - Total Specified Amount box.
- Part E, Section 20 - Special Instructions Section – indicate how much Supplemental Coverage is requested as a whole percent.

Providing Temporary Agreement

Temporary Insurance Agreement should be given to the applicant **except** in the following situations:
- The applicant has not paid the full first premium for the mode selected or authorized EFT draft for initial premium.
- If the Proposed Insured(s) answered "Yes" to the health question(s) on the Temporary Insurance Agreement section in the application.
- The total specified amount requested **exceeds $1,000,000**. The Producer should not collect any money.

Collecting Premium

For Annual, Quarterly and Semi-Annual billing modes:
- Collect 1 modal premium and send to Nationwide.

For Monthly EFT mode:

There are two options available for setting up monthly EFT:
1. Collect **NO** premium at the time of the application and Home Office will draft the initial premium on the issue date of the policy which is also the Policy Effective Date.

OR

2. Collect two months premium and the monthly draft day will be determined based upon policy effective date unless a specific day has been requested on the application.

To ensure proper premium drafting, indicate on the application in the Billing and Premium Information section the bank information to be used.

Ordering Medical Requirements
- Indicate what medical requirements have been ordered on the Producer's Certificate.
- Nationwide Underwriting will order the necessary medical requirements for you but contacting the paramedical provider yourself at the time of the application will speed up the overall process by 5-7 days.
- The medical underwriting requirements are based on each Proposed Insured's age and face amount of coverage which can be found on the medical requirements chart of the Underwriting Desk Reference. These requirements should be ordered through one of the Nationwide authorized paramedical providers:

APPS: 800-635-1677 **ExamOne: 877-933-9261** **Portamedic: 800-456-3888**

- When determining the medical requirements for age and amount, "AMOUNT" is equal to the amount of insurance applied for currently, plus any amount of insurance placed in force within the past 3 years with Nationwide.
- Nationwide Underwriting may request a report from the proposed insured(s)'s attending physician if it is determined that this information is needed to assess the risk.

QUESTIONS?
Please call our application **HELP-LINE** at 866-678-LIFE (5433).
Hours of Operation (Eastern Time) Monday – Friday 8:00 a.m. – 8:00 p.m.

Thank You For Your Business

On Your Side®

Important Information For United States Armed Forces Personnel

Before you purchase a product from a Nationwide life insurance company, we are required to inform you that the United States Government does not endorse or benefit from the sale of any of our products. In addition, there could be other options available to you as a current or former member of the United States Armed Forces.

Any member of the United States Armed Forces and/or their dependents can purchase this product. The Federal Government and its agencies do not offer or provide this product, and they do not sanction, recommend or encourage the sale of this product.

Additionally, we want to make sure you know that, as a member of the United States Armed Forces, you can purchase subsidized life insurance from the Federal Government under the Service Members' Group Life Insurance (SGLI) program. Through this program, you can get basic SGLI coverage up to $400,000. As of July 1, 2008, the premium for basic SGLI is $0.065 for each $1,000 of coverage. Nationwide does not offer coverage through this program.

The annuity contract or life insurance policy being discussed with you contains a "Right to Examine" period of no less than 10 days for you to decide if you want to keep it or cancel it. The length of this time period depends on the law of your state, and may vary depending on whether your purchase is replacing another contract or policy you own. You may choose to return the contract or policy during the "Right to Examine" period. If returned to Nationwide at the address shown below, the contract or policy becomes void and Nationwide will refund the contract value or policy value as required by law and according to the terms stated in your contract or policy.

Nationwide compensates only registered firms, financial advisors and state licensed insurance professionals who sell this product. Their compensation includes an allowance for promoting and marketing our products.

You may contact us at either www.nationwide.com or:

Nationwide Life Insurance Company
One Nationwide Plaza
Columbus, Ohio 43215
1-800-848-6331

If you have a complaint about the sale or solicitation of this policy on federal lands or facilities, please contact your state's department of insurance.

☐ NATIONWIDE LIFE INSURANCE COMPANY
☐ NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY

Application for Life Insurance — P.O. Box 182835, Columbus, Ohio 43218-2835

PART A – CLIENT INFORMATION

1. Proposed Primary Insured

Name *(First, MI, Last)* | SSN / Tax ID # - -

Address | City

State | Zip Code | County | Sex ☐ M ☐ F | Former Name

Marital Status ☐ Married ☐ Single ☐ Other_____ | Age | Date of Birth *(mm/dd/yyyy)* | State of Birth

Citizenship *(*If other, submit Foreign Supplement.)* ☐ U.S. ☐ Canada ☐ Other, how long have you lived in the U.S.?_____ | Driver's License # / State of Issue

Occupation | Employer | Daytime Phone ( ) ☐ Business ☐ Cell ☐ Home

E-Mail Address | Evening Phone ( ) ☐ Business ☐ Cell ☐ Home

2. Proposed Additional Insured

If applicable, complete for either:

a) Joint Insured for Survivorship Life Plan; or

b) Term Rider on Another Covered Person (i.e., Spouse/Children)

If additional space is required, use Special Instructions Section.

Name of Insured(s)	Birth Date	Birth State	Sex	Height	Weight	SSN / Tax ID #	Relationship to Insured

Joint/Spouse Proposed Additional Insured Information Only

Former Name | Address ☐ *(Check box if same as Proposed Primary Insured)*

City | State | Zip Code | County

Citizenship *(*If other, submit Foreign Supplement.)* ☐ U.S. ☐ Canada ☐ Other, how long have you lived in the U.S.?_____ | Driver's License # / State of Issue

Occupation | Employer | Daytime Phone ( ) ☐ Business ☐ Cell ☐ Home

E-Mail Address | Evening Phone ( ) ☐ Business ☐ Cell ☐ Home

3. Owner

Complete ONLY if Owner is not the Proposed Primary Insured.

Unless indicated the Proposed Primary Insured (Joint Insureds in the case of Survivorship) will own the policy.

If more than two Owners are requested, use Special Instructions Section.

Name *(First, MI, Last)* | SSN / Tax ID # - -

Address ☐ *(Check box if same as Proposed Primary Insured)* | City

State | Zip Code | County | Relationship to Insured | Date of Birth *(mm/dd/yyyy)*

E-Mail Address | Phone ( ) ☐ Business ☐ Cell ☐ Home

If more than one Owner the following will be applicable: 1) Ownership will be vested jointly with right of survivorship, otherwise to the Executor or Administrator of the last owner's estate. 2) All notices will be mailed to the one address listed above unless otherwise instructed. 3) For tax reporting purposes, only one Social Security Number can be used. The SSN shown above will be used unless otherwise instructed.

Joint Owner *(First, MI, Last)* | SSN / Tax ID # - -

Address ☐ *(Check box if same as Proposed Primary Insured)* | City

State | Zip Code | County | Relationship to Insured | Date of Birth *(mm/dd/yyyy)*

E-Mail Address | Phone ( ) ☐ Business ☐ Cell ☐ Home

TRUST - Submit a copy of first and signature pages of Trust document.

Exact Name of Trust	Trust Tax ID Number	Current Trustee(s)	Date of Trust

4. Contingent Owner

Complete this section to name an alternative Owner in the event the Insured survives the Owner.

Name *(First, MI, Last)*				SSN / Tax ID # - -
Address ☐ *(Check box if same as Proposed Primary Insured)*			City	
State	Zip Code	County	Relationship to Insured	Date of Birth *(mm/dd/yyyy)*

5. Primary Beneficiary Designations

If Survivorship Life Plan, the Proposed Insureds may not be named as Beneficiary.

If additional space is required, use Special Instructions Section.

When more than one Beneficiary is designated, payments will be made in equal shares to the Beneficiaries surviving the Insured, or in full to the last surviving Beneficiary, unless some other distribution of proceeds is provided.

☐ ***Check this box if Trust named in the Owner section is to be the Primary Beneficiary. If a different Trust is named as Primary Beneficiary or Trust is named as Contingent Beneficiary, provide the Trust information below.***

For Proposed Primary Insured

Primary Beneficiary(ies) Name(s) or Trust and Trustee(s)	Share %	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID #

For Proposed Additional Insured

Primary Beneficiary(ies) Name(s) or Trust and Trustee(s)	Share %	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID #

6. Contingent Beneficiary Designations

For Proposed Primary Insured

Contingent Beneficiary(ies) Name(s) or Trust and Trustee(s)	Share %	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID #

For Proposed Additional Insured

Contingent Beneficiary(ies) Name(s) or Trust and Trustee(s)	Share %	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID #

PART B – INSURANCE INFORMATION

7. Replacement and Other Policy Information

STOP

Be sure to answer all questions. If applicable, check the appropriate box.

☐ Yes ☐ No	a. Do you currently have any other Life Insurance or Annuities in force? *(If "yes", list below.)*
☐ Yes ☐ No	b. Is any person here proposed for coverage now applying for Life Insurance or Annuities with any other company? *(If "yes", provide name of Company, amount applied for and purpose of coverage.)*
☐ Yes ☐ No	c. Will any Life Insurance or Annuities for this or any other company be replaced, discontinued, reduced or changed if insurance now applied for is issued? *(If "yes", list below and complete appropriate replacement forms. If this is an IRC Sect 1035 Exchange, attach 1035 forms.)*

Insured	Company	Policy Number	Amount Of Coverage	Year Issued	To Be Replaced	1035 Exch	Nationwide Term Conversion
			$		☐ Yes ☐ No	☐	☐
			$		☐ Yes ☐ No	☐	☐
			$		☐ Yes ☐ No	☐	☐
			$		☐ Yes ☐ No	☐	☐

PART C - PLAN INFORMATION

8. Life Insurance Plan

Refer to the Illustration for the correct plan name.

(Print complete name of product being applied for.)

Term Plan:_____ Level Period: ☐ 10 Year ☐ 20 Year ☐ 30 Year

Permanent Plan*:_____

If a Variable Life product is being applied for, the Variable Life Fund Supplement **MUST be completed.*

Base Specified Amount	+	Additional Term Rider Amount *(Variable Universal Life case only)*	=	Total Specified Amount *(including Additional Term Rider)*
$_____		$_____		$_____

STOP

*Complete this section if you applied for an **Individual Variable Universal, Universal or Survivorship Life** Plan.*

Death Benefit Option *(If no option is selected here, Option 1 is elected.)*

☐ Option 1 .....(The Specified Amount, or a multiple of the Cash/Accumulated Value, whichever is greater.)
☐ Option 2 .....(The Specified Amount, plus the Cash/Accumulated Value, or a multiple of the Cash/Accumulated Value, whichever is greater.)
☐ Option 3 .....(The Specified Amount, plus the Accumulated Premium Account at _____%* interest or a multiple of the Cash/Accumulated Value, whichever is greater.) **Enter a percentage up to 12% maximum, **ONLY** if the Owner is a business entity. If nothing is entered or the Owner is not a business entity, 0% will apply.*

Internal Revenue Code Life Insurance Qualification Test Option

☐ Guideline Premium/Cash Value Corridor Test
☐ Cash Value Accumulation Test
(If no selection is made here, the Guideline Premium/Cash Value Corridor Test is elected.)

9. Optional Benefits

Select the appropriate benefit according to the illustration.

Variable or Universal Life Plans Only *(Subject to Plan availability.)*

☐ Spouse Rider..... $_____
☐ Children's Term Insurance Rider..... $_____
☐ Accelerated Benefit Rider for Health Care/Life Insurance Rider* ..... $_____
**Complete Supplement for* Accelerated Benefit Rider for Health Care/Life Insurance.
☐ Premium Waiver Rider ..... $_____
☐ Waiver of Monthly Deductions Rider
☐ Extended Death Benefit Guarantee Rider
_____ Guarantee Percentage *(Indicate percentage of specified amount)*
_____ Guarantee Duration *(Indicate number of years)*

☐ Accidental Death Benefit Rider..... $_____
☐ Adjusted Sales Load Rider _____%
(in whole percentages only) waived for _____ years
☐ Surrender Value Enhancement Benefit
☐ Change of Insured Rider
☐ Other Rider(s)_____
☐ Other Rider(s)_____
☐ Other Rider(s)_____

Survivorship Variable or Survivorship Universal Life Plans Only *(Subject to Plan availability.)*

☐ Four Year Term Rider* ..... $_____
If the **No Charge Four Year Term Insurance has been illustrated you should **NOT** select this rider.*

☐ Policy Split Option Rider
☐ Other Rider(s)_____
☐ Other Rider(s)_____

Whole or Term Life Plans Only *(Subject to Plan availability.)*

☐ 20 Year Spouse Rider ..... $_____
☐ Children's Term Insurance Rider..... $_____
☐ Accidental Death Benefit Rider..... $_____
☐ Guaranteed Insurability Benefit Rider.. $_____
☐ Waiver of Premium Disability Benefit Rider
☐ Owner's Waiver of Premium Death Benefit Rider (Complete Part E for the Owner)
Occupation_____
Height_____
Weight_____
State of Birth_____

☐ Owner's Waiver of Premium Death or Disability Benefit Rider (Complete Part E for the Owner)
Occupation_____
Height_____
Weight_____
State of Birth_____
☐ Other Rider(s)_____
☐ Other Rider(s)_____
☐ Other Rider(s)_____

Policy will be issued with Automatic Premium Loan Option (APL) for Whole Life Plans only, if available, unless the box below is checked.
☐ No, do not issue with APL.

PART D - PREMIUM AND BILLING INFORMATION

10. Initial Premium Payment

(Be sure to review Temporary Insurance Agreement to verify if the Proposed Insured qualifies to submit premium with the application.)

Initial Premium Payment $_____ (paid with application)

NOTE: Make all checks payable to **NATIONWIDE**.

11. Billing and Premium Information

Monthly Electronic Billing Option:

☐ Monthly EFT ..... $_____

*(**NOTE:** Monthly Draft Day will be determined based upon policy effective date unless a day is requested below.)*

Monthly Draft Day (1st – 28th):_____

Draft Options:
☐ *Checking - Use information on the Premium Check.
☐ *Checking - *(Attach a pre-printed Voided Check.)*
☐ *Savings - *(Attach a Voided Deposit Slip with account number and routing number.)*

If no check or deposit slip provided, indicate below the bank information to be used:

Financial Institution Name_____ Transit/ABA Number_____

Account Number_____ Type of Account: ☐ *Checking ☐ *Savings

** By providing my financial institution name and account information, I hereby authorize Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company to initiate debit entries to my checking/savings account indicated above and the Financial Institution to debit the same such account.*

Additional Billing and Payment Options *(check the applicable billing or payment option(s) and indicate the premium amount)*:

☐ Quarterly ..... $_____	☐ Billing Advantage ..... $_____
☐ Semi-Annual ..... $_____	Account Number_____
☐ Annual..... $_____	☐ 1035/Replacement..... $_____
☐ Single Premium ..... $_____	☐ Other..... $_____

12. Payor

If someone other than the Insured(s) or the Owner is billed for the premium for this policy.

Name *(First, MI, Last)*

Address	City	State	Zip Code

PART E - PERSONAL INFORMATION

13. Tobacco Use

All questions are to be answered by each Proposed Insured.

STOP

Be sure to answer this section.

Have you used tobacco or nicotine in any form:	**Proposed Primary Insured**	**Proposed Additional Insured**
a. In the last 5 years?	☐ Yes ☐ No	☐ Yes ☐ No
b. In the last 12 months?	☐ Yes ☐ No *If "yes", date last used.*_____	☐ Yes ☐ No *If "yes", date last used.*_____
c. If "yes", check all forms of tobacco or nicotine products used.	☐ Cigarettes ☐ Cigars ☐ Chewing Tobacco ☐ Pipe ☐ Other Tobacco ☐ Snuff ☐ Nicotine Products (gum, patch, etc.)	☐ Cigarettes ☐ Cigars ☐ Chewing Tobacco ☐ Pipe ☐ Other Tobacco ☐ Snuff ☐ Nicotine Products (gum, patch, etc.)

14. Physical Measurements

Fill in information for the Proposed Primary Insured.

Height	**Current Weight**	**Weight 1 Year Ago**	**Reason for Weight Gain or Loss**

15. Personal Physicians

If Child Rider coverage is requested, use Special Instructions Section to add Personal Physician information for each child.

	Proposed Primary Insured	**Proposed Additional Insured**
Name of Personal Physician:		
Address:		
Telephone Number:		
Date last consulted:		
Reason last consulted:		
Treatment given or medication prescribed:		

16. Personal Details *Explain all "yes" answers in Details box below unless instructed otherwise.*	**All questions are to be answered by each Proposed Insured.**	**Proposed Primary Insured**		**Proposed Additional Insured**		**Any Child**	
		Yes	No	Yes	No	Yes	No
	a. Have you ever had any application for Life or Health Insurance (or for reinstatement for Life or Health Insurance) declined, postponed, rated-up or limited?	☐	☐	☐	☐	☐	☐
	b. Have you ever applied for or received disability payments for any long term illness or injury?	☐	☐	☐	☐	☐	☐
	c. In the past 3 years have you engaged in, or do you intend to engage in: flying as a pilot, student pilot, or crew member; organized racing of an automobile, motorcycle, or any type of motor-powered vehicle, scuba diving, mountain climbing, hang gliding, parachuting, sky diving, bungee jumping or any type of body-contact or life-threatening sport? *(If "yes", complete an Aviation/Hazardous Activities Questionnaire.)*	☐	☐	☐	☐	☐	☐
	d. Have you ever had your driver's license suspended or revoked; or been convicted of driving while impaired or intoxicated, or been convicted in the past 3 years of more than one moving violation?	☐	☐	☐	☐	☐	☐
	e. Except as prescribed by a physician, have you ever used, or been convicted for sale or possession of cocaine or any other narcotic or illegal drug? *(If "yes", complete Drug Questionnaire.)*	☐	☐	☐	☐	☐	☐
	f. Have you ever been convicted of or pled guilty or no contest to a felony or been charged with a violation of any criminal law that is still pending?	☐	☐	☐	☐	☐	☐
	g. Have you had any bankruptcies in the past 7 years or do you have any suits or judgments pending against you at this time?	☐	☐	☐	☐	☐	☐
	h. Do you plan to travel or reside outside of the United States or Canada? *(If "yes", complete Supplement for Foreign Nationals or Travel.)*	☐	☐	☐	☐	☐	☐
	i. Do you belong to or intend to join any active or reserve military or naval organization? *(If "yes", complete Military Status Questionnaire.)*	☐	☐	☐	☐	☐	☐
	j. To the best of your knowledge, do you have a parent or sibling who died from cancer or cardiovascular disease prior to age 60? *(If "yes", provide relationship to Proposed Insured(s), age at death and cause of death, and if cancer, provide type.)*	☐	☐	☐	☐	☐	☐
	k. Have you been involved in any discussion about the possible sale or assignment of this policy to a life settlement, viatical, or other secondary market purchaser?	☐	☐	☐	☐	☐	☐
	l. Have you ever sold any life insurance policy to a life settlement, viatical, or other secondary market purchaser?	☐	☐	☐	☐	☐	☐
	m. Will any portion of the current or future premium for this policy be financed?	☐	☐	☐	☐	☐	☐
	n. Will any Insured or Policy Owner receive any payment in connection with the insurance issued on the basis of this application?	☐	☐	☐	☐	☐	☐

17. Explanation of Personal Details

If more space is needed, an additional blank sheet may be attached. Any Proposed Insured(s) or Owner(s) should sign and date additional pages.

Question Letter	Person	Dates	Details

18. Medical Questions

All questions are to be answered by each Proposed Insured.

Explain all "yes" answers in Details box below unless instructed otherwise.

To the best of your knowledge and belief, has anyone here proposed for insurance consulted a member of the medical profession for, been treated for, or been diagnosed as having:	Proposed Primary Insured		Proposed Additional Insured		Any Child	
	Yes	No	Yes	No	Yes	No
a. AIDS (Acquired Immune Deficiency Syndrome)?	☐	☐	☐	☐	☐	☐
b. Heart disease including heart attack, angina, or other chest pain, high blood pressure, shortness of breath, palpitations, heart murmur, phlebitis, or any other disorder of the heart or blood vessels?	☐	☐	☐	☐	☐	☐
c. Headaches, seizures, epilepsy, stroke, Alzheimer's disease, dementia, Parkinson's disease, multiple sclerosis, or any other brain or nervous disorder?	☐	☐	☐	☐	☐	☐
d. Depression, neurosis, affective disorder, psychosis, or any other mental or emotional disorder?	☐	☐	☐	☐	☐	☐
e. Asthma, emphysema, chronic bronchitis, tuberculosis, or any other disease of the lungs or respiratory system?	☐	☐	☐	☐	☐	☐
f. Colitis, ulcer, persistent diarrhea, rectal bleeding, or any other disease of the esophagus or digestive tract?	☐	☐	☐	☐	☐	☐
g. Sugar, protein or blood in the urine, kidney stones, sexually transmitted disease, or any other disease or disorder of the kidneys, bladder, prostate, breast, urinary tract or reproductive system?	☐	☐	☐	☐	☐	☐
h. Diabetes, hepatitis, cirrhosis or any other disease of the liver, pancreas, or thyroid?	☐	☐	☐	☐	☐	☐
i. Cancer, or any malignant or benign tumor or cyst, or any chronic disease of the skin or lymph glands?	☐	☐	☐	☐	☐	☐
j. Arthritis, rheumatoid arthritis, osteoporosis; or any paralysis or chronic back or muscle condition?	☐	☐	☐	☐	☐	☐
k. Alcoholism, narcotic addiction, drug use, or hallucinations?	☐	☐	☐	☐	☐	☐
l. Any disease of the eyes, ears, nose or throat?	☐	☐	☐	☐	☐	☐
To the best of your knowledge and belief, in the past 5 years, has anyone here proposed for insurance:						
m. Consulted, or been examined or treated by any physician, chiropractor, psychologist or other health care practitioner or by any hospital, clinic, or other health care facility not already disclosed on this application? *(If it was for a "check up", annual physical, employment physical, etc., so state and give findings and results.)*	☐	☐	☐	☐	☐	☐
n. Had any disease, disorder, injury, or operation not already disclosed on this application?	☐	☐	☐	☐	☐	☐
o. Had any x-rays, electrocardiograms, or other medical tests for reasons not already disclosed on this application?	☐	☐	☐	☐	☐	☐
p. Been medically advised to have any surgery, hospitalization, treatment or test that was not completed or results that you have not received?	☐	☐	☐	☐	☐	☐

19. Details of Medical History

If more space is needed, an additional blank sheet may be attached. Any Proposed Insured(s) or Owner(s) should sign and date additional pages.

Question Letter	Person	Dates	Details *(Be specific. Give full names, addresses and telephone number (if available) of physicians, hospitals, etc.)*

20. Special Instructions Section *If more space is needed, an additional blank sheet may be attached. Any Proposed Insured(s) or Owner(s) should sign and date additional pages.*	

21. Taxpayer ID Number
 
Check box, if applicable
	I certify under penalties of perjury that:
	• The number shown on this form is my correct taxpayer identification number and,
	• I am not subject to backup withholding because
	  ◆ I have not been notified that I am subject to backup withholding as a result of a failure to report all interest or dividends, or
	  ◆ the Internal Revenue Service has notified me that I am no longer subject to backup withholding, or that I am exempt from backup withholding, and
	• I am a U.S. person *(including a U.S. resident alien)*.
	☐ **Check this box if you have been notified by the IRS that you are currently subject to backup withholding because of failure to report interest or dividends on your tax return.**
	The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

PART F – IMPORTANT NOTICES	
Pre-Notice of Procedures as Required by The Fair Credit Reporting Act of 1970	This notice is to inform you that as part of our normal underwriting procedures in connection with an application for insurance: • An investigative consumer report may be made whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. This inquiry will 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, with respect to you, members of your family, and others having an interest in or closely connected with the insurance transaction; and • You may elect to be interviewed if an investigative consumer report is prepared in connection with this application. You are entitled to receive a copy of any investigative consumer report by submitting your request in writing. • Upon your written request, made within a reasonable time after you receive this notice, additional information as to the nature and scope of the investigation, if one is made, will be provided. You may send corrections and requests for additional information addressed to Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company, P.O. Box 182835, Columbus, Ohio 43218-2835. In the event of an adverse decision, you will be notified in writing.
Medical Information Bureau Disclosure Notice	Information regarding your insurability will be treated as confidential. Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company, or its reinsurer(s) 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. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734, telephone number 866-692-6901 (TTY 866-346-3642). The e-mail address of the Bureau's information office is www.mib.com. Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company or its reinsurer(s) may also release information in its file 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.

PART G – AGREEMENT AND AUTHORIZATION

Agreement

I understand and agree that:

- This application, any amendments to it, and any related medical examination(s) will become a part of the Policy and are the basis of any insurance issued upon this application.
- The Proposed Insured or Owner has a right to cancel this application at any time by contacting their producer or Nationwide in writing. No producer, medical examiner or other representative of Nationwide may accept risks or make or change any contract; or waive or change any of the Company's rights or requirements.
- If the full first premium is made in exchange for a Temporary Insurance Agreement, Nationwide will only be liable to the extent set forth in that Agreement.
- If the full first premium is not paid with this application, then insurance will only take effect when (1) a policy is issued by Nationwide and accepted by me; and (2) the full first premium is paid; and (3) all the answers and statements made on the application, medical examination(s) and amendments are true to the best of my knowledge and belief when (1) and (2) have occurred.

Authorization

I authorize: any licensed physician or medical practitioner; any hospital, clinic, pharmacy or other medical or medically related facility; any insurance company; the Medical Information Bureau; or any insurance support organization, who has knowledge of me; to give that information to the Medical Director of the Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company, or its reinsurers, for the purpose of underwriting my application in order to determine eligibility for Life Insurance and to investigate claims. By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this form; and I instruct any physician; health care professional; hospital; clinic; medical facility; or other health care provider to release and disclose my entire medical record. I understand that any information that is disclosed pursuant to this form may be redisclosed and no longer be covered by federal rules governing privacy and confidentiality of health information. This form, or a copy of it, will be valid for a period of not more than two and one-half years (30 months) from the date it was signed. I understand that I have the right to revoke this form in writing, at anytime, by sending a written request for revocation to Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company, Attention: Underwriting, P.O. Box 182835, Columbus, Ohio 43218-2835. I understand that a revocation is not effective to the extent that any of my providers have relied on this form; or to the extent that Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I further understand that if I refuse to sign this form to release my complete medical records, Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company may not be able to process my application. I understand that my authorized representative or I have a right to a copy of this form by sending a request to Nationwide in writing.

PART H - SIGNATURES AND PRODUCER'S CERTIFICATION

Proposed Insured(s) and Owner Signatures

I HAVE READ THIS APPLICATION AND AGREEMENT AND DECLARE THAT THE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND AND AGREE TO ALL ITS TERMS.

Signed at _____ (City/State), on _____ (Month/Day), _____ (Year)

_____ Full Name of Proposed Primary Insured *(print)*

X_____ Signature of Proposed Primary Insured *(or parent if Proposed Primary Insured is under age 15)*

_____ Full Name of Proposed Additional Insured *(print)*

X_____ Signature of Proposed Additional Insured *(if to be Insured)*

X_____ Signature of Applicant/Owner *(if other than the Proposed Insured(s))*

X_____ Signature of Applicant/Owner *(if other than the Proposed Insured(s))*

Producer's Certification

Be sure to answer all three questions

☐ Yes ☐ No	a. I have truly and accurately recorded all Proposed Insureds' answers on this application.
☐ Yes ☐ No	b. I have witnessed his/her/their signature(s) hereon. *(If "no", provide details in Special Instructions Section.)*
☐ Will ☐ Will Not	c. To the best of my knowledge, the insurance applied for will or will not replace any Life Insurance, and/or Annuities.

_____ Producer's Name *(print)*

X_____ Signature of Producer

_____ Firm

_____ Producer's Nationwide #

TEMPORARY INSURANCE AGREEMENT
NATIONWIDE LIFE INSURANCE COMPANY/NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY, COLUMBUS, OH

This Agreement provides a limited amount of Life Insurance coverage, for a limited period of time, subject to the terms of this Agreement.

HEALTH QUESTION

STOP

Question must be answered.

Proposed Primary Insured		Proposed Additional Insured		Any Child		Has anyone here proposed for insurance:
Yes	No	Yes	No	Yes	No	
☐	☐	☐	☐	☐	☐	Within the past 10 years, been treated for, consulted a licensed health care provider, or been diagnosed by a licensed health care provider as having: angina, or chest pain or discomfort; heart attack, heart murmur, or any other heart disorder; epilepsy, stroke or diabetes; AIDS (Acquired Immune Deficiency Syndrome); any brain, nervous, or mental disorder, any drug or alcohol addiction; any kidney disorder (other than kidney stones); or any cancer or other malignancy?

*If the above question is answered **YES or LEFT BLANK, NO COVERAGE** will take effect under this Agreement and no representative of Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company is authorized to accept money, and/or provide a temporary insurance receipt to the applicant.*

TERMS AND CONDITIONS

Amount of Coverage

***[$1,000,000]** overall maximum for all applications or agreements.*

Temporary Insurance under this Agreement will commence on the date of the application if the full first premium for the mode selected has been paid and accepted by Nationwide or authorized by Electronic Funds Transfer as advance payment for an application for Life Insurance. If any Proposed Insured dies while this temporary insurance is in effect, Nationwide will pay to the designated Beneficiary the lesser of:

- the amount of death benefits, if any, which would be payable under the policy and its riders if issued as applied for, excluding any accidental death benefits, or
- **[$1,000,000]** This total benefit limit applies to all insurance applied for under this and any other current applications to Nationwide and any other Temporary Insurance Agreements for Life Insurance whether applied for on the life or lives of one or more Proposed Insureds.

Date Coverage Terminates

***60 DAYS** maximum coverage.*

Temporary Life Insurance under this Agreement will terminate automatically on the earliest of:

- **60 days** from the date of this signed Agreement, or
- the date any policy is offered or issued to the Proposed Insured in connection with the above application, or
- the date Nationwide mails notice of termination of coverage and refund of the advance payment to the Proposed Insured, or the Owner, if different than the Proposed Insured.

Limitations

- Fraud or material misrepresentation in the application or in the answers to the Health question of this Agreement invalidates this Agreement and Nationwide's only liability is for refund of any payment made.
- This Agreement does not provide coverage for Proposed Insured's who are under 15 days of age or over the age of 70 on the date of the Agreement.
- If any Proposed Insured dies by suicide, while sane or insane, Nationwide's liability under this Agreement is limited to a refund of the payment made.
- There is no coverage under this Agreement if the check submitted as payment is not honored by the bank on first presentation or if the Electronic Funds Transfer is not processed by the bank.
- No one is authorized to waive or modify any of the provisions of this Agreement.

SIGNATURES

Proposed Insured(s) and Owner Signatures

I HAVE RECEIVED A COPY OF AND HAVE READ THIS AGREEMENT AND DECLARE THAT THE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND AND AGREE TO ALL ITS TERMS.

Dated *(mm/dd/yyyy)* _____ X_____
Signature of Proposed Primary Insured
(or parent if Proposed Primary Insured is under age 15)

X_____
Signature of Applicant/Owner
(if other than the Proposed Insured(s))

X_____
Signature of Proposed Additional Insured
(if to be Insured)

Initial Premium Receipt and Producer's Signature

An initial premium payment in the amount of $_____ has been submitted with this application. I have advised the Applicant/Owner that additional premium may need to be submitted at time of delivery.

X_____ _____ _____
Signature of Producer | Firm | Producer's Nationwide #

PRODUCER'S CERTIFICATE
These questions must be answered by the soliciting Producer.

1. Proposed Primary Insured

Name (First, MI, Last): *(Please print)*

Rate Class Illustrated:

2. Proposed Additional Insured

Name (First, MI, Last): *(Please print)*

Rate Class Illustrated:

3. Income/Net Worth

Client:	**Annual Income:**	**Net Worth:**
Proposed Primary Insured	$	$
Spouse/ Proposed Additional Insured	$	$

4. Type of Insurance

Personal: ☐ Death Benefit Protection ☐ Estate Succession ☐ Supplemental Retirement Benefit ☐ Educational Funding ☐ Wealth Enhancement/Transfer ☐ Charitable Planning ☐ Other_____

For Personal Insurance, complete the Life Financial Supplement or provide financial statements if:

- Specified amount is $1,000,001 or more for ages 18-70
- Specified amount is $100,001 or more for ages 71+

Business: ☐ Buy/Sell (Cross Purchase) ☐ Split Dollar Plan ☐ Buy/Sell (Stock Redemption) ☐ Key Person Insurance ☐ Executive Bonus ☐ Non-Qualified Deferred Compensation ☐ Insurance Based Retirement Plan ☐ Other_____

For Business Insurance, complete the Life Financial Supplement or provide financial statements if:

- Specified amount is $500,000 or more with all ages

5. Business Insurance

Complete this section if the Business Financial Supplement is not required.

Is Business: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Other _____

Indicate the participants and their percentage of ownership: _____

Assets: $	Liabilities: $	Net Worth: $
Net Profit After Taxes: $	Net Profit Prior Year: $	Estimated "Market" Value of Business: $

6. For Juvenile Applicants Only

Indicate how much is in force with all companies.

On the Father: $_____		On the Mother: $_____		On the Owner/ Guardian:$_____
Siblings	Age:	Amount: $_____	Age:	Amount: $_____
	Age:	Amount: $_____	Age:	Amount: $_____

7. Additional Information

All questions in this section are to be fully completed by the soliciting producer before a final offer of coverage is provided.

a. Who began negotiations for this application? ☐ Producer ☐ Owner ☐ Proposed Primary Insured ☐ Proposed Additional Insured ☐Other _____

b. How well do you know:
Proposed Primary Insured? ☐ Met very recently ☐ Known for _____ years ☐ Relative – Relationship_____
Proposed Additional Insured? ☐ Met very recently ☐ Known for _____ years ☐ Relative - Relationship_____

c. Was everyone proposed for insurance present at the time of application? ☐ Yes ☐ No
If no, please explain:_____

d. List all other producers that were involved directly or indirectly during the sales process:
_____

e. For the questions below, please provide full details for yes answers in the Remarks section. If any changes occur to these answers before the policy is issued and placed in force, the home office must be notified immediately.

1. Have you, the producer, been involved in any discussion about the possible sale of this policy to a life settlement or other secondary market provider? ☐ Yes ☐ No
2. Will any portion of the premium for this policy be financed? ☐ Yes ☐ No
3. Will any insured or policy owner receive any payment or gift in connection with this policy? ☐ Yes ☐ No

f. Will there be split commissions? *(If "yes", fill out Split Commissions form or use Remarks section)* ☐ Yes ☐ No

8. Ordering Requirements

Unless indicated in this section, Nationwide will order all Requirements.

Proposed Primary Insured:
Have you ordered requirements? ☐ Yes ☐ No
If yes, please identify:
☐ Paramed Exam ☐ Urine ☐ Blood ☐ Stress EKG ☐EKG
Paramed Company ordered from:_____
☐ APS Doctor/Facility_____

Proposed Additional Insured:
Have you ordered requirements? ☐ Yes ☐ No
If yes, please identify:
☐ Paramed Exam ☐ Urine ☐ Blood ☐ Stress EKG ☐ EKG
Paramed Company ordered from:_____
☐ APS Doctor/Facility_____

9. Remarks

If more space is needed, an additional blank sheet may be attached. Producer should sign and date additional pages.

10. Producer's Information

Producer's Name & Firm (Please Print):

Date:

Phone Number:	Fax Number:	E-Mail Address:

Nationwide Life Insurance Company
Nationwide Life Insurance Company of America
Nationwide Life and Annuity Company of America
Nationwide Life and Annuity Insurance Company

1035 EXCHANGE PACKET

- ☐ State Replacement form(s) (if applicable)
- ☐ An illustration
- ☐ Policy or check Lost Policy Statement box on 1035 Exchange Form
- ☐ Copy of the inforce illustration, statement or other document.
- ☐ Original signature(s)
- ☐ A separate 1035 Exchange Form for each company being replaced.

Submit paperwork to:

Regular Mail:
Nationwide Financial
Attn: Life Underwriting
PO Box 182835
Columbus, OH 43218-2835

Express/Overnight Mail:
Nationwide Financial
Attn: Life Operations
RR1-04-D4
5100 Rings Rd.
Dublin, OH 43017-1522

Our service to you. . .Nationwide will:

- ☐ Overnight the 1035 Exchange documents to the Relinquishing Company once underwriting is completed.
- ☐ Regularly communicate with the Relinquishing Company to ensure timely transfer of the 1035 Exchange funds).
- ☐ Proactively contact you if the Relinquishing Company has additional requirements to complete the Exchange.
- ☐ Provide immediate status of any pending case or the client may call the New Business Help Line 1-866-678-Life(5433).
- ☐ Apply the 1035 Exchange proceeds the day it is received by Nationwide.
- ☐ Perform a quality check of the policy prior to its prompt mailing to you.

Top 5 Ways to Speed Up 1035 Exchanges From Relinquishing Companies

1. Producer and/or client complete due diligence call to the relinquishing company prior to completing 1035 Exchange paper work and submitting life application to verify policy number(s),name of the insured, current ownership, assignments, outstanding loans, and current cash value. (Due to Privacy Act, many relinquishing companies will not provide information to Nationwide Representatives)

2. Complete the entire 1035 Exchange form because it improves timely processing by relinquishing companies.

3. When applicable, have the correct owner(s)/trustee(s) sign and add titles to the 1035 Exchange form and include full name of the trust with date it was created on ownership line and Trust Tax ID numbers.

4. When applicable, send in supporting forms i.e.

   A) If Previous policy is collaterally assigned, please send the release of assignment form with authorized signatures.

   B) If owned by a trust, please send in documentation to support authorized trust/trustees, especially if there has been a change in ownership or trustees since initial policy issued. Most relinquishing companies require at least page 1 and signature page of trust documents.

   C) If owned by a company, the corporate resolution is required. This document should be on company letterhead and state the title of the person(s) signing the 1035 Exchange form stating the assignees are authorized to sign on behalf of the company.

5. Work closely and communicate often with the client to secure proper signatures, documents, and quick return of relinquishing companies' forms during the relinquishing companies' conservation efforts.

Nationwide Life Insurance Company
Nationwide Life Insurance Company of America
Nationwide Life and Annuity Company of America
Nationwide Life and Annuity Insurance Company

INTERNAL REVENUE CODE 1035 EXCHANGE FORM

Section A – POLICY TO BE EXCHANGED (Complete one form for each owner, insured and relinquishing company)

Relinquishing Company's Name: _____ Phone Number: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Owner(s): _____ Soc. Sec. No. or Tax ID: – –

Insured: _____ Soc. Sec. No. or Tax ID: – –

Policy Number	Estimated 1035 Amount	Outstanding Loan Amount	Loans to be Carried Over (1)	Loans to be Extinguished (2)	Collateral Assignment	Irrevocable Benficiaries

(1) There are restrictions limiting the maximum loan value which may be carried over to Nationwide's Variable Life policies. Such restrictions are based on the existing loan value and the net surrender value of the policy contemplated for exchange.

(2) Outstanding loans which are extinguished or forgiven upon exchange may be reportable as taxable income to the extent of any gain within the policy. Please consult with your tax advisor before contemplating an exchange with an outstanding loan.

Section B – LOST POLICY STATEMENT ☐ Relinquishing Company's Policy is not available

Section C – ABSOLUTE ASSIGNMENT

I hereby assign and transfer to Nationwide Life Insurance Company, without exception, limitation, or reservation all assignable benefits, interest, and property rights to the above referenced policies. I also warrant there are no other assignments, legal proceedings by creditors or others and that a petition in bankruptcy has not been filed against me. The sole purpose of this assignment is to achieve an exchange of insurance policies under the Internal Revenue Code Section 1035. I understand the above policies will be surrendered for their respective cash surrender proceeds, if any, and applied to a Nationwide policy. I understand and agree that Nationwide Life Insurance Company is participating in the transaction as an accommodation to me and that Nationwide makes no representations or assumes any liability for my tax treatment associated with this exchange.

Section D – 1035 DISCLOSURE

I hereby acknowledge that I have read the "IRC Section 1035 Disclosure Statement" and fully understand the importance of correctly determining the tax status of all policies to be exchanged, as well as, the possible tax consequences which can result under the situations described with in the statement.

*** Section E – I wish to waive any conservation effort that may be in effect with the relinquishing company.** ☐

Section F – SIGNATURE (Must be signed by owner of policy being transferred)

By signing below, I hereby expressly represent that the above statements are true to the best of my knowledge and that no person, firm, or corporation other than the undersigned has any interest in this policy, and that no proceedings of insolvency or bankruptcy have been instituted or are pending against undersigned.

Owner Signature: (Relinquishing company requires original owner/trustee(s) signature. Please sign with title if applicable) X _____ Date: _____

Joint Owner/Trustee (if applicable) Signature: (All trustee signature and titles are required) X _____ Date: _____

Nationwide Life Insurance Company
Nationwide Life Insurance Company of America
Nationwide Life and Annuity Company of America
Nationwide Life and Annuity Insurance Company

P.O. Box 182835, Columbus, Ohio 43218-2835

INTERNAL REVENUE CODE SECTION 1035 EXCHANGE DISCLOSURE

Under certain conditions, Internal Revenue Code Section 1035 allows for the exchange of life insurance, endowments and annuities as non-taxable events. While these rules normally allow policy owners to take advantage of modern policy features without recognizing a gain or loss on existing policies, certain situations can create a recognized taxable event.

Life insurance contracts issued before June 21, 1988 receiving preferential tax treatment of pre-death distributions an non-modified endowment contracts, as defined by Internal Revenue Code Section 7702 and 7702A, may lose this treatment if the owner tries to combine the cash surrender value of existing contracts with money from sources other than policies being exchanged, to form the cash value of the new policy. Conversely, receipt (either actual or constructive) by the owner, of any portion of the surrender proceeds from contracts being exchanged, may be treated as a taxable event. This includes outstanding policy loans extinguished during the exchange process. Similarly, taking possession of surrender proceeds either by cashing a surrender check or endorsing such check over to the replacing company, may also cause the transaction to be treated as a taxable event. If Section 1035 surrender proceeds are received by the owner they should be immediately returned to the company issuing the check with a written request to reissue the check in the name of the replacing company.

An exchange should not be initiated if the policy owner anticipates a need for any portion of the existing cash values within this time period. The policy owner and the Internal Revenue Service will receive an Internal Revenue Form 1099R indicating an exchange has been made.

If two or more policies are being exchanged for a single contract and at least one of the existing contracts is a modified endowment contract, the new policy will also be a modified endowment contract. If the tax status of existing policies are in doubt, clarification should be sought from the issuing company before initiating a Section 1035 Exchange.

The foregoing discussion is general and is not intended as tax advice. Counsel and other competent advisors should be consulted for more complete information. This discussion is based on the Company's understanding of federal income tax laws as they are currently interpreted by the Internal Revenue Service. No representation is made as to the likelihood of continuation of these current laws and interpretations.

NATIONWIDE LIFE INSURANCE COMPANY

One Nationwide Plaza, Columbus OH 43215-2220 (614) 249-7111

NOTICE AND CONSENT FOR AIDS VIRUS (HIV) BLOOD, URINE OR ORAL FLUID TESTING

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood (as in needles shared during intravenous drug use).

The AIDS related virus (HIV) antibody test detects the presence of antibodies, naturally occurring proteins in the sample fluid, produced by the body in response to the AIDS related virus. The HIV antigen test directly identifies AIDS viral particles. To evaluate your insurability the Insurer indicated above has requested that you provide a sample of blood, urine or oral fluid (saliva) for testing and analysis to determine the presence of HIV antibodies. The purpose of the test is to determine whether you may have been infected with HIV. If you are infected, you are probably not insurable. This is not a test for AIDS. AIDS can only be diagnosed by medical evaluation. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the results. A series of three tests will be performed by a licensed laboratory through a medically accepted and Federal Drug Administration (FDA) approved procedure.

This test will be performed according to the following protocol:

1. An initial ELISA test will be done.
    a. If the initial ELISA test is positive, it will be repeated.
    b. If the initial ELISA test is negative, a negative finding will be reported.
2. If the second ELISA test is:
    a. Positive, a Western Blot test will be performed to confirm the positive results of the two ELISA tests.
    b. Negative, a third ELISA test will be performed.
        1) If the third ELISA test is positive, a Western Blot test will be performed to confirm the previous results.
        2) If the third ELISA test is negative, a negative result will be reported.
3. Only if at least two ELISA tests and a Western Blot test are all positive, will the result be reported as positive.

The above tests performed on a saliva sample are not as reliable as they are when performed on a blood sample. You may request a blood sample be used instead of a saliva sample. Either way, the insurer will pay for the cost of your testing in relation to your insurability.

The tests for HIV antibodies are very sensitive. Errors are rare, but they do occur. Possible errors include false positive and false negatives. A false positive test gives a positive result, even though you are not infected. This happens only rarely and is more common in persons who have engaged in high risk behavior. Retesting should be done to confirm the validity of a positive test. A false negative gives a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons. It takes at least 4-12 weeks for a positive result to develop after a person is infected.

All test results are required to be treated confidentially. They will be reported by the laboratory to us. The test results may be disclosed as required by law, or to employees who have the responsibility of making underwriting decisions on our behalf. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test results of a saliva sample will not be released to anyone else not indicated above without your express written consent. The test result from a blood sample may be released to those persons indicated above and the Medical Information Bureau (MIB), an Insurance Information exchange, under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS.

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to us as being positive, you are entitled to that information if you so desire. Because a trained person should deliver that information so that you can understand clearly what the results mean, you are asked to list your private physician so that we can have him or her tell you the test results and explain their meaning.

Physician's Name

Address

City

State Zip

I have read and understood this notice and consent for testing. I voluntarily consent to the collection of ☐ saliva ☐ urine or ☐ blood from me, the testing of that specimen, and the disclosure of the test results as described above. I have read the information on this form about what a test result means and understand that I should contact a local AIDS service group, a list of which has been given to me, or my private physician for further information and counseling if the test is positive.

A photo copy of this form will be as valid as the original.

Signature of Proposed Insured

Social Security Number and/or Drivers License Number and State

Date

Printed Name

Witness

AVAILABLE COUNSELING SERVICES

SAN FRANCISCO AIDS FOUNDATION

10 United Nations Plaza
San Francisco, CA 94102
(415) 487-3000

AIDS SERVICES FOUNDATION OF ORANGE COUNTY

17982 Sky Park Circle
Suite J
Irvine, CA 92714
(714) 253-1500

SACRAMENTO AIDS FOUNDATION

100 "K" Street
Suite 201
Sacramento, CA 95814
(916) 448-2437

SAN DIEGO AIDS PROJECT

140 Arbor Drive
San Diego, CA 92103
(619) 686-5000

CENTRAL VALLEY AIDS TEAM

P. O. Box 4640
Fresno, CA 83744
(209) 264-2437

AIDS PROJECT-EAST BAY

651 20th Street
Oakland, CA 94612
(510) 834-8181

AIDS PROJECT-LOS ANGELES

1313 North Vine St
Los Angeles, CA 90028
(213) 993-1600

ARIS PROJECT

1550 The Alameda
Suite 100
San Jose, CA 95126
(408) 293-2747

NATIONWIDE LIFE INSURANCE COMPANY

One Nationwide Plaza, Columbus OH 43215-2220 (614) 249-7111

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    a. Positive, a Western Blot test will be performed to confirm the positive results of the two ELISA tests.
    b. Negative, a third ELISA test will be performed.
        1) If the third ELISA test is positive, a Western Blot test will be performed to confirm the previous results.
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3. Only if at least two ELISA tests and a Western Blot test are all positive, will the result be reported as positive.

The above tests performed on a saliva sample are not as reliable as they are when performed on a blood sample. You may request a blood sample be used instead of a saliva sample. Either way, the insurer will pay for the cost of your testing in relation to your insurability.

The tests for HIV antibodies are very sensitive. Errors are rare, but they do occur. Possible errors include false positive and false negatives. A false positive test gives a positive result, even though you are not infected. This happens only rarely and is more common in persons who have engaged in high risk behavior. Retesting should be done to confirm the validity of a positive test. A false negative gives a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons. It takes at least 4-12 weeks for a positive result to develop after a person is infected.

All test results are required to be treated confidentially. They will be reported by the laboratory to us. The test results may be disclosed as required by law, or to employees who have the responsibility of making underwriting decisions on our behalf. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test results of a saliva sample will not be released to anyone else not indicated above without your express written consent. The test result from a blood sample may be released to those persons indicated above and the Medical Information Bureau (MIB), an Insurance Information exchange, under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS.

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to us as being positive, you are entitled to that information if you so desire. Because a trained person should deliver that information so that you can understand clearly what the results mean, you are asked to list your private physician so that we can have him or her tell you the test results and explain their meaning.

Physician's Name

Address

City

State Zip

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A photo copy of this form will be as valid as the original.

Signature of Proposed Insured

Social Security Number and/or Drivers License Number and State

Date

Printed Name

Witness

AVAILABLE COUNSELING SERVICES

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10 United Nations Plaza
San Francisco, CA 94102
(415) 487-3000

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651 20th Street
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(510) 834-8181

AIDS PROJECT-LOS ANGELES

1313 North Vine St
Los Angeles, CA 90028
(213) 993-1600

ARIS PROJECT

1550 The Alameda
Suite 100
San Jose, CA 95126
(408) 293-2747

NATIONWIDE FINANCIAL

LICENSING SERVICES DIVISION PRODUCER INFORMATION FORM

ALL INFORMATION IS REQUIRED UNLESS NOTED AS "If Applicable" (Please print legibly or type)

Will you sell **PRIMARILY** in a bank, credit union or savings and loan? ☐ Yes ☐ No If Yes, Name:_____

Please indicate which products you will sell: ☐ Individual Annuities ☐ Individual Life ☐ Fixed Only ☐ Group Annuities ☐ Group Retirement Trust

Full Name:_____ Social Security Number:_____
EXACTLY AS SHOWN ON LICENSE

Date of Birth:_____ National Producer Number:_____

State(s) where business will be sold:_____ (Note: Broker Dealer/Firm must be licensed/appointed in the state(s))

Broker/Dealer Name:_____ NASD U-4 Status Report CRD Number:_____
IF APPLICABLE

Agency Name:_____ Fixed Firm:_____
IF APPLICABLE IF APPLICABLE

Business Address:_____
STREET ADDRESS OR P O BOX

_____
CITY STATE ZIP CODE COUNTY

Business Telephone:(_____)_____ Business Fax:(_____)_____

Business Cell Phone:(_____)_____ Business E-mail Address:_____

Resident Address:_____
STREET ADDRESS

_____
CITY STATE ZIP CODE COUNTY

Resident Telephone:(_____)_____

MUST BE COMPLETED BY PRODUCER: (Please attach a detailed letter of explanation for any "Yes" answer to the following questions)

Have you ever been convicted of, pled no contest to, or are currently under indictment for any criminal felony or misdemeanor excluding minor traffic violations? ☐ Yes ☐ No

Have you filed a bankruptcy petition, been declared bankrupt or insolvent within the past ten years? ☐ Yes ☐ No

Are you currently indebted to any insurance company or do you now have or have you ever had any unsatisfied judgments, liens, or garnishments against you? ☐ Yes ☐ No

Have you ever had an appointment canceled by an insurance company for reasons other than lack of production? ☐ Yes ☐ No

Have you ever been suspended, disqualified or disciplined by any state, federal or self-regulatory agency? ☐ Yes ☐ No

I, _____, hereby authorize Nationwide and its agents to make an independent investigation of my background, references, character, past employment, education, criminal or police records, including those mandated by both public and private organizations and all public records for the purpose of confirming the information contained on my application and/or obtaining other information which may be material to my qualifications for appointment.

I release Nationwide and/or its agents and any person or entity, which provides information pursuant to this authorization, from any and all liabilities, claims or lawsuits in regard to the information obtained from any and all of the above referenced sources used.

I affirm that all of the information provided on the foregoing statement is true, accurate and complete to the best of my knowledge. Should any of the information change, I will promptly notify Nationwide in writing.

_____ _____
Producer Signature Date

NATIONWIDE LIFE INSURANCE COMPANY MAILING ADDRESS
LICENSING SERVICES DIVISION RR1-07-F3
NATIONWIDE INSURANCE ENTERPRISE
PO BOX 182021
COLUMBUS OH 43218

EXPRESS MAILING ADDRESS
LICENSING SERVICES DIVISION RR1-07-F3
NATIONWIDE INSURANCE ENTERPRISE
5100 RINGS RD
COLUMBUS OH 43017

LICENSING FAX NUMBER
1-877-634-5264

NATIONWIDE LIFE INSURANCE LICENSING PHONE NUMBER
1-800-321-6064

PRIVATE SECTOR RETIREMENT PLANS LICENSING PHONE NUMBER
1-800-367-5939

Mail To: **Nationwide Life Insurance Company**
Nationwide Life and Annuity Insurance Company
P.O. Box 182835
Columbus, OH 43218-2835
1-800-547-7548
www.nationwidefinancial.com

LIFE FINANCIAL SUPPLEMENT

to Application for **BUSINESS** Life Insurance

(May be used in lieu of a copy of most recent formal financial statement.)

The Life Financial Supplement is necessary for business insurance applications with all ages at $500,000 and over specified amount. (May also be necessary on lesser amounts if requested by Nationwide). A copy of the most recent financial statement is preferred.

Proposed Insured's Name_____ Social Security No._____
First Middle Last

Occupation/Title_____

1. Name of Company_____
2. Address of Company_____
3. Organization Type: ☐ C Corporation ☐ S Corporation ☐ LLC ☐ Partnership ☐ Sole Proprietorship ☐ Other_____
4. Purpose of Organization/Type of Business_____
5. Insured's Percent of Ownership_____%
6. Insured's Annual Earned Compensation: Salary_____ Commission_____ Bonus_____ Other_____
7. Current Company Book Values: Assets $_____ Liabilities $_____ Net Worth $_____
8. CURRENT COMPANY MARKET VALUE
   Market Value $_____
   Market Value of Insured's % of Ownership $_____
9. COMPANY NET PROFIT (Before Taxes & Bonuses)
   This Year (Estimated) $_____
   Last Year (_____) $_____
   Year Before Last (_____) $_____
10. What other Stockholders, Partners, or Key Persons are also being insured in favor of the Company? (Give names and positions.)_____
11. PURPOSE OF BUSINESS INSURANCE (Indicate and furnish details.)

☐ **EXECUTIVE BENEFIT PLAN FUNDING** (Indicate plan purpose and premium contribution.)
☐ Deferred Compensation - Annual Contribution $_____ ☐ Bonus - Annual Contribution $_____
☐ Other_____ - Annual Contribution $_____

☐ **KEY PERSON -** What is the Proposed Insured's position or function in the Company? What special skills, knowledge, or abilities does he/she possess which makes the insurance necessary? How will these funds be utilized? _____

☐ **STOCK REDEMPTION / BUY AND SELL**
a. Is there a written agreement:
☐ In effect? (Attach a signed copy, if available.)
☐ Contemplated? (Give expected finalization date:_____ , _____)
b. How is the business being valued in the agreement? (Book Value? Market Value? Etc.)_____
c. Who are other participants and their percentages?_____

☐ **BUSINESS LOAN** (Include a copy of the loan agreement, if available.)
a. Name and address of lender:_____
b. Amount of Loan $_____ c. Date of Loan_____
d. The repayment terms are:_____
e. The purpose of the loan is:_____
f. Is the lender *requiring* the insurance? ☐ Yes ☐ No g. If issued, will the policy be assigned? ☐ Yes ☐ No
h. Any bankruptcies in the past 7 years? ☐ Yes ☐ No If "yes", give details below.
i. Are there any suits pending or judgments against you at this time? ☐ Yes ☐ No If "yes", give details below.
Details:_____

I understand that Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company will rely on the above statements in determining the need and justification for the insurance applied for and I represent that all answers are true and accurate statements to the best of my knowledge and belief as of the date of application for life insurance.

Date_____ Signature of Proposed Insured_____

Date_____ Signature of Applicant_____
(If someone other than the Proposed Insured)

Date_____ Signature of Witness_____

Mail To: **Nationwide Life Insurance Company**
Nationwide Life and Annuity Insurance Company
P.O. Box 182835
Columbus, OH 43218-2835
1-800-547-7548
www.nationwidefinancial.com

LIFE FINANCIAL SUPPLEMENT

to Application for **PERSONAL** Life Insurance

(May be used in lieu of a copy of most recent formal financial statement.)

The Life Financial Supplement is necessary for applications with ages 18-70 at $1,000,000 specified amount and ages 71 and up at $100,000 and over specified amount. (May also be necessary on lesser amounts if requested by Nationwide). A copy of the most recent financial statement is preferred.

Proposed Insured's Name _____ Social Security No. _____
First Middle Last

Occupation _____ Employer or Self-Employed Name _____

Employer Address _____

Type of Business _____

PERSONAL EARNED INCOME (Annual)

For: Calendar Year Ended _____ OR Calendar Year To End _____ (estimated)

1. **Salaried**
   - a. Salary $_____
   - b. Bonus or Commissions $_____
   - c. Other (Describe) _____ $_____
   - d. **TOTAL COMPENSATION** (a plus b plus c) **$**_____
   - e. Spouse's Earned Income $_____

2. **Self-Employed**
   - a. 1) Gross Sales or Services $_____
     2) Less Cost of Goods Sold $_____
     3) Less Business Expenses $_____
     4) Adjusted Gross Income $_____
   - b. Other (Describe) _____ $_____
   - c. **NET EARNINGS** (a plus b) **$**_____

PERSONAL UNEARNED INCOME (Annual)

1. Dividends $_____
2. Interest $_____
3. Rents $_____
4. Other (Describe) _____ $_____
5. **TOTAL** **$**_____

PERSONAL WORTH (Current Market Value)

ASSETS		LIABILITIES	
1. Cash in Savings, Stocks, Bonds	$_____	1. Unpaid Interest and Taxes	$_____
2. Notes and Accounts Receivable	$_____	2. Notes and Accounts Payable	$_____
3. Life Insurance Cash Values	$_____	3. Loans on Life Insurance	$_____
4. Real Estate - Residence	$_____	4. Mortgage or Liens on Real Estate - Residence	$_____
5. Real Estate - Other (Not Included Above)	$_____	5. Mortgage or Liens on Real Estate - Other	$_____
6. Net Business Interest (Not Included Above)	$_____	6. Other Long-Term Debt	$_____
7. Personal Property	$_____	7. Other Liabilities (Describe) _____	$_____
8. Other Assets (Describe) _____	$_____	8. **TOTAL LIABILITIES**	**$**_____
9. **TOTAL ASSETS**	**$**_____		

PERSONAL NET WORTH (TOTAL ASSETS minus TOTAL LIABILITIES) $_____

PURPOSE OF PERSONAL INSURANCE

☐ Estate Conservation (Taxes) ☐ Income Replacement ☐ Premium Financing
☐ Retirement Funding ☐ Debt Cancellation ☐ Other _____

Explanation: _____

10. Have you been involved in any discussion about the possible sale or assignment of this policy to a life settlement, viatical, or other secondary market provider? ☐ Yes ☐ No If "yes", give details below.
11. Have you ever sold a policy to a life settlement, viatical, or other secondary provider? ☐ Yes ☐ No If "yes", give details below.
12. Will any portion of the premium for this policy be financed? ☐ Yes ☐ No If "yes", give details below.
13. Will any insured or policy owner receive any payment in connection with the insurance issued on the basis of this application? ☐ Yes ☐ No If "yes", give details below.

Details: _____

I understand that Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company will rely on the above statements in determining the need and justification for the insurance applied for and I represent that all answers are true and accurate statements to the best of my knowledge and belief as of the date of application for life insurance.

Date _____ Signature of Proposed Insured _____

Date _____ Signature of Applicant _____
(If someone other than the Proposed Insured)

Date _____ Signature of Witness _____

☐ NATIONWIDE LIFE INSURANCE COMPANY
☐ NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY

P.O. Box 182835, Columbus, Ohio 43218-2835

ACCELERATED BENEFIT RIDER FOR HEALTH CARE/LIFE INSURANCE SUPPLEMENT

(Use when base policy is currently applied for)

Name of Proposed Insured _____ Social Security Number ___ - ___ - ___
(first, middle, last)

RIDER SPECIFIED AMOUNT $ _____

PERSONAL INFORMATION *(If any question in this section is answered "Yes", the Proposed Insured is ineligible for coverage.)*

		YES	NO
1.	Are you confined to bed or house or require assistance or supervision or limited in any way from performing any of the following daily activities: bathing, continence, eating, dressing, toileting, transferring (moving into or out of a bed, chair, or wheel chair)?	☐	☐
2.	Do you use any medical appliance such as but not limited to, respiratory equipment (oxygen or ventilator) or dialysis equipment or dependent on the use of a walker, a wheelchair, or other motorized ambulatory device?	☐	☐
3.	Do you currently have a vascular access port, peg or feeding tube?	☐	☐
4.	Do you have an authorized Power of Attorney in place currently, due to any present or past mental or physical disability?	☐	☐

SUPPLEMENTAL INFORMATION

1. To the best of your knowledge and belief, during the past 5 years have you:
   a. been confined to a hospital, nursing home, or residential care facility? ☐ Yes ☐ No
   b. received home care services, physical, or rehabilitative therapy? ☐ Yes ☐ No
   c. sought medical advice or treatment for loss of appetite, falling, fainting, unstable gait, bladder control, dizziness, or deterioration of vision? ☐ Yes ☐ No
   d. been limited in any way, or used any equipment such as crutches to aid in mobility? ☐ Yes ☐ No
   e. experienced shortness of breath or leg cramps when 4 blocks are walked at a normal pace? ☐ Yes ☐ No

   Provide details for "yes" answers. _____
2. a. Have you been actively at work daily on a full-time basis (minimum 30 hours per week) for the past 6 months? (Disregard vacation days and absences that total less than 5 days.) ☐ Yes ☐ No
   b. If "yes", what is your occupation? _____
   c. Employer name and address. _____
   d. If "no", are you ☐ Retired ☐ Disabled ☐ Other _____
   Please explain. _____
3. Do you drive a motor vehicle? ☐ Yes ☐ No If "yes", approximate number of miles driven per year? _____
4. With whom do you live? ☐ No One ☐ Spouse ☐ Other _____
5. Do you live in a retirement community? ☐ Yes ☐ No If "yes", what services do you receive? (e.g. meals, medications, laundry, house cleaning) _____

INSURANCE INFORMATION

a. List all Long Term Care Insurance now in force on the Proposed Insured or lapsed within the past 12 months. If none, write "NONE".

COMPANY	POLICY NUMBER	TO BE REPLACED?	LAPSE DATE	POLICY TYPE	BENEFIT AMOUNT	YEAR ISSUED
		☐ YES ☐ NO				
		☐ YES ☐ NO				

		YES	NO
b.	Will the Long Term Care Rider applied for replace existing Long Term Care Insurance on the Proposed Insured? (If "yes", provide details in ***a*** above.) *(Complete and send replacement forms where applicable.)*	☐	☐
c.	Is the Proposed Insured now applying for Long Term Care Insurance with any other company? If "yes", state the company and benefit being applied for.	☐	☐

CAUTION: If your answers on this application are misstated or untrue, Nationwide may have the right to deny benefits or rescind your policy.

Signed at _____ (City/State) , on _____ (Month/Day) , _____ (Year) .

I have truly and accurately recorded all Proposed Insured's answers on this application and have witnessed his/her signature(s) hereon.

To the best of my knowledge, the insurance applied for ☐ will ☐ will not (CHECK ONE) replace any long term care insurance.

_____
Producer's Signature Firm

_____
Producer's Name (Print) License ID Number

_____
Signature of Primary Insured

_____
Signature of Applicant (if other than the Primary Insured)

_____
Signature of Owner

NATIONWIDE LIFE INSURANCE COMPANY
NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY
P.O. Box 182835, Columbus, Ohio 43218-2835

Please check forms that have been delivered and received.

- ☐ Important Notice Regarding Policies Available
- ☐ Outline of Coverage
- ☐ HICAP Notice
- ☐ LTC Insurance Shopper's Guide
- ☐ LTC Insurance Personal Work Sheet
- ☐ Notice to Applicant Regarding Replacement of Accident and Sickness or LTC Insurance

Agent's Signature	Date
Agent's Signature	Date

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

NATIONWIDE LIFE INSURANCE COMPANY
NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY
ONE NATIONWIDE PLAZA
COLUMBUS, OHIO 43215-2220

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to your application, you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with a contract to be issued by Nationwide Life Insurance Company or Nationwide Life and Annuity Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT, BROKER, OR OTHER REPRESENTIVE

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

(1) Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy

(2) State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy for similar benefits to the extent time was spent under the original policy.

(3) If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(4) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

_____

Signature of Agent, Broker or other Representative

Sales Representative's Name (must be typed): _____

Address (must be typed): _____

_____

The above “Notice to Applicant” was delivered to me on:

_____/_____/_____ Proposed Insured’s Signature_____
Date

Authorization for Release of Health-Related Information
Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company
Nationwide Life Insurance Company of America/Nationwide Life and Annuity Company of America
P.O. Box 182835, Columbus, Ohio 43218-2835
This authorization complies with the HIPAA Privacy Rule

_____ _____/_____/_____
Name of proposed insured/patient (please print) Date of birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other protected health information concerning me to Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company/Nationwide Life Insurance Company of America/Nationwide Life and Annuity Company of America ("NW") and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that NW may: 1) underwrite my application for coverage, 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 NW.

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to NW at: P.O. Box 182835, Columbus, Ohio 43218-2835, Attention: Life Underwriting. I understand that a revocation is not effective to the extent that any of My Providers have relied on this Authorization or to the extent that NW has a legal right to contest a claim under an insurance policy or to contest the policy itself. 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.

Authorization for Release of Health-Related Information
Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company
Nationwide Life Insurance Company of America/Nationwide Life and Annuity Company of America
P.O. Box 182835, Columbus, Ohio 43218-2835
This authorization complies with the HIPAA Privacy Rule

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, NW may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

_____ _____

Signature of Proposed Insured/Patient or Personal Representative Date

_____

Description of Personal Representative's Authority or Relationship to Patient

NATIONWIDE LIFE INSURANCE COMPANY
NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY
NATIONWIDE MUTUAL INSURANCE COMPANY
NATIONWIDE MUTUAL FIRE INSURANCE COMPANY
NATIONWIDE GENERAL INSURANCE COMPANY
NATIONWIDE PROPERTY AND CASUALTY INSURANCE COMPANY
Home Office: One Nationwide Plaza
Columbus, Ohio 43215-2220

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

A. I authorize Nationwide Life Insurance Company, and its affiliated insurance companies listed above (hereafter called "Nationwide"), its reinsurers, insurance support organizations, and consumer reporting agencies, and their authorized representatives, to obtain medical and other information from any source in order to evaluate my application with respect to me and any children proposed for insurance.

B. I authorize any physician, medical practitioner, other medical professional, hospital, clinic, other medical or medically related facility, the Veterans Administration, the Medical Information Bureau, Inc., my employer, any consumer reporting agency, insurance support organization or insurance company who possesses information of care, treatment, or advice about me or any children proposed for insurance, to furnish such information to any sales, marketing, underwriting or claims personnel of Nationwide Insurance Company or its representative upon presenting this authorization or a photocopy.

C. This authorization includes information about drugs, alcoholism or mental illness.

D. Nationwide or its reinsurers may make a brief report regarding me or any children proposed for insurance to other companies to whom I have applied or may apply.

E. This authorization will be valid from the date signed for a period of two and one half years.

F. I authorize Nationwide to obtain an investigative consumer report with respect to me and with respect to any children proposed for insurance.

G. I or my authorized representative have read this authorization and have received a copy. I or my authorized representative have also received copies of the "Notice Regarding MIB", the notice of information practices required by State Insurance Information and Privacy Protection Act and the notice required by the Federal Fair Credit Reporting Act.

H. ☐ I elect to be interviewed if an investigative consumer report is prepared in connection with this application.

I. ☐ I elect not to have personal information disclosed to non-affiliates of Nationwide for marketing purposes and to affiliates of Nationwide for purposes other than the marketing of insurance products and services.

J. The authorizations given and elections made above are effective with respect to the persons in their respective capacities as signed below.

Dated On	Proposed Insured (Parent or Guardian If Proposed Insured Is Juvenile)
Dated At (City and State)	Signature of Spouse or other Proposed Adult Insured
Agent's Name and Number	

NATIONWIDE LIFE INSURANCE COMPANY
NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY
One Nationwide Plaza
P.O. Box 182021
Columbus, Ohio 43218-2021

NOTICE REGARDING LIFE INSURANCE OR ANNUITY PRODUCT PURCHASE BY ELDER

Are you age 65 or older and thinking about buying a new life insurance policy or annuity?

If so, we are required by law to notify you that the sale or liquidation of any stock, bond, IRA, certificate of deposit, mutual fund, annuity, or other asset to fund the purchase of this product may have tax consequences, early withdrawal penalties, or other costs or penalties as a result of the sale or liquidation.

You or your personal agent may wish to consult independent legal or financial advice before selling or liquidating any assets and prior to the purchase of any life or annuity products being solicited, offered for sale, or sold.

☐ **NATIONWIDE LIFE INSURANCE COMPANY**
☐ **NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY**
COLUMBUS, OHIO 43215-2220

TERM LIFE - IMPORTANT NOTICE

This policy is similar to a term policy for the same level premium period, but does not provide any nonforfeiture benefits (such as cash surrender values) at any time during those years. This means that if you fail to pay a premium within a specified time of its due date, this policy will lapse without any value.

You should compare this policy to a level-premium term policy. Such a term policy would provide identical insurance coverage, but may also be required to provide nonforfeiture benefits at certain durations where this policy does not. However, the premiums for the term policy might be higher than the premiums for this policy.

When considering the purchase of this policy, you should compare the value of having nonforfeiture benefits (such as cash values) versus the level of the premiums that you will pay.

☐ NATIONWIDE LIFE INSURANCE COMPANY
☐ NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY
COLUMBUS, OHIO 43215-2220

UNIVERSAL LIFE - IMPORTANT NOTICE

This policy is guaranteed to stay in force for a number of years as long as you have paid at least as much as the required premiums. This is called a no-lapse guarantee.

Even though it contains a no-lapse guarantee, this policy may provide nonforfeiture benefits (such as cash surrender values) which are less than those that would be provided if the no-lapse guarantee were issued as a separate policy (for example, as a term policy). However, the premiums for the term policy might be higher than those for the no-lapse guarantee in this policy.

When considering the purchase of this policy, you should consider the value to you of higher nonforfeiture benefits versus the level of the premiums required to keep your insurance coverage in force.

IMPORTANT NOTICE

This policy is guaranteed to stay in force for a number of years as long as you have paid at least as much as the required premiums. This is called a no-lapse guarantee.

Even though it contains a no-lapse guarantee, this policy may provide nonforfeiture benefits (such as cash surrender values) which are less than those that would be provided if the no-lapse guarantee were issued as a separate policy (for example, as a term policy). However, the premiums for the term policy might be higher than those for the no-lapse guarantee in this policy.

When considering the purchase of this policy, you should consider the value to you of higher nonforfeiture benefits versus the level of the premiums required to keep your insurance coverage in force.

THIS NOTICE PROVIDES IMPORTANT INFORMATION FOR PRODUCERS SELLING NATIONWIDE PRODUCTS

I. MANDATORY PROOF OF DELIVERY REQUIREMENTS (CA, LA, PA, SD, WV)

California, Louisiana, Pennsylvania, S. Dakota, and West Virginia require proof of delivery of individual life policies, annuity contracts, and endowment contracts. The method of proof of delivery depends on the manner in which the policy or contract is delivered to the client.

Policy / Contract Delivery Method	Proof of Delivery
A. Hand delivered by producer to client	Three (3) copies of a signed delivery receipt must be executed by the producer and the consumer. The date of the signed delivery receipt is the date the free look periods begin. In a situation where you hand deliver contracts, you are responsible 'for obtaining' the signed delivery receipt, 'returning' it to the company and 'providing' your client with a copy.
B. Method other than hand delivery (i.e. mailed directly to the client)	Two delivery receipts will be mailed to the client with the contract. They will be asked to return a copy to the insurance company in a pre-addressed, postage paid, envelope.

It is very important to obtain proof that the contract was delivered. **The date of the signed delivery receipt is the date the free look periods begin**. In a situation where you hand deliver contracts, you are responsible to obtain the signed delivery receipt and return it to the company and provide a copy to the client.

- There are serious ramifications if signed delivery receipts are not obtained including: extended free look for the client could result in substantial gain/loss.
- Deficiencies found during Market Conduct Examinations could lead to sanctions and monetary penalties.

II. PA. FREE LOOK PERIODS AND DISCLOSURE REQUIREMENTS - UPDATE & REMINDER

Pennsylvania law has several free look provisions that relate to internal and external replacements as well as new business free looks. The table below will assist you in answering questions your client may have regarding Nationwide products and Pennsylvania's free look provisions.

Product Types	Transaction Type	Free Look
Individual • Variable Life • Fixed Annuity • Variable Annuity	*New Business* (no replacement involved)	10 days, contract value
Individual • Variable Life • Fixed Annuity • Variable Annuity	*Internal Replacement* (replacement of policy or contract from same insurer or insurer group)	45 days, contract value
Individual • Variable Life • Fixed Annuity • Variable Annuity	*External Replacement* (replacement of policy or contract issued by entity other than insurer or insurer group)	20 days, contract value

The free look provisions have been amended to reflect **refund of contract value** (not premium paid). This change has been noted on all effected Pennsylvania contracts. If you have questions regarding the free look provisions, please call a customer service representative.

NATIONWIDE LIFE INSURANCE COMPANY
NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY
One Nationwide Plaza
Columbus, OH 43215
1-800-882-2822

NOTICE REGARDING REPLACEMENT

REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one--or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefit.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing their policy.

_____ _____
Applicant's Signature Date

_____ _____
Agent's Signature Date

(Instruction: This section to be completed only in conjunction with annuity sales)

POLICY NO.	EXISTING CO.	NAME OF INSURED	ISSUE DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

IMPORTANT

Delivery of Notice to Senior

Any person meeting with a Senior, defined as someone who is 60 years or older, in the Senior's home, with respect to sales of life insurance or annuities, must deliver the **"Special Notice for Seniors Regarding In-Home Sales Meetings"** form, in writing to the Senior, at least 24 hours prior to the initial meeting in their home.

If the Senior has an existing insurance relationship with an insurance professional and requests a meeting with the insurance professional in the Senior's home the same day, a notice shall be delivered to the Senior prior to the meeting.

Special Notice for Seniors Regarding In-Home Sales Meetings

(1) During this visit or a follow-up visit, you will be given a sales presentation on the following (indicate all that apply):

( ) Life insurance, including annuities
( ) Other insurance products (specify):_____

(2) You have the right to have other persons present at the meeting, including family members, financial advisors, or attorneys.

(3) You have the right to end the meeting at any time.

(4) You have the right to contact the Department of Insurance for information, or to file a complaint.

California Department of Insurance
Consumer Assistance Telephone
1-800-927-HELP (4357)
(Calling from within California)

1-213-897-8921
(Outside California)

1-800-482-4833
(TDD - Telecommunication Devices for the Deaf)

(5) The following individuals will be coming to your home: (list all attendees, and insurance license information, if applicable.)

_____ _____

_____ _____

Nationwide® Privacy Statement

Thank you for choosing Nationwide®

Our privacy statement explains how we collect, use, share, and protect your personal information. So just how do we protect your privacy? In a nutshell, we respect your right to privacy and promise to treat your personal information responsibly. It's as simple as that. Here's how.

Confidentiality and security

We follow all data security laws. We protect your information by using physical, technical, and procedural safeguards. We limit access to your information to those who need it to do their jobs. Our business partners are legally bound to use your information for permissible purposes.

Collecting and using your personal information

We collect information about you when you ask about or buy one of our products or services. The information comes from your application, business transactions with us, publicly available sources, and consumer reports. Please know that we only use that information to sell, service, or market products to you.

We may collect the following types of information:

- Name, address, and Social Security number
- Assets and income
- Property address and value
- Account and policy information
- Consumer report information
- Family member and beneficiary information
- Public information

Sharing your information for business purposes

We share your information with other Nationwide companies and business partners. When you buy a product, we may share your personal information for everyday business purposes. Some examples include mailing your statements or processing transactions that you request. You cannot opt out of these. We also share your information with your agent or producer. They use your personal information to manage your policy or account. We may also share your personal information as federal and state law requires.

Sharing your information for marketing purposes

We don't sell your information for marketing purposes. We have chosen not to share your personal information with anyone except to service your product. So there's no reason for you to opt out. If we change our policy, we'll tell you and give you the opportunity to opt out before we share your information.

Using your medical information

We sometimes collect medical information. We may use this medical information for a product or service you're interested in, to pay a claim, or to provide a service. We may share this medical information for these business purposes if required or permitted by law. But we won't use it for marketing purposes unless you give us permission.

Accessing your information

You can always ask us for a copy of your personal information. Please call us at one of the phone numbers listed below to access your personal information or for questions about our privacy policy. We have a process that allows you to review your information and for your protection, we will verify your identity first. We can only give access to information that we control. We don't charge a fee for giving you a copy of your information now, but we may charge a small fee in the future.

Individual Annuities and Life and Health Operations 1-866-223-0303
TTY/TTD services 1-800-238-3035
Nationwide Investment Advisors, LLC 614-249-5948

You can change your personal information at MyNationwide.com or by calling your agent or producer. But we can't update information that other companies provide to us. So you'll need to contact these other companies to change and correct your information.

A parting word …

These are our privacy practices. They apply to all current, joint, and former clients of Nationwide Financial and the affiliates and subsidiaries that offer life insurance, banking services, and investments. This includes the following companies:

Nationwide Life Insurance Company
Nationwide Life and Annuity Insurance Company
Nationwide Retirement Solutions, Inc.
NFS Distributors, Inc.
Pension Associates, Inc.
Nationwide Investment Services Corporation
Nationwide Investment Advisors, LLC
Nationwide Financial Institution Distributors Agency, Inc.
Nationwide Retirement Solutions, Inc. of Arizona
Nationwide Retirement Solutions, Inc. of Ohio
Nationwide Retirement Solutions, Inc. of Texas
Nationwide Retirement Solutions Insurance Agency, Inc.
Nationwide Bank