NATIONWIDE® HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices (the "Notice") applies to Nationwide[1] and describes the legal obligations of Nationwide, and your legal rights regarding your Protected Health Information ("PHI" as that term is defined below) held by Nationwide under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Among other things, this Notice describes how your PHI may be used or disclosed to carry out treatment, payment, or long-term care insurance operations, or for any other purposes that are permitted or required by law.

Nationwide is required by HIPAA and certain state laws to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to your PHI. We are required to abide by the terms of this Notice so long as it remains in effect. Nationwide reserves the right to change the terms of this Notice and to make the new Notice effective for all PHI maintained by us, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of the revised Notice by mail to your last-known address on file.

Protected Health Information (PHI) includes individually identifiable health information that is created or received by Nationwide and that relates to: (1) your past, present, or future physical or mental health or condition, (2) the provision of health care to you, or (3) the past, present, or future payment for the provision of health care to you. PHI includes information of persons living or deceased.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Your Authorization. Certain uses and disclosures of PHI require your authorization. For example, most uses and disclosures of PHI for marketing purposes and disclosures that constitute a sale of PHI require a written authorization. Except as outlined below, we will not use or disclose PHI we receive about you in connection with a long-term care insurance application or contract without your written authorization. If you have given us an authorization, you may revoke it in writing at any time, unless we have already acted on the authorization. Once we receive your written revocation, it will only be effective for future uses and disclosures.

Disclosures for Treatment, Payment or Health Insurance Operations. We may use or disclose your PHI as permitted by law for your treatment, payment, or long-term care insurance operations. For instance, for your treatment, a doctor or facility involved in your care may request information we hold in order to make decisions about your care. For payment, we may disclose your PHI for claims-related purpose. For example, if you present a claim, we may obtain medical records from your doctors to determine if you are eligible for benefits under the terms of the insurance contract. For long-term care insurance operations, we may use and disclose your PHI for situations that include, but are not limited to, reviewing medical information you provided as part of your application, underwriting, quality assurance, and responding to customer inquiries regarding benefits and claims.

Family and Friends Involved In Your Care. With your approval, we may from time to time disclose your PHI to designated family, friends, and others who are involved in your care or in payment for your care in order to facilitate that person's involvement in caring for you or paying for your care.

If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited PHI with such individuals without your approval.

Business Associates. Certain aspects and components of our services are performed through contracts with outside persons or organizations. At times it may be necessary for us to provide your PHI to one or more of these

[1] Nationwide Life Insurance Company®, Nationwide Life and Annuity Insurance Company®, and the areas within Nationwide Mutual Insurance Company® that perform HIPAA covered functions.

outside persons or organizations. For example, we may disclose your PHI to a business associate to administer claims or to provide support services. In all cases, we require these business associates by contract to appropriately safeguard the privacy of your information.

Other Health-Related Products or Services. We may, from time to time, use your PHI in determining whether to provide information to you concerning enhancements to your long-term care insurance contract or to offer enhancements to your current coverage as permitted by HIPAA.

Plan Administration. If you are insured under a group long-term care insurance contract, we may disclose your PHI to the sponsor of your benefit plan for administrative purposes, provided we have received certification that the information will be maintained in a confidential manner and not used in any other manner not permitted by law.

Other Uses and Disclosures. We are permitted or required by law to make certain other uses and disclosures of your PHI without your authorization. We may release your PHI for any purpose required by law. This may include releasing your PHI to law enforcement agencies; public health agencies; government oversight agencies; workers compensation; for government audits, investigations, or civil or criminal proceedings; for approved research programs; when ordered by a court or administrative agency; to the armed forces if you are a member of the military; and any other disclosures we are required by law to make.

OTHER PRIVACY LAWS AND REGULATIONS

Certain other state and federal privacy laws and regulations may further restrict access to and uses and disclosures of your PHI or provide you with additional rights to manage such information. If you have questions regarding these rights, please send a written request to your designated contact as explained in the "Contact Information" section, below.

RIGHTS THAT YOU HAVE

Access to Your PHI. You have the right to copy and/or inspect much of the PHI that we retain on your behalf. All requests for access must be made in writing and signed by you or your personal representative. We may charge you a fee if you request a copy of the information. The amount of the fee will be indicated on the request form. A request form can be obtained by writing your designated contact at the address provided in the "Contact Information" section.

Amendments to Your PHI. You have the right to request that the PHI that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. If the information is incorrect or incomplete and we decide to make an amendment or correction, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. A request form can be obtained by writing to your designated contact at the address provided in the "Contact Information" section.

Accounting for Disclosures of Your PHI. You have the right to receive an accounting of certain disclosures of your PHI made by us, subject to certain exceptions. Requests must be made in writing and signed by you or your personal representative. A request form can be obtained by writing your designated contact at the address provided in the "Contact Information" section.

Restrictions on Use and Disclosure of Your PHI. You have the right to request restrictions on some of our uses and disclosures of your PHI. We will consider, but are not required to agree to, your restriction request. A request form can be obtained by writing your designated contact at the address provided in the "Contact Information" section.

Request for Confidential Communications. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your PHI from us by alternative means or at alternative

locations. A request form can be obtained by writing your designated contact at the address provided in the "Contact Information" section.

Right to be Notified of a Breach. You have the right to be notified in the event we discover a breach of your unsecured PHI.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice, even if you have requested such copy by e-mail or other electronic means.

Complaints. If you believe your privacy rights have been violated, you can file a written complaint with your designated contact as explained in the "Contact Information" section, below. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights, in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

CONTACT INFORMATION

If you have any questions about this Notice, need copies of any forms or require further assistance with any of the rights explained above, contact us by calling 1-800-848-6331, or mail your request to:

Nationwide
P.O. Box 182928
Columbus, OH 43218-2928

EFFECTIVE DATE

This Notice is effective July 1, 2015.

Life Application Instructions

Nationwide Life Insurance Company
Nationwide Life and Annuity Insurance Company

PO Box 182835, Columbus, OH 43218-2835
Phone: 800-848-6331 • Fax: **888**-677-7393. • nationwide.com

1. Submitting An Application

Nationwide YourLife® CareMatters℠

Reminders - Review the Pre-Qualification Guide for potential declines prior to application submission. Initials are required in Sections 3 & 17 of the application.

Permanently Retain - The originally signed and dated paperwork for your files for future reference.

Modified Endowment - Most policies will be MEC's. Please review the Sales Proposal to confirm if your case will be a MEC.

Contract Disclosure - If it is not, do not leave a MEC disclosure form with the client.
(MEC)

Personal Worksheet - If the form is not fully completed either by election or missing information, it will cause delays in underwriting the case.

Provide - The following Section contains a list of documents that should be completed/reviewed/provided to the indicated parties:

Submit To Nationwide	Leave With The Proposed Insured
• Application Part I • Sales Proposal • Long Term Care (LTC) Personal Worksheet • NAIC States – Replacement of Life Insurance or Annuities form (if applicable) • Temporary Insurance Agreement if applicable) • 1035 Policy Exchange Agreement & Documentation (if applicable) • Other State Specific Forms • Signed Receipt of Disclosure Statement for Accelerated Death Benefit for Terminal Illness Rider for AL, AK, CA, CT, DC, IL, IN, KS,KY, LA, MA, MI, MN, MS, MT, NC, OH, OK, OR, TX, VA. • Signed Non-Resident Sales Form (VLF-0402AO), if applicable. See form for instructions and specific restrictions.	• Outline of Coverage • *LTC Insurance Personal Worksheet • *Things You Should Know Before You Buy Long-Term Care • *A Shopper's Guide to Long-Term Care Insurance • Personal History Phone Interview Instructions • State Specific Forms • *The Policy Owner must confirm receipt of these documents by initialing the box in Section 18 of the application.

2. Where To Send

Fax or Email For Fastest Service	Regular Mail	Express Mail:
Fax Number: 1-888-677-7393 Email Address: LifeApps@nationwide.com	Nationwide Life Insurance Company P.O. Box 182835 Columbus, OH 43218-2835	Nationwide Financial Life Operations 3400 Southpark Place Ste A DSPF-D4 Grove City, OH 43123-4856

3. Providing A Temporary Insurance Agreement

Temporary Insurance Agreement should be given to the applicant **EXCEPT** in the following situations:

- The applicant has not paid full first premium for the mode selected or authorized EFT draft for initial premium.
- If the Proposed Insured answered "Yes" to the health question (b) in Section 10 of the application.
- The total specified amount requested exceeds **$500,000**. Do not collect any money.

4. Collecting Premium

For Direct Bill and Single Premium:

• Collect 1 modal premium and send to Nationwide.

For EFT:

There are 2 options available when setting up EFT mode:

• 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

• Collect the initial premium and the annual draft day will be determined based upon Policy Effective Date.

To ensure proper premium drafting, indicate on the application in the Electronic Draft Authorizations Section 7 the bank information to be used.

A note on paper billing:

If selecting Level Premium, Monthly, we do not offer paper billing (Direct Bill), so Electronic Draft must be selected.

For Web Remittance:

• Availability is only for Nationwide Agents.

• To submit without a policy number, use the Regional Office Code 97, B, and the Insured's Social Security Number. For example: 97B123456789 (Do not use 97B000000000 or 97B999999999.)

5. 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.

NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY

PART I Application for Individual Universal Life Insurance with Long-Term Care

P.O. Box 182835, Columbus, Ohio 43218-2835
Fax to: 1-888-677-7393 • nationwide.com

THIS CONTRACT FOR LONG-TERM CARE INSURANCE IS INTENDED TO BE A FEDERALLY QUALIFIED LONG-TERM CARE INSURANCE CONTRACT AND MAY QUALIFY YOU FOR FEDERAL AND STATE TAX BENEFITS.

SECTION 1 – PROPOSED INSURED

Name (First, MI, Last)	Sex ☐M ☐F	Date of Birth (mm/dd/yyyy)	State of Birth	SSN/Tax ID #

Address (Street/City/State/ZIP)	E-Mail Address

Marital Status	Phone #	Citizenship/Permanent Resident	How long have you lived in the U.S.?
☐Married ☐Single ☐Civil Union ☐Domestic Partner ☐Other_____	Best Time to Call: ☐AM ☐PM	☐U.S. ☐Canada ☐Green Card Holder ☐ Other_____	Months_____Years_____ Do you read and understand English? ☐Yes ☐No

Driver's License # / State of Issue	Occupation	Employer	Net Worth	Annual Income

SECTION 2 – POLICY OWNER -

(Complete only if Policy Owner is different than the Proposed Insured). If a Trust is named as Policy Owner, complete the Trust information below and submit a copy of the first and signature pages of the Trust document. If more than one Policy Owner (Joint Owner) or a Contingent Owner, designate by providing details in the Section 12 (include Policy Owner designation, name, SS#, date of birth, address, phone number, relationship to Insured and E-mail address).

Name (First, MI, Last)	SSN/Tax ID #	Date of Birth (mm/dd/yyyy)

Address (street/city/state/ZIP) ☐(Check box if same as Proposed Insured)	Phone #	Relationship to Insured
	E-mail Address	

Type of Policy Owner	
☐Individual ☐Employer ☐Trust ☐Rabbi Trust ☐Other	Exact Name of Trust_____ Trust Tax ID Number_____ Date of Trust _____ Current trustee_____

SECTION 3 – PLAN INFORMATION

Nationwide YourLife® CareMatters℠ Specified Amount $_____

a) Long-Term Care (LTC) Specified Benefit Period: (By selecting the total period, Nationwide will automatically issue the Long-Term Care Rider, and Long-Term Care Extension of Benefits if applicable, based on the specified period shown below).

- ☐ 2 Years (2 Year LTC Rider Specified Acceleration Period)
- ☐ 3 Years (3 Year LTC Rider Specified Acceleration Period)
- ☐ 4 Years (2 Year LTC Rider Specified Acceleration Period and 2 Year LTC Extension of Benefits Rider Specified Extension Period)
- ☐ 5 Years (3 Year LTC Rider Specified Acceleration Period and 2 Year LTC Extension of Benefits Rider Specified Extension Period)
- ☐ 6 Years (2 Year LTC Rider Specified Acceleration Period and 4 Year LTC Extension of Benefits Rider Specified Extension Period)
- ☐ 7 Years (3 Year LTC Rider Specified Acceleration Period and 4 Year LTC Extension of Benefits Rider Specified Extension Period)

b) Optional Long-Term Care Inflation Protection (You Must Select One and Initial)
I have reviewed the Outline of Coverage and the graphs that compare the benefit and premiums of this policy with and without Inflation Protection.

- ☐_____(Initials REQUIRED) I elect 5% compound interest Inflation Protection and reject 3% Simple interest Inflation Protection.
- ☐_____(Initials REQUIRED) I elect 3% Simple interest Inflation Protection and reject 5% Compound interest Inflation Protection. (Please sign below.)
- ☐_____(Initials REQUIRED) I hereby REJECT all Inflation Benefit Options, including the 5% compound Inflation Benefit Option. (Please sign below.)

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed the plan, and I reject 5 percent annual compound inflation protection.

_____ Signature of Applicant

_____ Date

SECTION 4 – BENEFICIARY DESIGNATIONS

☐Check this box if the Trust named in the Policy Owner section is to be the Primary Beneficiary. If a different Trust is named as Primary Beneficiary or a Trust is named as Contingent Beneficiary, provide the Trust information below. When more than one Primary Beneficiary is designated, payments will be made in equal shares to the Primary Beneficiaries surviving the Insured, or in full to the last surviving Primary Beneficiary, unless some other distribution of proceeds is provided.

%	Designation	Beneficiary Name	Date of Birth	Relationship to Insured	SSN/TAX ID #	Address & Phone #
	Primary ☐ Contingent ☐					
	Primary ☐ Contingent ☐					
	Primary ☐ Contingent ☐					

SECTION 5 – PREMIUM AND BILLING INFORMATION

☐Single Premium amount: $_____OR

☐Level Premium amount: $_____ ☐Annually or ☐Monthly for (select one) ☐5 Years ☐10 Years (If level premium, complete the rest of Section 5)

Total expected premium to be paid over the life of the Policy $_____(Required)

Billing method (Select one): ☐Direct Bill ☐Electronic Draft *(Bank information required, complete Section 7. A reminder will be provided prior to drafting.)*

SECTION 6 – INITIAL PREMIUM

Will initial premium be provided by 1035 Exchange proceeds? (Select one, if applicable) ☐Partially funded by 1035 Exchange ☐100% of Initial Premium *(Be sure to review the Temporary Insurance Agreement to verify if the Proposed Insured qualifies to submit premium with the application.)*

☐Check/Wire Premium with application (**NOTE:** Make all checks payable to **NATIONWIDE.**) ☐Web Remittance Premium

☐Draft amount indicated in the Premium and Billing Information section (Financial institution information required, complete Section 7). Premium will not be drafted until the Policy is underwritten and approved.

SECTION 7 – ELECTRONIC DRAFT AUTHORIZATIONS (The level premium will draft on each premium due date):

7a. Electronic Draft Options

Account Type: ☐*Checking (Use information on the initial premium check.) ☐*Checking (Provide a pre-printed voided check.)
☐*Savings (Provide a letter from the bank indicating the Transit/ABA number, Account number and Account Holder's name.)

7b. Complete only if a check or deposit slip is not provided. Confirm your account information with your bank prior to initiating any transaction. Nationwide is not liable for any errors or omissions in the information you provide that may delay the processing of your application.

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 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.

SECTION 8 – PAYOR - if other than Policy Owner

Name (First, MI, Last)	SSN/Tax ID #	Relationship to Insured

Address (street/city/state/ZIP) ☐ (Check box if same as Proposed Insured)

SECTION 9 – PERSONAL AND HEALTH INFORMATION - All questions are to be answered by the Proposed Insured, to the best of your knowledge and belief, within the time period specified.

	Proposed Insured
a. Have you used tobacco in any form in the last 12 months?	☐Yes ☐No
b. Have you used nicotine in any form in the last 12 months?	☐Yes ☐No
c. To the best of your knowledge and belief, during the past 7 years, have you been diagnosed, or treated by a member of the medical profession for diabetes?	☐Yes ☐No
d. To the best of your knowledge and belief, during the past 7 years, have you been diagnosed, or treated by a member of the medical profession for a stroke?	☐Yes ☐No
e. To the best of your knowledge and belief, during the past 7 years, have you been diagnosed, or treated by a member of the medical profession for cancer?	☐Yes ☐No
f. To the best of your knowledge and belief, during the past 7 years, have you been diagnosed, or treated by a member of the medical profession for heart disease?	☐Yes ☐No
g. To the best of your knowledge and belief, during the past 7 years, have you been diagnosed, or treated by a member of the medical profession for Alzheimer's disease?	☐Yes ☐No
h. To the best of your knowledge and belief, during the past 7 years, have you been diagnosed, or treated by a member of the medical profession for alcoholism?	☐Yes ☐No

SECTION 9 *(cont'd)* – PERSONAL AND HEALTH INFORMATION - All questions are to be answered by the Proposed Insured, to the best of your knowledge and belief, within the time period specified.	
i. To the best of your knowledge and belief, during the past 7 years, have you been diagnosed, or treated by a member of the medical profession for drug abuse?	**Proposed Insured** ☐Yes ☐No
j. To the best of your knowledge and belief, during the past 7 years, have you been diagnosed, or treated by a member of the medical profession for kidney disease?	☐Yes ☐No
k. To the best of your knowledge and belief, during the past 7 years, have you been diagnosed, or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS)?	☐Yes ☐No
If you answered "Yes" to any of these questions, then coverage under the Temporary Life Insurance Agreement is not available.	

SECTION 10 – TAXPAYER CERTIFICATION

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 the box if you have been notified by the IRS that you are currently subject to backup withholding as a result of failure to report interest or dividends on your tax returns.**

SECTION 11 – INSURANCE INFORMATION – REPLACEMENT AND OTHER POLICY INFORMATION	
a. Do you have any other Life Insurance or Annuities, including those with Long-Term Care coverage, either currently in force or that has been sold to a third party? (If "Yes", list below.)	**Proposed Insured** ☐Yes ☐No
b. Are you now applying for Life Insurance or Annuities, including those with Long-Term Care coverage, 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, including those with Long-Term Care coverage, 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.)	☐Yes ☐No
d. Have you had Life Insurance or Annuities, including those with Long-Term Care coverage, in the past 5 years that are no longer in force? (If "Yes", provide name of Company, face amount and reason coverage is no longer in force.)	☐Yes ☐No
e. Do you have any other Long-Term Care Insurance Policy or certificate (including a health care service contract or health maintenance organization contract), either currently in force or pending? (If "Yes", list below.)	☐Yes ☐No
f. Did you have another Long-Term Care Insurance Policy or certificate in force during the last 12 months that has terminated or lapsed? (If "Yes", list below.)	☐Yes ☐No
g. Are you covered by Medicaid (Medical Assistance)?	☐Yes ☐No
h. Do you intend to stop premium payments, replace, surrender, forfeit, assign to the Insurer, or take a cash withdrawal or loan from any Life Insurance Policy or Annuity contract to pay premiums on the applied for Policy? (If "Yes", list below.)	☐Yes ☐No
i. Do you intend to replace any of your medical or health insurance coverage, including any of your Long-Term Care coverage, with this applied for Policy? (If "Yes", list below.)	☐Yes ☐No

COVERAGE TYPE						**COMPANY**	**POLICY NUMBER**	**AMOUNT**	**YEAR ISSUED**	**TO BE REPLACED**	**1035**	**LAPSE/TERMINATION DATE**
Life	**Life w/ LTC**	**Annuity**	**Annuity w/ LTC**	**LTC**	**Health**							
										☐Yes ☐No		
										☐Yes ☐No		
										☐Yes ☐No		

SECTION 12 – SPECIAL INSTRUCTIONS SECTION

SECTION 13 – IMPORTANT NOTICES

PARTNERSHIP NOTICE

THIS RIDER IS AN APPROVED LONG-TERM CARE INSURANCE RIDER UNDER CALIFORNIA LAW AND REGULATIONS. HOWEVER, THE BENEFITS PAYABLE BY THIS RIDER WILL NOT QUALIFY FOR MEDI-CAL ASSET PROTECTION UNDER THE CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE.

FOR INFORMATION ABOUT POLICIES AND CERTIFICATES QUALIFYING UNDER THE CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE, CALL THE HEALTH INSURANCE COUNSELING AND ADVOCACY PROGRAM AT THE TOLL-FREE NUMBER, 1 (800) 434-0222.

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 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.

Information regarding your insurability will be treated as confidential. Nationwide Life and Annuity Insurance Company, or its reinsurer(s) may, however, make a brief report thereon to MIB, Inc., a not for profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB, Inc. member company for life or health insurance coverage or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB, Inc. file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB, Inc. information office is 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734, telephone number 866-692-6901. The website address of the MIB, Inc. information office is www.mib.com. 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.

SECTION 14 – AGREEMENT AND AUTHORIZATION

I understand and agree that:

- The Proposed Insured or Policy 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 any contract, or waive or change any of Nationwide'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 first scheduled premium is not paid with this application, then insurance will only take effect when: (1) the full first premium is paid; and (2) a Policy is issued by Nationwide and accepted by me.
- If I am not the Policy Owner of the Policy, there is no guarantee I will receive benefits to pay my Long-Term Care expense as the benefit will be paid to the Policy Owner.
- Monthly benefit payment under any elected Rider are based on the Insured meeting, the eligibility requirements under such Rider. Such monthly benefit payments are not provided based on, or as a reimbursement of actual expenses incurred.
- I also authorize Nationwide to make a brief report of my personal health information and protected health information to MIB, Inc.

SECTION 15 – HIPAA MEDICAL AUTHORIZATION

I authorize: any licensed physician or medical practitioner; any hospital; clinic; any pharmacy or pharmacy benefit managers; and other sources who maintain prescription drug records and related information; or other medical or medically related facility; any insurance company; MIB, Inc.; or any insurance support organization; to disclose any information **(excluding HIV)** concerning me; including; but not limited to, my entire medical/health record to the Medical Director of Nationwide Life and Annuity Insurance Company or its affiliates; including, but not limited to, RSA Medical; for the purpose of underwriting my application in order to determine eligibility for Life Insurance and to investigate claims.

I also authorize Nationwide to make a brief report of my personal health information and protected health information to MIB, Inc. By my signature below, I acknowledge that any agreements I have made to restrict my protected health information **(excluding HIV)** do not apply to this form; and I instruct any physician; health care professional; hospital; clinic; pharmacy or pharmacy benefit managers; medical facility; or other health care provider to release and disclose my entire medical/health record **(excluding HIV)**. I understand that any information that is disclosed pursuant to this form may be re-disclosed 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 any time, by sending a written request for revocation to 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 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 records, or, if I revoke this authorization before a Policy is issued, 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. This contract for Long-Term Care Insurance is intended to be a federally qualified Long-Term Care Insurance contract and may qualify you for federal and state tax benefits.

SECTION 16 – PROPOSED INSURED AND POLICY OWNER/TRUSTEE SIGNATURES

If you are signing on behalf of an entity, you represent that you are authorized to execute this document and to further represent that all requirements of those entities including the use of any seal (in the case of a Corporation and/or Trust) have been met.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

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

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

Signed at_____, on_____,_____
City/State Month/Day Year

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

_____
Full Name of Applicant/Policy Owner Signature of Applicant/Policy Owner

SECTION 17 – PRODUCER'S CERTIFICATION

I have truly and accurately recorded all Proposed Insured's answers on this application. ..... Yes☐ No☐
I have witnessed his/her/their signature(s) hereon. (If "No", provide details in Section 12). ..... Yes☐ No☐
To the best of my knowledge, the insurance applied for will or will not replace any Life Insurance, Annuities, and/or Long-Term Care Insurance. ..... Will ☐ Will Not ☐

_____
Producer's Name *(print)* Firm

X_____
Signature of Producer Producer's Nationwide # Phone Number

E-Mail Address_____**If there are split commissions, provide detail in Section 12.**

TEMPORARY INSURANCE AGREEMENT

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

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

This receipt must not be detached and in no event will there be any Temporary Insurance unless the full first premium required by Nationwide has been paid at the time of application.

Advance payment is being made in the amount of: $_____

For the face amount on the application of: $_____(or $500,000, whichever is less).

Make all checks payable to NATIONWIDE. Do not make checks payable to the producer or leave the payee blank.

TERMS AND CONDITIONS

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. If the 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 if issued as applied for; or
- **$500,000** 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 applied for on the life of the Proposed Insured.

DATE COVERAGE TERMINATES

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

LIMITATIONS

- Fraud or material misrepresentation in the application invalidates this Agreement, and Nationwide's only liability is for refund of any payment made.
- The Long-Term Care benefits as elected in Section 3a and 3b of the application, are NOT available under this Agreement.
- This Agreement does not provide coverage for Proposed Insured's who are over the age of 70 on the date of the Agreement.
- If question (b) in Section 9, Personal and Health Information, of the application is answered yes, then coverage under this Temporary Life Insurance Agreement is not available.
- If any Proposed Insured dies by suicide, 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.
- No one is authorized to waive or modify any of the provisions of this Agreement.

SIGNATURES AND PRODUCER CERTIFICATION

I HAVE RECEIVED A COPY OF THIS AGREEMENT. I UNDERSTAND AND AGREE TO ALL ITS TERMS. **CAUTION: If your answers on this application are misstated or untrue, the insurer may have the right to deny benefits or rescind your coverage.**

Signature of Proposed Insured _____ Date (mm/dd/yyyy) _____

Signature of Policy Owner *(if other than the Proposed Insured)* _____ Date (mm/dd/yyyy) _____

X_____ _____ _____

Signature of Producer _____ Producer's Nationwide # _____ Date (mm/dd/yyyy) _____

Firm _____

NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY

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

Please check forms that have been delivered and received.

- ☐ Outline of Coverage
- ☐ Health Insurance Counseling and Advocacy Program (HICAP Notice)
- ☐ Taking Care of Tomorrow: A Consumer's Guide to Long-Term Care
- ☐ Notice to Applicant Regarding Replacement of Accident and Sickness or Long-Term Care Insurance
- ☐ Long-Term Care Insurance Personal Worksheet
- ☐ Protection Against Unintended Lapse

Applicant's Signature	Date
Agent's Signature	Date

☐ 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

Nationwide Modified Endowment Contract (MEC) Authorization Form

Nationwide Life Insurance Company
Nationwide Life and Annuity Insurance Company
PO Box 182835, Columbus, OH 43218-2835
Phone: 800-848-6331 • Fax: **888**-677-7393 • nationwide.com

1. General Information (please print)

Only submit this form if you want your policy to be a Modified Endowment Contract (MEC).

Please print clearly, complete the form and provide all requested information to avoid processing delays.

Owner's Information:

Name: _____ Policy Number: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

SSN: _____ Phone: _____ Email: _____

Nationwide strives to provide excellent customer service to our Members. By providing your telephone number, you authorize the Nationwide Family of Companies to contact you via telephone using automated technology to assist you with your account.

Joint Owner's Name (if applicable): _____

Insured's Information:

Name: _____ SSN: _____

Date of Birth: _____

2. MEC Election and Disclosure

☐ I elect to have my policy established as a Modified Endowment Contract

I understand the life insurance policy I have applied for will be considered a Modified Endowment Contract (MEC) as defined by section 7702A of the Internal Revenue Code. Loans from a Modified Endowment Contract are subject to less favorable tax treatment than loans taken from policies which are not Modified Endowment Contracts. I understand that for more information regarding Modified Endowment Contracts and their potential income tax implications, I should consult my personal tax advisor.

3. Signature(s) (required)

PLEASE SIGN BELOW ONLY IF YOU INTEND FOR YOUR POLICY TO BECOME A MEC.

Owner:

Name (please print): _____

Signature: _____ **Date:** _____

Joint Owner (if applicable):

Name (please print): _____

Signature: _____ **Date:** _____

Nationwide Modified Endowment Contract (MEC) Authorization Form

Nationwide Life Insurance Company
Nationwide Life and Annuity Insurance Company
PO Box 182835, Columbus, OH 43218-2835
Phone: 800-848-6331 • Fax: **888**-677-7393 • nationwide.com

1. General Information (please print)

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Owner's Information:

Name: _____ Policy Number: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

SSN: _____ Phone: _____ Email: _____

Nationwide strives to provide excellent customer service to our Members. By providing your telephone number, you authorize the Nationwide Family of Companies to contact you via telephone using automated technology to assist you with your account.

Joint Owner's Name (if applicable): _____

Insured's Information:

Name: _____ SSN: _____

Date of Birth: _____

2. MEC Election and Disclosure

☐ I elect to have my policy established as a Modified Endowment Contract

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3. Signature(s) (required)

PLEASE SIGN BELOW ONLY IF YOU INTEND FOR YOUR POLICY TO BECOME A MEC.

Owner:

Name (please print): _____

Signature: _____ **Date:** _____

Joint Owner (if applicable):

Name (please print): _____

Signature: _____ **Date:** _____

Assignee:

Name (please print): _____

Signature: _____ **Date:** _____

Nationwide®

CALIFORNIA
STATE SPECIFIC FORMS

Replacement form on the reverse side of this page.
Please complete if applicable.

This packet includes these forms:

- Replacement Form (L-4351)
- Special Notice to Seniors Regarding In-Home Sales Meeting (Notice to Seniors)

Nationwide®

Notice Regarding Replacement of Life Insurance or Annuities

Nationwide Life Insurance Company
Nationwide Life and Annuity Insurance Company
One Nationwide Plaza, Columbus, Ohio 43215
Phone: 800-848-6331 • Fax: **888**-634-4472 • nationwide.com

Purpose

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 producer 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 Printed Name: _____

Applicant's Signature: _____ Date: _____

Joint Applicant's Printed Name: _____
(If applicable.)

Joint Applicant's Signature: _____ Date: _____

Producer's Printed Name: _____

Producer's Signature: _____ Date: _____

This form must be signed and dated on or before the application date.

Please complete this information in its entirety

Name of Insured	Existing Company	Policy Number

Nationwide®

Important Delivery Notice to Seniors

Nationwide Life Insurance Company
Nationwide Life and Annuity Insurance Company
One Nationwide Plaza, Columbus, Ohio 43215
Phone: 800-848-6331 • Fax: **888**-634-4472 • nationwide.com

Important Notice

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 Meeting"** form, in writing to the Senior, no less than 24 hours and no more than 14 days prior to that individual's initial meeting in the Senior's 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.

Nationwide®

Special Notice for Seniors Regarding In-Home Sales Meeting

Nationwide Life Insurance Company
Nationwide Life and Annuity Insurance Company
One Nationwide Plaza, Columbus, Ohio 43215
Phone: 800-848-6331 • Fax: **888**-634-4472 • nationwide.com

Read Carefully before Proceeding

Agent Information as it appears on his or her California insurance license.

Agent's Full Name: _____

Agent's License Number: _____

Agent's Mailing Address: _____

Agent's Telephone Number: _____

1. **I am a licensed insurance agent. My purpose for coming to your home is to sell, discuss and/or deliver one of 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
   800-927-HELP (4357)
   (Calling from within California)
   213-897-8921
   (Outside California)
   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®

Third Party Notice/Secondary Addressee Designation For Life Insurance

Nationwide Life Insurance Company
Nationwide Life and Annuity Insurance Company
PO Box 182835, Columbus, OH 43218-2835
Phone: 800-848-6331 • Fax: **888**-677-7393 • nationwide.com

1. General Information (please print)

Owner's Name: _____ Policy Number: _____

Owner's SSN: _____

Insured's Name: _____

Phone: _____

Nationwide strives to provide excellent customer service to our Members. By providing your telephone number, you authorize the Nationwide Family of Companies to contact you via telephone using automated technology to assist you with your account.

2. Purpose Of The Form

This form allows you to designate a person other than yourself to receive copies of important notices Nationwide may mail you. These notices are considered by Nationwide to include any notice regarding reductions or decreases in policy coverage or pending termination of your life insurance policy for nonpayment of premium and referred to as "Important Notices". This form also allows you to remove a designated person, or waive your right to designate a person, where it is required by law for us to collect this waiver. Please complete Section 3, 4, or 5 below. You may also use this form to both remove an existing third party and designate a new third party. To do this, please complete Sections 3 and 4.
Please Note: For policies issued in Maine, this form is part of the policy.

3. Designate A Third Party For Lapse Notices

Please designate the following individual as a third party on the above referenced life insurance policy. I authorize the third party designee to receive copies of Important Notices regarding my life insurance policy. Designation as a third party does not constitute acceptance of any liability on the part of the third party designee, or Nationwide, for services provided to the Policy Owner. The designation does not create the right to inquire or request changes on the life insurance policy. I understand it is my responsibility to notify the designated individual of their affiliation with this policy if no signature is provided.

Designee's Name: _____

Designee's Address: _____

Owner's Signature (Required): _____Date: _____

Designee's Signature (Recommended): _____Date: _____

Please Note: For policies issued in New Jersey the Designee's signature is required to complete this designation, not signing will delay processing.

4. Request To Remove A Third Party Designation For Lapse Notices

I _____(Policy Owner) or (current third party designee) request the following designee be removed from the life insurance policy referenced above. I understand the named designee will no longer receive copies of Important Notices.

Designee's Name: _____

Policy Owner's Signature (Required): _____ Date: _____

Current Designee's Signature: _____Date: _____

5. Waiver Of Third Party Designation

Protection against unintended lapse.
I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice. I understand I can designate a person at any time in the future.

Owner's Signature (Required): _____Date: _____

Nationwide®

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

NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY
P.O. Box 182835, Columbus, Ohio 43218-2835 • 1-800-848-6331 • nationwide.com • FAX NUMBER: 1-**888**-677-7393

According to your (application)(information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with long-term care insurance coverage to be issued by 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 coverage. For your own 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 coverage.

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

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present coverage. 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.

(3) If, after due consideration, you still wish to terminate your present coverage 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 coverage had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

_____
Date

_____
(Applicant's Signature)

COMPARISON TO YOUR CURRENT COVERAGE: I have reviewed your current long-term care coverage. To the best of my knowledge, the replacement of insurance involved in this transaction materially improves your position for the following reasons:

_____Additional or different benefits (please specify)_____

_____No change in benefits, but lower premiums.

_____Fewer benefits and lower premiums.

_____Other (please specify)_____

_____
(Signature of Agent and Name of Insurer)

_____
(Signature of Applicant)

_____
(Date)

Nationwide®

THINGS YOU SHOULD KNOW BEFORE YOU BUY LONG-TERM CARE INSURANCE

NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY
P.O. Box 182835, Columbus, Ohio 43218-2835 • 1-800-848-6331 • FAX NUMBER: 1-**888**-677-7393
nationwide.com

SECTION 1: LONG-TERM CARE INSURANCE

- A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
- You should not buy this insurance policy unless you can afford to pay the premiums every year.
- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

SECTION 2: MEDICARE

- Medicare does not pay for most long-term care.

SECTION 3: MEDICAID

- Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should not buy this policy if you are now eligible for Medicaid.
- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

SECTION 4: SHOPPER'S GUIDE

- Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "A Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

SECTION 5: COUNSELING

- Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. For more information about the senior health insurance counseling program in your state, contact the state agency listed in the Directories in the above mentioned Shopper's Guide To Long-Term Care Insurance.

SECTION 6: FACILITIES

- Some long-term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move into a different state from where they purchased their long-term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

Nationwide®

LONG-TERM CARE INSURANCE PERSONAL WORKSHEET

NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY
P.O. Box 182835, Columbus, Ohio 43218-2835 • 1-800-848-6331 • FAX NUMBER: 1-**888**-677-7393
nationwide.com

Proposed Insured:_____Social Security #/TaxID:_____

This worksheet will help you understand some important information about this type of insurance. State law requires companies issuing this policy to **give** you some important facts about premiums and premium increases and to **ask** you some important questions to help you and the company decide if you should buy this policy. Long-term care insurance can be expensive and it may not be right for everyone.

SECTION 1: PREMIUM INFORMATION

The premium for the coverage you are considering will be: (Check one)

☐ a one-time single premium of $_____

☐ $_____ per year/month for 5 years ☐ $_____ per year/month for 10 years.

The premium quoted in this worksheet is not guaranteed and may change during the underwriting process.

A rate guide is available that compares the policies sold by different insurers, the benefits provided in those policies, and sample premiums. The rate guide also provides a history of the rate increases, if any, for the policies issued by different insurers in each state in which they do business, for the current year and for the nine preceding years. You can obtain a copy of this rate guide by calling the Department of Insurance's consumer toll-free telephone number (1-800-927-HELP), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free telephone number (1-800-434-0222), or by accessing the Department of Insurance's Internet web site (www.insurance.ca.gov).

SECTION 2: TYPE OF POLICY & THE COMPANY'S RIGHT TO INCREASE PREMIUMS ON THE COVERAGE YOU CHOOSE

Noncancellable - The company **cannot** increase your premiums on this policy.

SECTION 3: PREMIUM INCREASE HISTORY

The company has sold long-term care insurance since 1999 and has sold this policy since 2017. The company has never increased its rates for any long-term care policy or rider it has sold in this state or any other state.

SECTION 4: QUESTIONS ABOUT YOUR INCOME

You do **not** have to answer the questions that follow. They are intended to make sure you have thought about how you'll pay premiums and the cost of care your insurance does not cover. If you do not want to answer these questions, you should understand that the company might refuse to insure you.

What resources will you use to pay your premium?

☐ Current income from employment ☐ Current income from investments ☐ Other current income
☐ Savings ☐ Sell investments ☐ Sell other assets ☐ Money from my family ☐ Other_____

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Could you afford to keep this policy if your spouse or partner dies first?

☐ Yes ☐ No ☐ Had not thought about it ☐ Do not know ☐ Does not apply

What is your household annual income from all sources? (Check one)

☐ Under $10,000 ☐ $10,000-$19,999 ☐ $20,000-$29,999 ☐ $30,000-$49,999 ☐ $50,000 or over

Do you expect your income to change over the next 10 years? (Check one)

☐ No ☐ Yes, expect increase ☐ Yes, expect decrease

SECTION 4: QUESTIONS ABOUT YOUR INCOME - CONTINUED

If you plan to pay premiums from your income, have you thought about how a change in your income would affect your ability to continue to pay the premium?

☐ Yes ☐ No ☐ Do not know

Will you buy inflation protection? (Check one) ☐ Yes ☐ No

Inflation may increase the cost of long-term care in the future.

If you do not buy inflation protection, how will you pay for the difference between future costs and your daily benefit amount?

☐ From my income ☐ From savings ☐ From investments ☐ Sell other assets
☐ Money from my family ☐ Other

The national average annual cost of long-term care in 2012 was $90,520, but this figure varies across the country. In ten years the national average annual cost would be about $147,548 if costs increase 5% annually.

What elimination period are you considering?
90 calendar day elimination period

Approximate cost of care for this period: $22,320
($248 per day times number of days in elimination period, where $248 represents the most recent estimate of the national daily average cost of long-term care)

How do you plan to pay for your care during the elimination period? (Check all that apply)

☐ From my Income ☐ From my Savings/Investments ☐ My family will pay

SECTION 5: QUESTIONS ABOUT YOUR SAVINGS AND INVESTMENTS

Not counting your home, about how much are all of your assets (your savings and investments) worth? (Check one)

☐ Under $20,000 ☐ $20,000-$30,000 ☐ $30,000-$50,000 ☐ Over $50,000

Do you expect the value of your assets to change over the next ten years? (Check one)

☐ No ☐ Yes, expect to increase ☐ Yes, expect to decrease

If you are buying this policy to protect your assets and your assets are less than $50,000, experts suggest you think about other ways to pay for your long-term care.

SECTION 6: DISCLOSURE STATEMENT

Check one:	☐ The answers to the questions above describe my financial situation. **OR** ☐ I choose not to complete this information.

By my signature below, I agree that the company and/or its producer (below) has reviewed this worksheet with me, including the premium, premium increase history, and potential for premium increases in the future. I understand the information contained in this worksheet.

SECTION 7: SIGNATURE(S) REQUIRED

Signed:_____ _____
(Applicant/Policy Owner's Signature) (Date)

☐ I explained to the Applicant/Policy Owner the importance of answering these questions

Signed:_____ _____
(Producer) (Date)

Producer's Printed Name:_____

In order for us to process your application, please return this signed worksheet to Nationwide, along with your application.

My producer has advised me that this long-term care insurance policy does not seem to be suitable for me. However, I still want the company to consider my application.

Signed:_____ _____
(Applicant/Policy Owner's Signature) (Date)

Someone from the company may contact you to discuss your answers and the suitability of this policy for you.

Receipt of Disclosure Statement for Accelerated Death Benefit for Terminal Illness Rider

Nationwide Life Insurance Company
Nationwide Life and Annuity Insurance Company
PO Box 182835, Columbus, OH 43218-2835
Phone: 866-678-5433 • Fax: **888**-677-7393 • nationwide.com

1. Important

Signed Receipt of Disclosure Statement for Accelerated Death Benefit for Terminal Illness Rider for AL, AR, CA, CT, DC, IL, IN, KS, KY, LA, MA, MI, MN, MS, MT, NC, OH, OK, OR, TX, VA, WA.

2. General Information (Please print)

Owner's Name: _____ SSN: _____

Primary Insured's Name (if different than Owner): _____

3. Acknowledgment & Signature(s)

This is to acknowledge that I have received the **Disclosure Statement for Accelerated Death Benefit for Terminal Illness Rider.**

Owner's Name (please print): _____

Owner's Signature: _____ Date: _____

Primary Insured's Name (if different than Owner): _____

Primary Insured's Signature: _____ Date: _____

Agent's Name: _____

Agent's Signature: _____ Date: _____

PLEASE NOTE: It is the agent's responsibility to have this form completed and signed by both the primary insured and agent (and policy holder if different from the primary insured) prior to or at the time of application.

Upon completion, provide one copy to the primary insured and return the original to Nationwide at the address provided above.

Nationwide®

Protection Against Unintended Lapse
Nationwide Life And Annuity Insurance Company
PO Box 182835 • Columbus, OH 43218-2835
Phone: 800-848-6331 • Fax to: **888**-677-7393 • nationwide.com

Protection Against Unintended Lapse

California insurance law requires you to make the following election with a wet signature.

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for non-payment of premium. I understand that notice will not be given until 30- days after a premium is due and unpaid.

Please check one of the following:

☐ I elect NOT to designate any person to receive this notice.

☐ I elect to designate a person to receive this notice.

_____ _____

Signature of Applicant Date

Complete information below ONLY if you elect a person to receive this notice

Name of Designee *(first, middle, last)*:_____

Address of Designee:_____

Phone Number of Designee:_____

If you wish to name more than one designee, please attach a separate sheet. You may change the named designee at any time by notifying Nationwide in writing at the following address: PO Box 182835, Columbus, Ohio 43218-2835.

Nationwide®
is on your side

DISCLOSURE STATEMENT FOR ACCELERATED DEATH BENEFIT FOR TERMINAL ILLNESS RIDER

Please Keep For Your Records

Benefit Provided by the Accelerated Death Benefit for Terminal Illness Rider ("ADB Rider"):

This accelerated benefit provides for a one-time, lump sum, advance payment of a portion of the Death Benefit Proceeds of the Policy when the Insured has a Terminal Illness. A Terminal Illness is an illness diagnosed by a Physician that is expected to result in death within 12 months of the diagnosis. The Physician shall not be any Insured, Policy Owner, Beneficiary, or a relative thereof.

The accelerated death benefit of this life insurance product may provide benefits to pay for long-term care services, but it is NOT a long-term care insurance policy and the amount this product pays you, may not be enough to cover your medical, nursing home or other bills. You may use the Accelerated Death Benefit Payment for any purpose. Unless it has been otherwise assigned or designated by the Policy Owner, the Accelerated Death Benefit Payment shall be paid to the Policy Owner or the Policy Owner's estate while the Insured is living. **Unlike conventional life insurance proceeds, accelerated benefits payable under the ADB Rider COULD BE TAXABLE IN SOME CIRCUMSTANCES.** We recommend that you contact a tax advisor when making tax-related decisions about electing to receive and use benefits from an accelerated death benefit product.

Consequences of this Benefit:

Receipt of accelerated death benefits from a life insurance policy MAY ADVERSELY AFFECT MEDICAID and SUPPLEMENTAL SECURITY INCOME ("SSI") ELIGIBILITY. The mere fact that you own a Policy with an option to accelerate the death benefit may affect your eligibility for these government programs. In addition, exercising the option to accelerate death benefits and receiving those benefits before you apply for these programs, or while you are receiving government benefits, may affect your initial or continued eligibility. Contact the Medicaid Unit of your local Division of Medical Assistance and the Social Security Administration for more information.

Eligibility and Conditions for Payment:

The Eligibility and Conditions for Payment of the accelerated death benefit are as stated in the ADB Rider. Your request for an application for the accelerated death benefit under the ADB Rider must be received at our Home Office in a form satisfactory to us. Once we receive your request for an application, we will send the forms necessary for filing a claim for the Accelerated Death Benefit Payment. If the claim form is not provided within fifteen (15) days after your request, the claim requirements are deemed to have been met by providing us with written proof that the Insured has a Terminal Illness.

Limitations on the Accelerated Death Benefit Payment:

The maximum amount of the accelerated death benefit to be paid if the Insured meets the requirements of the Eligibility and Conditions for Payment section of the ADB Rider shall not exceed fifty percent (50%) of the base Policy Specified Amount. In addition to the foregoing, the Accelerated Death Benefit Payment must be at least $10,000.00 and shall not exceed $250,000.00. We reserve the right to require the base Policy Specified Amount to be at least $50,000.00 on the date your request for the acceleration benefit is processed at our Home Office.

Effect on Death Benefit, Policy Values and Premiums:

If the Accelerated Death Benefit Payment is made, the Policy values **WILL BE SUBJECT TO REDUCTIONS** as of the ADB Rider Effective Date. These reductions will be made to the base Policy Specified Amount, Cash Value, Indebtedness if any, required Premium if any, and any other Policy charges in effect at the time the request for payment is processed under this ADB Rider. Concurrent with receipt of the Accelerated Death Benefit Payment, the Policy Owner and any irrevocable beneficiaries will be provided with the ADB Rider Specifications Page which demonstrates the effect of the acceleration on the death benefit and other Policy values.

HERE IS AN EXAMPLE OF THE EFFECT OF AN ACCELERATED DEATH BENEFIT PAYMENT ON A LIFE INSURANCE POLICY. ACTUAL VALUES WILL BE DETERMINED ON THE DATE THE CLAIM IS PROCESSED.

(1) Policy Specified Amount:		$ 500,000.00
(2) Requested Percentage of Policy Specified Amount:		20%
(3) Amount to be Accelerated (Unadjusted Payment):		$ 100,000.00
(4) (a) Reduced by Estimated Charges and Adjustments		
(i) Administrative Expense Charge	$ 250.00*	
(ii) Interest Rate Discount on the amount to be Accelerated	5.00%	
(iii) Policy Premium/Policy Charges** Due on Accelerated Portion (12 months)	$ 5369.00	
(iv) Risk Charge on the amount to be Accelerated***	3.60%	
(b) Reduced by Overdue Premium (if applicable)	$ 0.00	
(c) Proportional reduction to Indebtedness (if applicable)	$ 0.00	
(d) Total Accelerated Death Benefit Payment payable to the Policy Owner	$ 85,781.00	
(5) Reduced Policy Specified Amount:		$ 400,000.00
(6) Premium Necessary to Keep Policy in Force		
(a) Premium before Acceleration of Death Benefit		$ 26,845.00 per year
(b) Premium after Acceleration of Death Benefit		$ 21,476.00per year
(7) Effect on Cash Value		
(a) Cash Value before Acceleration of Death Benefit		$ 131,957.00
(b) Cash Value after Acceleration of Death Benefit		$ 105,565.60

*** We may charge less, but will never charge more than the maximum Administrative Expense Charge stated above. For policies issued in Florida, the maximum Administrative Expense Charge is $100.00.**

**** Referred to as Policy Premium in Whole Life policies, policy premium or policy charges in Universal Life and Variable Universal Life Products.**

IMPORTANT NOTICE TO APPLICANT/BUYER REGARDING ACCELERATED DEATH BENEFITS

For policies issued in California:

The benefits provided by this accelerated death benefit are not intended to provide, and will never provide, long-term care insurance, nursing home insurance, or home care insurance. If you are interested in long-term care or nursing home or home care insurance, you should consult with an insurance agent licensed to sell that insurance, inquire with the insurance company offering the accelerated death benefits, or visit the California Department of Insurance Internet Web site (www.insurance.ca.gov) section regarding long-term care insurance.

If you choose to accelerate a portion of your death benefit, doing so will reduce the amount that your beneficiary will receive upon your death.

Receipt of accelerated death benefits may be taxable. Prior to electing to buy the accelerated death benefit, you should seek assistance from a qualified tax adviser.

Receipt of accelerated death benefits may affect eligibility for public assistance programs, such as Medi-Cal or Medicaid. Prior to electing to buy the accelerated death benefit, you should consult with the appropriate social services agency concerning how receipt of accelerated death benefits may affect that eligibility.

For policies issued in Washington:

This accelerated life benefit does not and is not intended to qualify as long-term care under Washington state law. Washington state law prevents this accelerated life benefit from being marketed or sold as long-term care.