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: 866-678-5433 • Fax: **888**-677-7393 • nationwide.com

1. Submitting the Application

Obtaining Supplemental Forms - 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 visiting our website at nationwide.com.

Submit to Nationwide

For Intelligent Underwriting submission:

- When requesting Intelligent Underwriting a copy of the application signed by the proposed insured, owner if different, and producer.

*For more details on Acceleration, please see Intelligent Underwriting Marketing Materials (FLM-1062AO)

To prepare your client for the interview, please see the Intelligent Underwriting Interview prep guide (LAM-2824AO).

You will be notified throughout each stage of the underwriting process:

- Application is received, and policy number established
- Personal and Health Interview completed by insured
- Accelerated Decision, if applicable, or if an abbreviated exam with labs have been ordered
- Other underwriting requirements needed such as citizenship documents, medical records, etc
- Final Underwriting Decision

If necessary, Nationwide Underwriting will order an Abbreviated Paramed Exam (Quick Check Exam) with Blood, Urine, and EKG (if applicable).

For Standard Application submission:

- Provide copy of the Part A application and Part B Personal and Medical application to client
- State required forms
- Signed Indeterminate Premium Disclosure for NY, MS and TX (Term Only)
- Signed Receipt of Disclosure Statement for

  Accelerated Death Benefit for Terminal Illness Rider. Please reference LAFF-0195AO for a list of applicable states.
- Signed Non-Resident Sales Form (VLF-0402AO), if applicable
- Long Term Care Rider Supplement Form, if applicable
- Appropriate disclosures as required
- Permanently retain the original signed and dated paperwork for your files for future reference

Submission Instructions

Fax or Email For Fastest Service
Email: LifeApps@nationwide.com
Fax: 888-677-7393

Regular Mail
Nationwide Life Insurance Company
PO Box 182835
Columbus, OH 43218-2835

Express Mail
Nationwide Financial Life Operations
3400 Southpark Place, Ste A, DSPF-D4
Grove City, OH 43123

NOTE: Please use the specific submission instructions for your firm if different than the information provided in this section.

2. Available Products

Use This List Of Available Products When Filling In The Plan Name In The Life Insurance Plan Section Of The Application. Some products may not have state approval - please refer to the Illustration/Sales Proposal for confirmation.

UNIVERSAL LIFE:

- Nationwide No-Lapse Guarantee UL II[1]

INDEXED UNIVERSAL LIFE:

- Nationwide® Indexed Universal Life Accumulator II
- Nationwide® Indexed Universal Life Protector II[2]
- Nationwide New Heights® Indexed Universal Life Accumulator

WHOLE LIFE:

- Nationwide YourLife® 20-pay WL
- Nationwide YourLife® WL 100

TERM LIFE:

- Nationwide YourLife® Guaranteed Level 10-year Term
- Nationwide YourLife® Guaranteed Level 15-year Term
- Nationwide YourLife® Guaranteed Level 20-year Term
- Nationwide YourLife® Guaranteed Level 30-year Term

VARIABLE UNIVERSAL LIFE:

- Nationwide® Variable Universal Life Accumulator
- Nationwide® Variable Universal Life Protector[2]

[1]For this product, you must elect either the Guarantee Attained Age up to 70 or 120. Also, only Death Benefit Option 1 is available.
[2]The Extended No-Lapse Guarantee Rider on this product is not available if Death Benefit Option 2 is selected.

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 questions in the Temporary Insurance Agreement section of the application.
- The total specified amount requested exceeds **$1,000,000**. The Producer should not collect any money.

4. Collecting Premium

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

For Monthly EFT mode: There are 2 options available when setting up EFT mode:

- Collect **NO** premium at the time the full application is returned and signed and Home Office will draft the initial premium on the issue date of the policy which is also the Policy Effective Date

  OR

- Collect 2 modal premiums and the draft day will be determined based upon policy effective date unless a specific day has been requested on the application, draft day 1st - 28th

To ensure proper premium drafting, indicate on the application in the EFT Authorization Information section the bank information to be used. This will be filled out when the full application is delivered for signatures once an underwriting decision is made.

5. 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 EMSI: 800-872-3674

- 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.

Nationwide®

LONG-TERM CARE II
INDIVIDUAL LIFE INSURANCE SUPPLEMENT

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

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: GENERAL INFORMATION – Please Print.

Proposed Insured's Name:_____ Policy Number: (If In-Force Policy Addition) _____

Proposed Insured's Social Security Number:_____ Long-Term Care Specified Amount: $_____

Elected Percentage for Maximum Monthly LTC Rider Benefit Determination:* *(select one)* ☐ 2% ☐ 3% ☐ 4%

*The elected percentage is one factor used to determine the maximum monthly LTC rider benefit. See the Illustration/ Sales Proposal or Long-Term Care Rider for additional information.

SECTION 2: PERSONAL INFORMATION (To be completed by the Proposed Insured)

If any question in this section is answered "Yes", the Proposed Insured is ineligible for coverage.

	YES	NO
1. Do you require assistance, supervision, or are you limited in any way from performing any daily activities? (ex. bathing, continence, eating, dressing, toileting, or transferring in or out of bed or chair)	☐	☐
2. In the past 7 years, have you used or do you use oxygen, a catheter, a colostomy bag, or a dialysis machine either regularly or intermittently?	☐	☐
3. In the past 7 years, have you used or do you use a walker, crutches, a wheelchair, or other motorized ambulatory device either regularly or intermittently?	☐	☐
4. Do you currently have a vascular access port, peg or feeding tube?	☐	☐
5. Currently or in the past, has another person or entity been authorized to handle your personal, medical and/or financial affairs due to a mental or physical disability?	☐	☐
6. Are you eligible for or receiving disability benefits?	☐	☐

SECTION 3: SUPPLEMENTAL INFORMATION (To be completed by the Proposed Insured)

	YES	NO
1. During the past 5 years have you:		
a. Been confined to a hospital, for more than 2 weeks, nursing home, or residential care facility?	☐	☐
b. Received home care services, physical, or rehabilitative therapy?	☐	☐
c. Sought medical advice or treatment for:		
1. loss of appetite?	☐	☐
2. falling?	☐	☐
3. fainting?	☐	☐
4. unstable gait?	☐	☐
5. bladder control?	☐	☐
6. dizziness?	☐	☐
7. deterioration of vision?	☐	☐
2. Occupational History		
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.)	☐	☐
3. Do you drive a motor vehicle?	☐	☐
4. Marital Status: ☐ Married ☐ Civil Union ☐ Domestic Partner ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐ Other_____		
5. Do you live with another person?	☐	☐
6. Do you live in a retirement community where you receive assistance with meals, medications, laundry, and/or house cleaning?	☐	☐
7. Are you a citizen of any country other than the United States of America or in the next 12 months have any plans to reside outside of the United States?	☐	☐

SECTION 4: INSURANCE INFORMATION

	YES	NO
a. Will the rider applied for replace existing Long-Term Care Insurance on the Proposed Insured? *(If "yes", provide details below.)*	☐	☐
b. Do you intend to replace any of your medical or health insurance coverage with this policy? *(If "yes", provide details below.)*	☐	☐
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.)*	☐	☐
d. Are you covered by Medicaid?	☐	☐
e. Do you have another Long-Term Care Insurance policy or certificate in force (including Health Care service contract, or Health Maintenance Organization contract)? *(If "yes", provide details below.)*	☐	☐

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

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

SECTION 5: 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.

SECTION 6: SIGNATURES (Required)

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 RECEIVED A COPY OF AND 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.

Name of Primary Proposed Insured:_____

Signature of Primary Proposed Insured:_____Date:_____

Signature of Applicant (If other than Primary Proposed Insured):_____Date:_____

Signature of Owner (if other than Primary Proposed insured):_____Date:_____

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 Name Firm

_____

Producer's Signature License ID Number

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

☐ Long-Term Care Rider – Potential Rate Increase Disclosure Form

☐ Protection Against Unintended Lapse

Applicant's Signature	Date
Producer's Signature	Date

Nationwide®

Application for Individual Life Insurance
Nationwide Life And Annuity Insurance Company

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

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 *(If outside U.S., provide country.)*	
Email Address		Phone #	Driver's License #/State of Issue	
Occupation	Employer	Annual Income	Net Worth	

Can you read and understand English? ☐ Yes ☐ No
If "no", please provide primary spoken language:_____

Citizenship *(If other than U.S, submit Foreign Supplement.)*
☐ U.S.
☐ Green Card Holder Issue Date_____ Expiration Date_____
☐ Other_____ Issue Date_____ Expiration Date_____

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.*

Joint/Spouse Proposed Additional Insured Information Only:

Name *(First, MI, Last)*				SSN/Tax ID #
Address ☐ *(Check box if same as Proposed Primary Insured.)*				City
State	Zip Code	County	Sex ☐ M ☐ F	Former Name
Relationship to Primary Insured	Date of Birth *(mm/dd/yyyy)*	State of Birth *(If outside U.S., provide country.)*		
Email Address		Phone #	Driver's License #/State of Issue	
Occupation	Employer	Annual Income	Net Worth	

Can you read and understand English? ☐ Yes ☐ No
If "no", please provide primary spoken language:_____

Citizenship *(If other than U.S, submit Foreign Supplement.)*
☐ U.S.
☐ Green Card Holder Issue Date_____ Expiration Date_____
☐ Other_____ Issue Date_____ Expiration Date_____

Child Proposed Additional Insured Information Only:

Name of Child Insured(s)	Birth Date	Birth State	Sex	Height	Weight	SSN/ Tax ID #	Relationship to Primary Insured	Address & Phone # *(Check box if same as Proposed Primary Insured.)*
								☐
								☐
								☐
								☐

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. TRUST - Submit a copy of first and signature pages of Trust document. If more than two Owners are requested, use Special Instructions Section.*

Type of Owner ☐ Individual ☐ Employer ☐ Trust ☐ Rabbi Trust ☐ Other_____	Relationship to Insured	SSN/Tax ID/Trust Tax ID #

Individual Name *(First, MI, Last)* or Employer Name	DOB *(if applicable) (mm/dd/yyyy)*

Exact Name of Trust or Plan	Current Trustee(s)	Date of Trust or Plan

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

State	Zip Code	County	Phone #	Email Address

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.

Type of Owner ☐ Individual ☐ Employer ☐ Trust ☐ Rabbi Trust ☐ Other_____	Relationship to Insured	SSN/Tax ID/Trust Tax ID #

Joint Individual Name *(First, MI, Last)* or Employer Name	DOB *(if applicable) (mm/dd/yyyy)*

Exact Name of Trust or Plan	Current Trustee(s)	Date of Trust or Plan

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

State	Zip Code	County	Phone #	Email Address

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. Secondary Addressee – NOTE: While a policy is in force, you have the right, at any time, to designate a "Secondary Addressee" by sending us written request containing the name and address of such person.

Name *(For the purpose of notification of past due premium payment and possible lapse in coverage.)*

Address

6. 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 the Primary Beneficiary and the Owner are the same.***

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 #	Address & Phone #

6. Primary Beneficiary Designations *(cont'd)* – *If Survivorship Life Plan, the Proposed Insureds may not be named as Beneficiary. If additional space is required, use Special Instructions Section.*

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 #	Address & Phone #

7. Contingent Beneficiary Designations – *If additional space is required, use Special Instructions Section.*

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 #	Address & Phone #

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 #	Address & Phone #

Plan Information

8. Life Insurance Plan – *The Variable Life Fund Supplement **MUST** be completed if applying for a Variable Product. The IUL Allocation Form **MUST** be completed if applying for an Indexed UL Product.*

Product *(select one and print the Plan Name below):*

☐ No-Lapse Guarantee Universal Life - *(Select One):*
- ☐ Guarantee up to Attained Age 70
- ☐ Guarantee up to Attained Age 120

☐ Term Life – Term Level Period *(Select One)*:
- ☐ 10 Year ☐ 20 Year
- ☐ 15 Year ☐ 30 Year

☐ Universal Life ☐ Variable Universal Life ☐ Indexed Universal Life ☐ Whole Life ☐ Survivorship Life

Plan Name:_____
(REQUIRED: Print complete name of product being applied for, refer to the Illustration/Sales Proposal for the correct Plan Name.)

Base Specified Amount	+	Additional Term Rider/Supplemental Coverage Amount *(check plan for availability)*	=	Total Specified Amount *(including Additional Term Rider/Supplemental Coverage)*
$_____		$_____		$_____

9. Additional Options – *Complete this section if you applied for a **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.)

10. Optional Benefits – *Check Plan for Availability.*

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

☐ Children's Term Insurance Rider..... $_____
☐ Long Term Care Rider*..... $_____
**Complete Supplement for Long Term Care Rider.*
☐ Accidental Death Benefit Rider..... $_____
☐ Extended No-Lapse Guarantee Rider**
  ☐ Guarantee up to Attained Age 90
  ☐ Guarantee up to Attained Age 120
***This rider is not available with the Premium Waiver Rider.*
☐ Return of Premium Feature
(Periodic Access Minimum Surrender Value Rider)
☐ Surrender Charge Option
Please select only one option below. *(After the policy is issued, this option cannot be changed.)*
  ☐ High Early Cash Value
  ☐ Performance

☐ Change of Insured Rider
☐ Other Rider(s)_____
Can select only one:
☐ Premium Waiver Rider..... $_____
☐ Waiver of Monthly Deductions Rider
Can select only one:
☐ Surrender Value Enhancement Benefit
☐ Conditional Return of Premium Rider
Rider Benefit Option must be selected *(only applicable to the IUL Accumulator II product):*
  ☐ Option A
  ☐ Option B

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.*
☐ Extended No-Lapse Guarantee Rider
  ☐ Guarantee up to Attained Age 90
  ☐ Guarantee up to Attained Age 120

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

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

☐ 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 B for the Owner)
Occupation_____
Height_____
Weight_____
State of Birth_____

☐ Owner's Waiver of Premium Death or Disability Benefit Rider *(Complete Part B 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 (APLO) for Whole Life Plans only, if available, unless the box below is checked.
☐ **No, do not issue with APLO.**

Future Billing And Premium Information – ***(Funds must be drawn from U.S. Institutions.)***

11. Amount Paid With Application – *Check the applicable option and indicate the premium amount being submitted with the application.*

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

☐ Check/Wire amount with application ..... $_____
(**NOTE:** Make all checks payable to **NATIONWIDE**.)
☐ Web Remittance (this option is not available for VUL products)..... $_____
☐ Draft initial payment only (indicate initial premium amount and complete Section 13b) ..... $_____
☐ Draft initial payment and future payments (indicate initial premium amount and complete Sections 12 & 13)..... $_____

12. Future Billing and Payment Options - *Check the applicable billing or payment option(s) and indicate the premium amount.*

Billing Options:	Payment Options:
☐ EFT* ..... $_____	☐ Single Premium ..... $_____
**If selected, complete Section 13, Electronic Draft Authorization.*	☐ Billing Advantage ..... $_____
☐ Quarterly ..... $_____	Account Number_____
☐ Semi-Annual ..... $_____	☐ 1035 Exchange ..... $_____
☐ Annual ..... $_____	☐ Other ..... $_____

13. Electronic Draft Authorization

13a. Electronic Draft Options:

Draft Frequency:	Draft Options:
☐ Monthly ☐ Quarterly* ☐ Semi-Annual* ☐ Annual*	☐ **Checking - Use information on the initial premium check.
*Available for Term/Whole Life products only	☐ **Checking - (Provide a pre-printed voided check.)
Draft Day (1st–28th):_____	☐ **Savings - (Provide a letter from the bank indicating the Transmit/ABA number, Account number and Account Holder's name.)
*(**NOTE**: Draft Day will be determined based upon policy effective date unless a day is requested above.)*	

13b. 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 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.*

14. 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

Insurance Information

15. Replacement and Other Policy Information – *Be sure to answer all questions. If applicable, check the appropriate box.*

a. Do you have any other Life Insurance or Annuities currently 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.)* _____	☐ Yes ☐ No
d. Is any person here proposed for coverage had Life Insurance or Annuities in the past 3 years that is no longer in force? *(If "yes", provide name of Company, face amount and reason coverage is no longer in force.)* _____	☐ Yes ☐ No
e. Have you applied for Life Insurance or Annuities in the past 12 months? *(If "yes", provide name of Company, and face amount.)* _____	☐ Yes ☐ No

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

Financial And Health Information

16. Financial – *Provide additional details for all "yes" answers in Special Instructions Section unless instructed otherwise. This section needs to be completed by each Proposed Insured and Owner/Trustee, if other than Proposed Insured(s).*

All questions must be answered by each Proposed Insured and Owner/ Trustee, if other than Proposed Insured(s). For each "yes" answer, indicate the appropriate item(s) and provide details.	**Proposed Primary Insured**		**Proposed Additional Insured**		**Owner/ Trustee if other than Proposed Insured(s)**	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**
a. Is this policy being purchased for the purpose of selling or assigning this policy to a life settlement company, trust, limited liability corporation, viatical, or other secondary market purchaser?	☐	☐	☐	☐	☐	☐
b. Have you entered into any agreement, or made arrangements, for the sale or assignment of this policy to a life settlement company, trust, limited liability corporation, viatical, or other secondary market purchaser?	☐	☐	☐	☐	☐	☐
c. Have you been involved in any communication about the possible sale or assignment of this policy to a life settlement company, trust, limited liability corporation, viatical, or other secondary market purchaser?	☐	☐	☐	☐	☐	☐
d. Have you ever sold any life insurance policy to a life settlement company, trust, limited liability corporation, viatical, or other secondary market purchaser?	☐	☐	☐	☐	☐	☐
e. Will any portion of the current or future premium for this policy be financed?	☐	☐	☐	☐	☐	☐
f. Will any Insured or Policy Owner receive any payment in connection with the insurance issued on the basis of this application?	☐	☐	☐	☐	☐	☐

17. Tobacco Use

Have you used tobacco or nicotine in any form?	**Proposed Primary Insured**	**Proposed Additional Insured**
In the last 12 months?	☐ Yes ☐ No *If "yes", date last used.*_____	☐ Yes ☐ No *If "yes", date last used.*_____

18. Health Question – *Provide additional details for all "yes" answers in Special Instructions.*

Question must be answered by each Proposed Insured(s).	**Proposed Primary Insured**		**Proposed Additional Insured**		**Any Child**	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**
To the best of your knowledge and belief, within the past 5 years, has anyone here proposed for insurance consulted a member of the medical profession for, been treated for, or been diagnosed as having diabetes, stroke, cancer, heart disease, schizophrenia, alcoholism, or drug abuse?	☐	☐	☐	☐	☐	☐

19. Special Instructions – *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.*

Part C – 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 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.

MIB, Inc. Disclosure Notice: 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.

Information Practices: Nationwide has a privacy policy to protect your personal information, and it is available to you upon request. To issue an insurance policy, we need to obtain information about you. Some of that information will come from you, and some will come from other sources, including consumer reports such as an insurance score based on information contained in your credit report. Personal information may in certain circumstances be disclosed to third parties without your specific authorization as permitted or required by law. You have the right to access and correct your personal information.

Part D – Agreement, Authorization And Signature

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 Life and Annuity Insurance Company ("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.
- Nationwide may obtain and use consumer reports for each insured in the processing and/or underwriting of this application for life insurance.

No Illustration Acknowledgement

If an illustration matching the life insurance policy as applied for is not being submitted to Nationwide, please select the reason why:

☐ I did not receive a life insurance illustration

☐ The life insurance illustration provided to me does not match the life insurance policy as applied for

By signing this application:

Applicant Acknowledgement – I understand that an illustration matching the life insurance policy as issued will be provided to me no later than the time the life insurance policy is delivered.

Producer Acknowledgement – I have not presented an illustration as applied for and will provide an illustration matching the policy as issued no later than the time the policy is delivered. A signed copy must be returned to Nationwide.

Taxpayer ID Number – *Check box, if Applicable.*

I certify under penalties of perjury that:

- **The Taxpayer Identification Number or Social Security Number listed on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), 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. citizen or other U.S. person, and,**
- **The FATCA (Foreign Account Tax Compliance Act) code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct (FATCA does not apply as this is a US account)**

☐ **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.**

Part D – Agreement, Authorization And Signature *(cont'd)*

HIPAA Compliant Authorization: I authorize: any licensed physician or medical practitioner; any hospital; clinic; 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, in any format, including, but not limited to paper and/or electronic, any information *(excluding HIV)* concerning me; including, but not limited to, my entire medical/health record to the Medical Director of Nationwide or its subsidiaries; affiliates; or sub-contractors; 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 understand that the aforementioned parties requesting access to my (electronic or paper) medical records are acting as a patient authorized representative and will attempt to access my medical records in the most efficient manner possible, including electronic interchange through a health information exchange or directly through my providers' electronic health record system. I also authorize Nationwide to make a brief report of my health information, including 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 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 any time, by sending a written request for revocation to Nationwide, 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 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 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.

Proposed Insured(s) and Owner/Trustee Signatures – *All Financial questions in Section 16 (a through f) are required to be answered for both the Proposed Insured(s) and Owner, if not Proposed Insured(s).*

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.

THE INTERNAL REVENUE SERVICE DOES NOT REQUIRE YOUR CONSENT TO ANY PROVISION OF THIS DOCUMENT OTHER THAN THE CERTIFICATIONS REQUIRED TO AVOID BACKUP WITHHOLDING.

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

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

_____ X_____
Full Name of Proposed Additional Insured *(print)* Signature of Proposed Additional Insured *(if to be Insured)*

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

Part E - Producer's Certification

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 or Annuities.

_____ X_____
Producer's Name *(print)* Signature of Producer

_____ _____
Firm Producer's Nationwide #

Temporary Insurance Agreement
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 – *Question must be answered by each Proposed Insured(s).*

Proposed Primary Insured		Proposed Additional Insured		Any Child		
Yes	No	Yes	No	Yes	No	
☐	☐	☐	☐	☐	☐	To the best of your knowledge and belief, within the past 5 years, has anyone here proposed for insurance consulted a member of the medical profession for, been treated for, or been diagnosed 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 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, 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 – *Be sure to include the amount of the initial premium payment.*

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 #

Nationwide®

Application for Individual Life Insurance
Nationwide Life And Annuity Insurance Company

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

Part B – Personal And Health Information

1. Proposed Insured(s)

Proposed Primary Insured *(First, MI, Last)*	SSN/Tax ID #
Proposed Additional Insured *(First, MI, Last)*	SSN/Tax ID #

2. Tobacco Use

Proposed Primary Insured	Proposed Additional Insured
In the past 5 years, have you vaped or used tobacco, nicotine or marijuana in any form?	
☐ Yes ☐ No *If "yes", date last used.* _____ *(mm/yyyy)*	☐ Yes ☐ No *If "yes", date last used.* _____ *(mm/yyyy)*
If "yes", check all forms of tobacco or nicotine products used. If Cigar, please provide the number used per month.	
☐ Cigarettes ☐ Cigar(s)_____ ☐ E-Cigarettes/Vapor ☐ Pipe ☐ Chewing Tobacco/Snuff ☐ Hookah ☐ Other Tobacco ☐ Marijuana ☐ Nicotine Products (Gum, Patch, etc.)	☐ Cigarettes ☐ Cigar(s)_____ ☐ E-Cigarettes/Vapor ☐ Pipe ☐ Chewing Tobacco/Snuff ☐ Hookah ☐ Other Tobacco ☐ Marijuana ☐ Nicotine Products (Gum, Patch, etc.)

3. Physical Measurements – *Fill in information for the Proposed Primary Insured and Proposed Additional Insured.*

	Height	Current Weight	Weight 1 Year Ago	Details of Weight Gain or Loss
Proposed Primary Insured				
Proposed Additional Insured				

4. Personal Physicians – *If Child Rider coverage is requested, use an additional blank sheet to add Personal Physician information for each child.*

	Proposed Primary Insured	Proposed Additional Insured	Any Child
Name of Personal Physician:			
Address:			
Telephone Number:			
Date Last Consulted:			
Reason Last Consulted and Outcome:			
Treatment Given or Medication Prescribed:			

5. Personal Details – *Explain all "yes" answers in Section 6 Details box below unless instructed otherwise.*

All questions are to be answered by each Proposed Insured. For each "yes" answer, indicate the appropriate item(s) and provide details.	**Proposed Primary Insured**		**Proposed Additional Insured**		**Any Child**	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**
a. Have you ever had any application for Life Insurance *(or any application for reinstatement for Life Insurance)* declined, postponed, rated-up, or limited?	☐	☐	☐	☐	☐	☐
b. In the past 5 years, have you applied for or received disability payments for any long term illness or injury?	☐	☐	☐	☐	☐	☐
c. In the past 2 years, have you engaged in, or do you intend to engage in within the next 12 months: flying as pilot; organized racing of any type of motor-powered vehicle; scuba diving, mountain climbing, or any type of sky sports? *(If "yes", please complete an Aviation/Hazardous Activities Questionnaire.)*	☐	☐	☐	☐	☐	☐
d. In the past 5 years, have you pled guilty to or been convicted of reckless driving, driving under the influence of alcohol or drugs, had a driver's license suspended or revoked, or in the past 3 years had more than three moving violations?	☐	☐	☐	☐	☐	☐
e. 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?	☐	☐	☐	☐	☐	☐
f. In the next 12 months, do you plan to travel or reside outside of the United States? *(If "yes", complete Supplement for Foreign Nationals or Travel.)*	☐	☐	☐	☐	☐	☐
g. Are you a member or plan to be a member of the US Armed Forces, National Guard, or Reserves? *(If "yes", complete Military Status Questionnaire.)*	☐	☐	☐	☐	☐	☐
h. Have you had any bankruptcies in the past 7 years or do you have any suits or judgments pending against you at this time?	☐	☐	☐	☐	☐	☐
i. 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.)*	☐	☐	☐	☐	☐	☐
j. In the past 5 years, have you at any point averaged more than 3 drinks per day? *(If "yes", how much, what kind (beer, wine, liquor), and how often?)*	☐	☐	☐	☐	☐	☐

6. Explanation of Personal Details – *If more space is needed, an additional blank sheet may be attached. Any Proposed Insured(s) should sign and date additional pages.*

Question Letter	**Person**	**Dates**	**Details**

7. Health Questions – *All questions are to be answered by each Proposed Insured. Explain all "yes" answers in Section 8 Details box unless instructed otherwise. See Section 9 Appendix for reference.*

To the best of your knowledge and belief, within the past 5 years, 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. Disease or disorder of the heart?	☐	☐	☐	☐	☐	☐
c. Disease or disorder of the arteries, blood, or blood vessels ***(excluding HIV testing)***?	☐	☐	☐	☐	☐	☐
d. Diabetes or any disorder of the endocrine system?	☐	☐	☐	☐	☐	☐
e. Disease or disorder of the brain, muscle, or nervous system?	☐	☐	☐	☐	☐	☐
f. Disease or disorder of the lungs or respiratory system?	☐	☐	☐	☐	☐	☐
g. Cancer or tumors *(other than basal cell carcinoma)?*	☐	☐	☐	☐	☐	☐
h. Disease or disorder of the kidneys or liver?	☐	☐	☐	☐	☐	☐
i. Disease or disorder of the stomach or digestive system?	☐	☐	☐	☐	☐	☐
j. Disease or disorder of the bones, joints, or back?	☐	☐	☐	☐	☐	☐
k. Auto-Immune ***(other than HIV)*** or connective tissue disorder?	☐	☐	☐	☐	☐	☐
l. Behavioral, psychological, or psychiatric disorder *(including depression or anxiety)*?	☐	☐	☐	☐	☐	☐
m. Alcoholism, alcohol abuse, drug addiction, or illegal drug use?	☐	☐	☐	☐	☐	☐
n. Disease of the ears, nose, throat, or eyes *(excluding vision correction)*?	☐	☐	☐	☐	☐	☐
o. Disease or disorder of the reproductive system?	☐	☐	☐	☐	☐	☐
Have you in the past 5 years:						
p. Consulted, been referred to, or been examined or treated by any health care professional or facility not already disclosed ***(excluding HIV testing)***?	☐	☐	☐	☐	☐	☐
q. Had any abnormal test that has not already been disclosed ***(excluding HIV testing)***?	☐	☐	☐	☐	☐	☐
r. Been medically advised to have any surgery, hospitalization, treatment or test that was not completed or results that you have not received ***(excluding HIV testing)***?	☐	☐	☐	☐	☐	☐
s. Taken or is currently taking any medications, other than already disclosed, to include prescription or over-the-counter medications for more than 5 days? *(Give details of dosage and frequency.)*	☐	☐	☐	☐	☐	☐

8. Details of Health History – *If more space is needed, an additional blank sheet may be attached. Any Proposed Insured(s) should sign and date additional pages.*

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

9. Appendix to Section 7 Health Questions
a. AIDS *(Acquired Immune Deficiency Syndrome)*
b. Including, but not limited to, heart attack, chest pain, shortness of breath, congestive heart failure, heart murmur, valvular heart disease, irregular heart beat, palpitations, high blood pressure, or other defects or disorders of the heart
c. Including, but not limited to, aneurysm, peripheral vascular disease, or any blockage or narrowing of the arteries or veins or other disorder of the blood vessels, anemia, elevated cholesterol, hemophilia, clotting factors, or any other disorders of the red or white blood cells or platelets
d. Including, but not limited to, diabetes, high blood sugar, sugar in the urine, thyroid, parathyroid, pituitary, or any other disorders of the endocrine system
e. Including, but not limited to, stroke or TIA *(transient ischemic attack)*, Alzheimer's disease, dementia, memory loss, cognitive disorder, seizure, multiple sclerosis, muscular dystrophy, cerebral palsy, Parkinson's disease, ALS *(Lou Gehrig's disease)*, or any form of muscular atrophy, or any other brain, spinal cord, or nervous system disorder
f. Including, but not limited to, asthma, emphysema, COPD *(Chronic Obstructive Pulmonary Disease)*, sleep apnea, or any other disease or disorder of lungs or respiratory system
g. Including, but not limited to, leukemia, lymphoma, any malignant or benign tumor, cyst or polyp, or any disorder of the lymph glands
h. Including, but not limited to, cirrhosis, hepatitis, protein or blood in urine, or any other disease or disorder of the kidney or liver
i. Including, but not limited to, ulcerative colitis, Crohn's Disease, disease or disorder of the stomach, pancreas, gall bladder, or any other disease or disorder of the intestinal or digestive tract
j. Including, but not limited to, arthritis, rheumatism, or any disease or disorder of the back, spine, bones, or joints
k. Including, but not limited to, lupus, scleroderma, or any other connective tissue or other auto-immune disease
l. Including, but not limited to, depression, anxiety, attention deficit disorders, bipolar, eating disorders, schizophrenia, or any other mental, behavioral, psychological, or psychiatric disorders
m. Including, but not limited to, cocaine, narcotics, or misuse of prescription medication other than advised by a physician
n. Disease of the ears, nose, throat, or eyes *(excluding vision correction)*
o. Including, but not limited to, ovarian cyst/tumors, prostate enlargement, testicular mass, or any other disease or disorder of the reproductive system or breasts

10. Proposed Insured(s)

I acknowledge that all the statements and answers on this form are complete and true to the best of my knowledge and belief, whether written by my own hand or not, and I agree that they are to be the basis for any insurance issued hereon. I agree that a copy of this Part B shall be attached to and form a part of any policy issued.

Signed this day of_____, _____
Month/Day Year

X_____ X_____

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

Signature of Proposed Additional Insured
(if to be Insured)

☐ 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 LIFE INSURANCE COMPANY
NATIONWIDE LIFE AND ANNUITY 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

LIFE-3483-C (12/2004) CA

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**
☐ **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.

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®

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®

LONG-TERM CARE RIDER ("RIDER") POTENTIAL RATE INCREASE DISCLOSURE FORM

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

This form is required by state law. It is not intended to imply that your rates will increase.

1. RATE SCHEDULE:

This Rider has a monthly charge, a complete description of which can be found within the Rider.

The monthly rider charge applicable to you is stated in your Policy Specifications Pages (also called "Policy Data Pages"). We have the right to increase the monthly rates, up to the Guaranteed Maximum Monthly LTC Rider Charge Rate Per $1,000 of LTC Rider Specified Amount. The monthly rider charge will remain in effect as long as the Rider remains active.

2. POTENTIAL RATE REVISION:

This Rider is guaranteed renewable. This means that we have no right to make unilateral changes to any provision of this Rider. However, we do have the right to increase the current monthly rider charge rate, on a class basis, but any increase will not exceed the guaranteed maximum monthly rider charge as stated in your Policy Specification Pages. A complete description of the monthly rider charge can be found within the Rider.

3. RATE ADJUSTMENTS:

Any change in your monthly rider charge will be effective on the first monthly policy anniversary that occurs on or after 60 days following notification from us of the rate adjustment.

In the future, if you receive an increase in your monthly rider charge, you will be notified of the new monthly rider charge and you will be able to exercise at least one of the following options:

- Pay the increased monthly rider charge, which may eventually require you to pay additional premium to continue in force, as is, the policy to which this Rider is attached
- Reduce the benefits of the policy to which this Rider is attached, to a level such that your premiums will not increase (subject to state law)
- Send us a written request to terminate your Rider

Nationwide®

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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.

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 $2,000,001 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 $500,001 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: