NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY

Application for Individual Life Insurance

P.O. 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

E-Mail Address | Phone # ( ) ☐ AM ☐ PM

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

Occupation | Employer | Citizenship *(If other, submit Foreign Supplement.)* ☐ U.S. ☐ Canada ☐ Other, how long have you lived in the U.S.?_____

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 # | Date of Birth *(mm/dd/yyyy)*

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

County | State of Birth | Sex ☐M ☐F | Height | Weight | Phone # ( ) ☐ AM ☐ PM

E-Mail Address | Former Name | Relationship to Primary Insured

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

Occupation | Employer | Citizenship *(If other, submit Foreign Supplement.)* ☐ U.S. ☐ Canada ☐ Other, how long have you lived in the U.S.?_____

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 ☐ Qualified Plan ☐ 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 # ( ) ☐AM ☐PM | E-Mail 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 ☐ Qualified Plan ☐ 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 # ( ) ☐AM ☐PM | E-Mail 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 Trust named in the Owner section is to be the Primary Beneficiary. If a different Trust is named as Primary Beneficiary or Trust is named as Contingent Beneficiary, provide the Trust information below.***

For Proposed Primary Insured

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

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 #

8. 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

☐ **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.**

PLAN INFORMATION

9. Life Insurance Plan

STOP

*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): ☐Universal Life ☐Variable Universal Life ☐Whole Life ☐Survivorship Life

Term Life – Term Level Period (select one): ☐10 Year ☐15 Year ☐20 Year ☐30 Year

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)*
$_____		$_____		$ 0

10. Additional Options

STOP

*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.)

11. Optional Benefits

Check Plan for Availability.

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

☐ Spouse Rider..... $_____

☐ Children's Term Insurance Rider..... $_____

☐ Accelerated Benefit Rider for Health Care/Life Insurance*..... $_____

**Complete Supplement for Accelerated Benefit Rider for Health Care/Life Insurance.*

☐ Accidental Death Benefit Rider..... $_____

☐ Extended Death Benefit Guarantee Rider

_____ Guarantee Percentage *(Indicate percentage of specified amount)*

_____ Guarantee Duration *(Indicate number of years)*

☐ 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.

☐ Adjusted Sales Load Rider _____% *(in whole percentages only)* waived for _____ years

☐ 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 (cannot be elected with Extended Death Benefit Guarantee Rider)

☐ Surrender Charge Waiver Options ☐ Full ☐ Partial

(If the Full or Partial option is not selected, standard surrender charges will be applied.)

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

☐ Four Year Term Rider**..... $_____

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

☐ Policy Split Option Rider

☐ Other Rider(s)_____

☐ Other Rider(s)_____

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

☐ 20 Year Spouse Rider ..... $_____

☐ Children's Term Insurance Rider..... $_____

☐ Accidental Death Benefit Rider..... $_____

☐ Guaranteed Insurability Benefit Rider $_____

☐ Waiver of Premium Disability Benefit Rider

☐ Owner's Waiver of Premium Death Benefit Rider (Complete Part 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

12. 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 14b) ..... $_____

☐ Draft initial payment and future payments (indicate initial premium amount and complete Sections 13 & 14) ..... $_____

13. 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 14, Electronic Draft Authorization.*	☐ Billing Advantage ..... $_____
☐ Quarterly ..... $_____	Account Number _____
☐ Semi-Annual ..... $_____	☐ 1035 Exchange ..... $_____
☐ Annual ..... $_____	☐ Other ..... $_____

14. Electronic Draft Authorization

14a. Electronic Draft Options:

Draft Frequency:

☐ Monthly ☐ Quarterly* ☐ Semi-Annual* ☐ Annual*

*Available for Term/Whole Life products only

Draft Day (1st –28th): _____

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

Draft Options:

☐ **Checking - Use information on the initial premium check.

☐ **Checking - (Provide a pre-printed voided check.)

☐ **Savings - (Provide a letter from the bank indicating the Transmit/ABA number, Account number and Account Holder's name.)

14b. 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.*

15. 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

16. Replacement and Other Policy Information

STOP

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

☐ Yes ☐ No	a. Do you have any other Life Insurance or Annuities either currently in force or that has been sold to a third party? *(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.)* _____

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

FINANCIAL INFORMATION

17. Financial Questions

Explain all "yes" answers in Section 18 Details box below unless instructed otherwise.

STOP

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?	☐	☐	☐	☐	☐	☐

18. Explanation of Financial Details

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

Question Letter	Person	Dates	Details

PART B - PERSONAL AND HEALTH INFORMATION

19. Tobacco Use

All questions are to be answered by each Proposed Insured.

STOP

Be sure to answer this section.

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

20. Physical Measurements

Fill in information for the Proposed Primary Insured.

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

21. Personal Physicians

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

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

22. Personal Details

Explain all "yes" answers in Section 23 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 or Health Insurance *(or any application for reinstatement for Life or Health Insurance)* declined, postponed, rated-up or limited?	☐	☐	☐	☐	☐	☐
b. Have you ever applied for or received disability payments for any long term illness or injury?	☐	☐	☐	☐	☐	☐
c. In the past 3 years have you engaged in, or do you intend to engage in: flying as a pilot, student pilot, or crew member; organized racing of an automobile, motorcycle, or any type of motor-powered vehicle; scuba diving, mountain climbing, hang gliding, parachuting, sky diving, bungee jumping, soaring, or ballooning? *(If "yes", complete an Aviation/ Hazardous Activities Questionnaire.)*	☐	☐	☐	☐	☐	☐
d. Have you ever had your driver's license suspended or revoked; or ever been convicted of driving while impaired or intoxicated, or in the past 3 years been convicted of more than one moving violation?	☐	☐	☐	☐	☐	☐
e. Except as prescribed by a physician, have you ever used, or been convicted for sale or possession of cocaine or any other narcotic or illegal drug? *(If "yes", complete Drug Questionnaire.)*	☐	☐	☐	☐	☐	☐
f. Have you ever been charged with a violation of any criminal law?	☐	☐	☐	☐	☐	☐
g. In the next 12 months, do you plan to travel or reside outside of the United States or Canada? *(If "yes", complete Supplement for Foreign Nationals or Travel.)*	☐	☐	☐	☐	☐	☐
h. Do you belong to or intend to join any active or reserve military or naval organization? *(If "yes", complete Military Status Questionnaire.)*	☐	☐	☐	☐	☐	☐
i. Have you had any bankruptcies in the past 7 years or do you have any suits or judgments pending against you at this time?	☐	☐	☐	☐	☐	☐
j. To the best of your knowledge, do you have a parent or sibling who died from cancer or cardiovascular disease prior to age 60? *(If "yes", provide relationship to Proposed Insured(s), age at death, and cause of death, and if cancer, provide type.)*	☐	☐	☐	☐	☐	☐
k. Can you read and understand English?	☐	☐	☐	☐	☐	☐

23. Explanation of Personal Details

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

Question Letter	Person	Dates	Details

HEALTH INFORMATION

24. Health Questions

All questions are to be answered by each Proposed Insured.

Explain all "yes" answers in Section 25 Details box unless instructed otherwise.

To the best of your knowledge and belief, has anyone here proposed for insurance consulted a member of the medical profession for, been treated for, or been diagnosed as having:	Proposed Primary Insured		Proposed Additional Insured		Any Child	
	Yes	No	Yes	No	Yes	No
a. AIDS (Acquired Immune Deficiency Syndrome)?	☐	☐	☐	☐	☐	☐
b. Heart disease including heart attack, angina, or other chest pain, cardiomyopathy, shortness of breath, congestive heart failure, heart murmur, or other disorder of the heart?	☐	☐	☐	☐	☐	☐
c. Irregular heart beat, palpitations, high blood pressure, high cholesterol, or high triglycerides?	☐	☐	☐	☐	☐	☐
d. Aneurysm, carotid artery disease, deep venous thrombosis, phlebitis, peripheral vascular disease, any other disorder of the blood vessels, or pulmonary embolism?	☐	☐	☐	☐	☐	☐
e. Headaches, seizures, epilepsy, stroke, Alzheimer's disease, dementia, Parkinson's disease, multiple sclerosis, or any other brain or nervous disorder?	☐	☐	☐	☐	☐	☐
f. Depression, neurosis, affective disorder, psychosis, or any other mental or emotional disorder?	☐	☐	☐	☐	☐	☐
g. Asthma, emphysema, chronic bronchitis, tuberculosis, or any other disease of the lungs or respiratory system?	☐	☐	☐	☐	☐	☐
h. Colitis, ulcer, persistent diarrhea, rectal bleeding, Crohn's disease, ulcerative colitis, or any other disease of the esophagus or digestive tract?	☐	☐	☐	☐	☐	☐
i. Sugar, protein or blood in the urine, kidney stones, sexually transmitted disease, or any other disease or disorder of the kidneys, bladder, prostate, breast, urinary tract or reproductive system?	☐	☐	☐	☐	☐	☐
j. Diabetes, hepatitis, cirrhosis or any other disease of the liver, pancreas, or thyroid?	☐	☐	☐	☐	☐	☐
k. Disorder of the blood including anemia, sickle cell disorders, thalassemia, hemophilia, or any other disorder of the red blood cells, or white blood cells, platelets, or clotting factors **(excluding HIV testing)?**	☐	☐	☐	☐	☐	☐
l. Cancer, or any malignant or benign tumor or cyst, or any chronic disease of the skin or lymph glands?	☐	☐	☐	☐	☐	☐
m. Arthritis, rheumatoid arthritis, osteoporosis; or any paralysis or chronic back or muscle condition?	☐	☐	☐	☐	☐	☐
n. Alcoholism, narcotic addiction, drug use, or hallucinations?	☐	☐	☐	☐	☐	☐
o. Any disease of the eyes, ears, nose or throat?	☐	☐	☐	☐	☐	☐
To the best of your knowledge and belief, in the past 5 years, has anyone here proposed for insurance:						
p. Consulted, or been examined or treated by any physician, chiropractor, psychologist or other health care practitioner or by any hospital, clinic, or other health care facility not already disclosed on this application? *(If it was for a "check up", annual physical, employment physical, etc., so state and give findings and results.)*	☐	☐	☐	☐	☐	☐
q. Had any disease, disorder, injury, or operation not already disclosed on this application?	☐	☐	☐	☐	☐	☐
r. Had any x-rays, electrocardiograms, or other medical tests for reasons not already disclosed on this application **(excluding HIV testing)?**	☐	☐	☐	☐	☐	☐
s. Been medically advised to have any surgery, hospitalization, treatment or test that was not completed or results that you have not received?	☐	☐	☐	☐	☐	☐
t. Currently taking any medication other than indicated above to include prescription, over-the-counter medications for more than 5 days, dietary supplements, "natural" or herbal medications? *(Give details of dosage and frequency.)*	☐	☐	☐	☐	☐	☐
u. Used alcoholic beverages? *(If "yes", how much, what kind (beer, wine, liquor), and how often.)*	☐	☐	☐	☐	☐	☐

25. Details of Health History *If more space is needed, an additional blank sheet may be attached. Any Proposed Insured(s) or Owner(s) should sign and date additional pages.*	**Question Letter**	**Person**	**Dates**	**Details** *(Be specific. Give full names, addresses and telephone numbers (if available) of physicians, hospitals, etc.)*

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

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 non-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. I authorize Nationwide to report information to MIB, Inc. 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 (TTY 866-346-3642). 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.

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.

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 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 also authorize Nationwide to report 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

STOP

All Financial questions in Section 17 (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 _____ (City/State), on _____ (Month/Day), _____ (Year)

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

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

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

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

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

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

PART E - PRODUCER'S CERTIFICATION

Producer's Certification

STOP

Be sure to answer all three questions.

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

_____ (Producer's Name *(print)*)

X_____ (Signature of Producer)

_____ (Firm)

_____ (Producer's Nationwide #)

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

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

HEALTH QUESTION

STOP

Question must be answered by each Proposed Insured(s).

Proposed Primary Insured		Proposed Additional Insured		Any Child		Has anyone here proposed for insurance:
Yes	No	Yes	No	Yes	No	
☐	☐	☐	☐	☐	☐	To the best of your knowledge and belief, within the past 10 years, 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_____ X_____
Signature of Applicant/Owner *(if other than the Proposed Insured(s))*
Signature of Proposed Additional Insured *(if to be Insured)*

Initial Premium Receipt and Producer's Signature

STOP

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 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

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

Important Delivery of Notice to Senior

Nationwide Life Insurance Company and Nationwide Life and Annuity Insurance Company
One Nationwide Plaza, Columbus, Ohio 43215, 1-800-882-2822

IMPORTANT

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.

Special Notice for Seniors Regarding In-Home Sales Meeting

Nationwide Life Insurance Company and Nationwide Life and Annuity Insurance Company
One Nationwide Plaza, Columbus, Ohio 43215, 1-800-882-2822

Agent's Full Name: _____
(As it appears on his or her California insurance license.)
Agent's License Number: _____
Agent's Mailing Address: _____
Agent's Telephone Number: _____
(As listed on his or her California insurance license.)

(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
1-800-927-HELP (4357)
(Calling from within California)

1-213-897-8921
(Outside California)

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

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

Life insurance products are issued by Nationwide Life Insurance Company or Nationwide Life and Annuity Insurance Company, Columbus, Ohio. The general distributor for variable life insurance products is Nationwide Investment Services Corporation, member FINRA. In MI only: Nationwide Investment Svcs. Corporation.

Nationwide®
On Your Side

California
State Specific Forms

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

This packets includes these forms:

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

Notice Regarding Replacement of Life Insurance or Annuities

Nationwide Life Insurance Company and Nationwide Life and Annuity Insurance Company
One Nationwide Plaza, Columbus, Ohio 43215, 1-800-882-2822

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: X _____ Date: _____

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

Joint Applicant's Signature: X _____ Date: _____

Producer's Printed Name: _____

Producer's Signature: X _____ Date: _____

For Annuities Only: This section should only be completed in conjunction with annuity sales.

Policy Number	Existing Company	Name of Insured	Issue Date

Important Delivery of Notice to Senior

Nationwide Life Insurance Company and Nationwide Life and Annuity Insurance Company
One Nationwide Plaza, Columbus, Ohio 43215, 1-800-882-2822

IMPORTANT

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.

Special Notice for Seniors Regarding In-Home Sales Meeting

Nationwide Life Insurance Company and Nationwide Life and Annuity Insurance Company
One Nationwide Plaza, Columbus, Ohio 43215, 1-800-882-2822

Agent's Full Name: _____
(As it appears on his or her California insurance license.)
Agent's License Number: _____
Agent's Mailing Address: _____
Agent's Telephone Number: _____
(As listed on his or her California insurance license.)

(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
1-800-927-HELP (4357)
(Calling from within California)

1-213-897-8921
(Outside California)

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

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

Life insurance products are issued by Nationwide Life Insurance Company or Nationwide Life and Annuity Insurance Company, Columbus, Ohio. The general distributor for variable life insurance products is Nationwide Investment Services Corporation, member FINRA. In MI only: Nationwide Investment Svcs. Corporation.

Notice Regarding Replacement of Life Insurance or Annuities

Nationwide Life Insurance Company and Nationwide Life and Annuity Insurance Company
One Nationwide Plaza, Columbus, Ohio 43215, 1-800-882-2822

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: X _____ Date: _____

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

Joint Applicant's Signature: X _____ Date: _____

Producer's Printed Name: _____

Producer's Signature: X _____ Date: _____

For Annuities Only: This section should only be completed in conjunction with annuity sales.

Policy Number	Existing Company	Name of Insured	Issue Date

Nationwide®
is on your side

THIRD PARTY NOTICE/SECONDARY ADDRESSEE DESIGNATION FOR LIFE INSURANCE

☐Nationwide Life Insurance Company ☐Nationwide Life and Annuity Insurance Company

• P.O. Box 182835, Columbus, Ohio 43218-2835 • Phone: 1-800-848-6331 • SERVICE FAX NUMBER: 1-**888**-677-7393 • nationwide.com

SECTION 1: GENERAL INFORMATION

Owner's Name:_____ Policy Number(s):_____

Owner's Social Security Number:_____

Insured's Name:_____

Telephone Number:_____

SECTION 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.**

SECTION 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 and New York the Designee's signature is required to complete this designation, not signing will delay processing.

SECTION 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:_____

SECTION 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:_____

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

1. Proposed Primary Insured	Name (First, MI, Last): *(Please print)*	Rate Class Illustrated:
2. Proposed Additional Insured	Name (First, MI, Last): *(Please print)*	Rate Class Illustrated:

3. Income/Net Worth

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

4. Type of Insurance

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

For Personal Insurance, complete the Life Financial Supplement or provide financial statements if:
- Specified amount is $1,000,001 or more for ages 18-70
- Specified amount is $100,001 or more for ages 71+

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

For Business Insurance, complete the Life Financial Supplement or provide financial statements if:
- Specified amount is $500,000 or more with all ages

5. Business Insurance

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

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

Indicate the participants and their percentage of ownership: _____

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

6. For Juvenile Applicants Only

Indicate how much is in force with all companies.

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

7. Additional Information

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

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

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

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

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

e. For the questions below, please provide full details for yes answers in the Remarks section. If any changes occur to these answers before the policy is issued and placed in force, the home office must be notified immediately.
1. Have you, the producer, been involved in any discussion about the possible sale of this policy to a life settlement or other secondary market provider? ☐ Yes ☐ No
2. Will any portion of the premium for this policy be financed? ☐ Yes ☐ No
3. Will any insured or policy owner receive any payment or gift in connection with this policy? ☐ Yes ☐ No

f. Will there be split commissions? *(If "yes", fill out Remarks section to provide information)* ☐ 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:

CERTIFICATION OF TRUST

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

SECTION 1: POLICY INFORMATION (This request MUST be Notarized to be processed)

Please complete form in its entirety. If an item does not apply to the trust or your situation, please make the item N/A to avoid processing delays.

Policy or Contract Number(s):

Owner Name:

Insured or Annuitant Name:

SECTION 2: TRUST INFORMATION (Required Information)

Trust Name:

Date of Trust AND Date of Any Amendments to Trust:	Trust Tax Indentification (TIN/EIN/SSN):	State Trust Established?:
Settlor/Grantor Name(s):		State Law That Governs Trust?:

Current Trustee Name:	Current Trustee Name:
Current Trustee Address:	Current Trustee Address:
Current Trustee Phone:	Current Trustee Phone:

If more than two trustees, please attach additional sheet with trustee names, addresses, telephone numbers and signatures.

Original Trustee Names (if any):

Successor Trustees (if any):

Applicable powers, limitations and/or restrictions of trustee(s) in dealing with trust assets. If no restrictions or limitations are imposed, please state the same below.

Type of Trust: ☐ Irrevocable ☐ Revocable (If "Revocable" selected, list persons with power to revoke)

Person with Power to Revoke:	Person with Power to Revoke:

If the trust has more than one trustee, select one: **(Required)**
☐ Must Act in Unison ☐ May Act Independently ☐ Other (Only designated trustees may bind trust, list names)

Person with Power to Bind:	Person with Power to Bind:

SECTION 3: CERTIFICATION

Nationwide Life Insurance Company and/or Nationwide Life and Annuity Insurance Company are referenced throughout as "Nationwide".

As trustee(s) for the trust named in Section 2, I/we acknowledge and agree that:

- I/we have the authority to make this certification.
- The trust agreement to which this certification applies is in existence, and in full force and effect and has not been revoked, modified or amended in any way that would cause the representations in this document to be incorrect.
- The trust is not supervised by a court.
- Under the trust agreement and applicable law, I/we have full authority to give Nationwide instructions regarding the purchase, surrender, encumbrance, management or disposition of life insurance policies, annuity contracts or income products.
- Unless we advise Nationwide in writing to the contrary, any one trustee may individually act or execute any documents on behalf of and bind the trust.
- If any of the current trustees resign, the trust is responsible for naming a new trustee. Nationwide may rely on the authority of one (1) or more successor trustees without proof of their succession.
- I/we do not hold Nationwide responsible for any tax consequences due to the purchase or surrender of this life insurance policy or annuity contract or income product, and confirm that I/we understand the tax requirements for this investment.
- Nationwide will not assume any responsibilities other than its contractual obligations as the issuer of a life insurance policy, annuity contract or income product.
- The information contained in this document is correct, and the trustees understand and agree that Nationwide will rely on this information for all purposes relating to issuing and maintaining a life insurance policy, annuity contract or income product where the trust named in Section 2 is the owner and/or beneficiary.
- *Nebraska Domiciled Trust Only:* I have attached a list of the name of each beneficiary and the relationship to the grantor, settler or testator as required under R.R.S. Neb. § 30-38,102 et seq.

SECTION 4: SIGNATURES

The undersigned, on behalf of the trust, agree(s) to indemnify and hold harmless Nationwide from any and all liabilities and expenses, including attorneys' fees, for claims, judgments, surcharges, or settlement amounts for acting on transaction requests of the types specified above or otherwise relying on this certification/affidavit. Each trustee will be jointly and severally liable for performing the obligations stated above. Such obligations and this indemnification will survive termination of the trust and will be binding upon all heirs, successors, or assigns. The undersigned agree(s) to promptly inform Nationwide, in writing, of any amendment to the trust, any change in the composition of the trustees, or any other event that could affect the representations made in this document. I/we understand that Nationwide will rely on this certification/affidavit until it receives signed written notice of any changes as noted above.

Current Trustee Signature:		Current Trustee Signature:	
Print Name:	Date (mm/dd/yyyy):	Print Name:	Date (mm/dd/yyyy):

SECTION 5: NOTARY SIGNATURE AND STAMP (Required)

The signer(s) named in this certification have appeared before me, have been sworn and have attested that the information contained in this certification is true.

Notary Signature:	Date (mm/dd/yyyy):
Seal:	My Commission Expires:

NATIONWIDE LIFE PREMIUM PAYMENT BY ELECTRONIC FUND TRANSFER AUTHORIZATION

Nationwide Life Insurance Company • Nationwide Life and Annuity Insurance Company
Mail to: P.O. Box 182835, Columbus, Ohio 43218-2835 • Phone: 1-800-848-6331 • TDD # 1-800-238-3035
Fax to: 1-**888**-677-7393 • nationwide.com

SECTION 1: GENERAL INFORMATION – Please Print

Insured's Name:_____ Policy/Plan Number:_____

Policy Owner's Name:_____ Producer's Name:_____

SECTION 2: REQUEST TYPE

Purpose for submitting this authorization (Check appropriate box):

☐ New Pre-authorized Payment Plan ☐ Change in Bank/Checking Account
☐ Addition of New Policy to Plan ☐ Change Pre-Authorized Payment Plan

Draft Amount: $_____ **(If policy begins with "L", amount is not elective. The premium is predetermined.)**

Draft Date (1st-28th): ☐

Draft Frequency (select one) ☐ Monthly ☐ Quarterly* ☐ Semi Annual* ☐ Annual* *available for Term or Whole Life Products only

Financial Institution Name:_____

Financial Institution Address (Street, City, State, Zip):_____

Bank Account Holder's Name(s):_____

Transit/ABA Routing Number:_____ Account Number:_____

Please Select One:

☐ Checking **(A Copy of a Pre-printed Voided Check is Recommended for Proper Processing. Starter checks will not be accepted.)**

☐ Savings **(A Letter from the bank indicating the ABA Routing number, Account number, and the Account Holder's Name for verification is Recommended for Proper Processing.)**

- When submitting a company check, provide a letter from the company or bank confirming authorization of individual to sign on company checks. This person must sign this form as Account Holder.
- Verify with your financial institution that your account permits electronic funds transfers (ACH debits). Some institutions do not permit debits or if permitted, they may require a different routing or account number to be used.

SECTION 3: PREMIUM APPLICATION

The Total Payment is to be applied as follows: (If more than (4) policies, include on additional page)

Policy Number	Insured	Policy Payment

If sufficient funds are not available on the draft day, a second draft attempt will be made within 5 business days. Your Financial Institution may charge a fee for these attempts if sufficient funds are not available.

SECTION 4: AUTHORIZATION

I hereby authorize Nationwide Life Insurance Company (hereafter called the "Company") to initiate debit entries to my checking/savings account indicated above and the Financial Institution named above (hereafter called the "Financial Institution") to debit the same such account. I understand this completed form must be received and recorded at Nationwide Home Office at least 10 business days prior to the first Financial Institution draft day. Any future change request, including discontinuing drafts, must also be received at least 10 business days prior to the draft day. This authority is to remain in full force until the Company and the Financial Institution have received written notification on recorded line from me of its termination or upon policy termination, or upon debit of my last scheduled premium payment, whichever occurs first.

SECTION 5: SIGNATURE(S) Required.

Bank Account Holder's Signature/Authorization*:_____Date_____

Signor's Daytime Phone Number:_____
(Used only if questions arise about information on this form.)

Signor's Email Address:_____

*If multiple names are listed on the account using "and" between the names, all named account holder signatures are required. (Sign in blank space below.)