1-800-VIP-LIFE

NEW BUSINESS TRANSMITTAL FORM

Agent/Broker Name:_____

Agent/Broker Email:_____

Agent/Broker Phone:_____

Agent/Broker Fax:_____

Client (s) Name:_____

_____

Date:_____

Carrier:_____

Product:_____ (Term/UL/SUL/VUL/MoneyGuard/Annuity)

Attached, I have enclosed the following (please check):

Application:_____

Exam:_____

APS:_____

Check:_____ in the amount of:_____

** IF NO EXAM IS ATTACHED I WOULD LIKE (please check):

_____ VIP TO ORDER THE EXAM

_____I WILL ORDER THE EXAM

LIFE APPLICATION INSTRUCTIONS

On Your Side®

Submitting Application

Obtaining Supplemental Forms

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

What to send:

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

Where to send:

	Regular Mail:	**Express Mail:**
*FOR THE FASTEST SERVICE USE FAX. **Fax Number:** 1-888-677-7393	Nationwide Life Insurance Company P.O. Box 182835 Columbus, OH 43218-2835	Nationwide Financial Life Operations RR1-04-D4 5100 Rings Road Dublin, OH 43017-1522

Available Products

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

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

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

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

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

Completing the Application

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

Providing Temporary Agreement

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

Collecting Premium

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

For Monthly EFT mode:

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

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

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

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

  APPS: 800-635-1677 **ExamOne: 877-933-9261** **Portamedic: 800-456-3888**
- When determining the medical requirements for age and amount, "AMOUNT" is equal to the amount of insurance applied for currently, plus any amount of insurance placed in force within the past 3 years with Nationwide.
- Nationwide Underwriting may request a report from the proposed insured(s)'s attending physician if it is determined that this information is needed to assess the risk.

QUESTIONS?

Please call our application **HELP-LINE** at 866-678-LIFE (5433).

Hours of Operation (Eastern Time) Monday – Friday 8:00 a.m. – 8:00 p.m.

Thank You For Your Business

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

Application for Life Insurance

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

PART A – CLIENT INFORMATION

1. Proposed Primary Insured

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

Address | City

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

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

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

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

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

2. Proposed Additional Insured

If applicable, complete for either:

a) Joint Insured for Survivorship Life Plan; or

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

If additional space is required, use Special Instructions Section.

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

Joint/Spouse Proposed Additional Insured Information Only

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

City | State | Zip Code | County

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

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

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

3. Owner

Complete ONLY if Owner is not the Proposed Primary Insured.

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

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

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

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

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

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

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

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

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

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

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

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

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

4. Contingent Owner

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

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

5. Primary Beneficiary Designations

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

If additional space is required, use Special Instructions Section.

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

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

For Proposed Primary Insured

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

For Proposed Additional Insured

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

6. Contingent Beneficiary Designations

For Proposed Primary Insured

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

For Proposed Additional Insured

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

PART B – INSURANCE INFORMATION

7. Replacement and Other Policy Information

STOP

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

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

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

PART C - PLAN INFORMATION

8. Life Insurance Plan

Refer to the Illustration for the correct plan name.

(Print complete name of product being applied for.)

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

Permanent Plan*:_____

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

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

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

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

☐ Option 1 .....(The Specified Amount, or a multiple of the Cash/Accumulated Value, whichever is greater.)

☐ Option 2 .....(The Specified Amount, plus the Cash/Accumulated Value, or a multiple of the Cash/Accumulated Value, whichever is greater.)

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

Internal Revenue Code Life Insurance Qualification Test Option

☐ Guideline Premium/Cash Value Corridor Test

☐ Cash Value Accumulation Test

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

9. Optional Benefits

Select the appropriate benefit according to the illustration.

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

☐ Spouse Rider..... $_____

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

☐ Long Term Care Rider* ..... $_____

**Complete Supplement for Long Term Care Rider.*

☐ Premium Waiver Rider ..... $_____

☐ Waiver of Monthly Deductions Rider

☐ Extended Death Benefit Guarantee Rider

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

_____ Guarantee Duration *(Indicate number of years)*

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

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

☐ Surrender Value Enhancement Benefit

☐ Change of Insured Rider

☐ Other Rider(s)_____

☐ Other Rider(s)_____

☐ Other Rider(s)_____

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

☐ Four Year Term Rider* ..... $_____

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

☐ Policy Split Option Rider

☐ Other Rider(s)_____

☐ Other Rider(s)_____

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

☐ 20 Year Spouse Rider..... $_____

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

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

☐ Guaranteed Insurability Benefit Rider.. $_____

☐ Waiver of Premium Disability Benefit Rider

☐ Owner's Waiver of Premium Death Benefit Rider (Complete Part E for the Owner)

Occupation_____

Height_____

Weight_____

State of Birth_____

☐ Owner's Waiver of Premium Death or Disability Benefit Rider (Complete Part E for the Owner)

Occupation_____

Height_____

Weight_____

State of Birth_____

☐ Other Rider(s)_____

☐ Other Rider(s)_____

☐ Other Rider(s)_____

Policy will be issued with Automatic Premium Loan Option (APL) for Whole Life Plans only, if available, unless the box below is checked.

☐ **No, do not issue with APL.**

PART D - PREMIUM AND BILLING INFORMATION

10. Initial Premium Payment

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

Initial Premium Payment $_____ (paid with application)

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

11. Billing and Premium Information

Monthly Electronic Billing Option:

☐ Monthly EFT ..... $_____

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

Monthly Draft Day (1st – 28th):_____

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

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

Financial Institution Name_____ Transit/ABA Number_____

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

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

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

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

12. Payor

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

Name *(First, MI, Last)*

Address	City	State	Zip Code

PART E - PERSONAL INFORMATION

13. Tobacco Use

All questions are to be answered by each Proposed Insured.

STOP

Be sure to answer this section.

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

14. Physical Measurements

Fill in information for the Proposed Primary Insured.

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

15. Personal Physicians

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

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

16. Personal Details

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

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

17. Explanation of Personal Details

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

Question Letter	Person	Dates	Details

18. Health Questions

All questions are to be answered by each Proposed Insured.

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

To the best of your knowledge and belief, within the past 10 years, has anyone here proposed for insurance 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), or any other AIDS-related condition, or received a positive result of an HIV (Human Immunodeficiency Virus) test?	☐	☐	☐	☐	☐	☐
b. Heart disease including heart attack, angina, or other chest pain, high blood pressure, shortness of breath, palpitations, heart murmur, phlebitis, or any other disorder of the heart or blood vessels?	☐	☐	☐	☐	☐	☐
c. Headaches, seizures, epilepsy, stroke, Alzheimer's disease, dementia, Parkinson's disease, multiple sclerosis, or any other brain or nervous disorder?	☐	☐	☐	☐	☐	☐
d. Depression, neurosis, affective disorder, psychosis, or any other mental or emotional disorder?	☐	☐	☐	☐	☐	☐
e. Asthma, emphysema, chronic bronchitis, tuberculosis, or any other disease of the lungs or respiratory system?	☐	☐	☐	☐	☐	☐
f. Colitis, ulcer, persistent diarrhea, rectal bleeding, or any other disease or disorder of the esophagus or digestive tract?	☐	☐	☐	☐	☐	☐
g. Sugar, protein or blood in the urine, kidney stones, sexually transmitted disease, or any other disease or disorder of the kidneys, bladder, prostate, breast, urinary tract or reproductive system?	☐	☐	☐	☐	☐	☐
h. Diabetes, hepatitis, cirrhosis or any other disease of the liver, pancreas, or thyroid?	☐	☐	☐	☐	☐	☐
i. Cancer, or any malignant or benign tumor or cyst, or any chronic disease of the skin or lymph glands?	☐	☐	☐	☐	☐	☐
j. Arthritis, rheumatoid arthritis, osteoporosis; or any paralysis or chronic back or muscle condition?	☐	☐	☐	☐	☐	☐
k. Alcoholism, narcotic addiction, drug use, or hallucinations?	☐	☐	☐	☐	☐	☐
l. Any disease or disorder of the eyes, ears, nose or throat?	☐	☐	☐	☐	☐	☐
To the best of your knowledge and belief, in the past 5 years, has anyone here proposed for insurance:						
m. Consulted, or been examined or treated by any physician, chiropractor, psychologist or other health care practitioner or by any hospital, clinic, or other health care facility not already disclosed on this application? *(If it was for a "check up", annual physical, employment physical, etc., so state and give findings and results.)*	☐	☐	☐	☐	☐	☐
n. Had any disease, disorder, injury, or operation not already disclosed on this application?	☐	☐	☐	☐	☐	☐
o. Had any x-rays, electrocardiograms, or other medical tests for reasons not already disclosed on this application?	☐	☐	☐	☐	☐	☐
p. Been medically advised to have any surgery, hospitalization, treatment or test that was not completed or results that you have not received?	☐	☐	☐	☐	☐	☐

19. Details of 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 number (if available) of physicians, hospitals, etc.)*

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

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

PART F – FRAUD STATEMENTS AND IMPORTANT NOTICES	
TEXAS only:	Any person who submits an application or a claim containing a false or deceptive statement, and does so with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, may be guilty of insurance fraud.
Pre-Notice of Procedures as Required by The Fair Credit Reporting Act of 1970	This notice is to inform you that as part of our normal underwriting procedures in connection with an application for insurance: • An investigative consumer report may be made whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. This inquiry will include information as to character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation, with respect to you, members of your family, and others having an interest in or closely connected with the insurance transaction; and • You may elect to be interviewed if an investigative consumer report is prepared in connection with this application. You are entitled to receive a copy of any investigative consumer report by submitting your request in writing. • Upon your written request, made within a reasonable time after you receive this notice, additional information as to the nature and scope of the investigation, if one is made, will be provided. You may send corrections and requests for additional information addressed to Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company, P.O. Box 182835, Columbus, Ohio 43218-2835. In the event of an adverse decision, you will be notified in writing.
Medical Information Bureau Disclosure Notice	Information regarding your insurability will be treated as confidential. Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company, or its reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734, telephone number 866-692-6901 (TTY 866-346-3642). The e-mail address of the Bureau's information office is www.mib.com. Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company or its reinsurer(s) may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

PART G – AGREEMENT AND AUTHORIZATION

Agreement

I understand and agree that:

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

Authorization

I authorize: any licensed physician or medical practitioner; any hospital, clinic, pharmacy or other medical or medically related facility; any insurance company; the Medical Information Bureau; or any other organization, institution or person who has knowledge of me; to give that information to the Medical Director of the Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company, or its reinsurers, for the purpose of underwriting my application in order to determine eligibility for Life Insurance and to investigate claims. By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this form; and I instruct any physician; health care professional; hospital; clinic; medical facility; or other health care provider to release and disclose my entire medical record without restriction. 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 years (24 months) from the date it was signed. I understand that I have the right to revoke this form in writing, at anytime, by sending a written request for revocation to Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company, Attention: Underwriting, P.O. Box 182835, Columbus, Ohio 43218-2835. I understand that a revocation is not effective to the extent that any of my providers have relied on this form; or to the extent that Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I further understand that if I refuse to sign this form to release my complete medical records, Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company may not be able to process my application. I understand that my authorized representative or I have a right to a copy of this form by sending a request to Nationwide in writing.

PART H - SIGNATURES AND PRODUCER'S CERTIFICATION

Proposed Insured(s) and Owner Signatures

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

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

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

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

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

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

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

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

Producer's Certification

Be sure to answer all three questions

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

_____ Producer's Name *(print)*

X_____ Signature of Producer

_____ Firm

_____ Producer's Nationwide #

TEMPORARY INSURANCE AGREEMENT

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

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

HEALTH QUESTION

Question must be answered.

Proposed Primary Insured		Proposed Additional Insured		Any Child		To the best of your knowledge and belief, has anyone here proposed for insurance:
Yes	No	Yes	No	Yes	No	
☐	☐	☐	☐	☐	☐	Within the past 10 years, 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; Acquired Immune Deficiency Syndrome (AIDS), any AIDS-related disorder or positive HIV (Human Immunodeficiency Virus) test result; any brain, nervous, or mental disorder, any drug or alcohol addiction; any kidney disorder (other than kidney stones); or any cancer or other malignancy?

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

TERMS AND CONDITIONS

Amount of Coverage

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

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

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

Date Coverage Terminates

***60 DAYS** maximum coverage.*

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

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

Limitations

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

SIGNATURES

Proposed Insured(s) and Owner Signatures

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

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

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

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

Initial Premium Receipt and Producer's Signature

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

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

PRODUCER'S CERTIFICATE

These questions must be answered by the soliciting Producer.

1. Proposed Primary Insured

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

Rate Class Illustrated:

2. Proposed Additional Insured

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

Rate Class Illustrated:

3. Income/Net Worth

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

4. Type of Insurance

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

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

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

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

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

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

5. Business Insurance

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

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

Indicate the participants and their percentage of ownership: _____

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

6. For Juvenile Applicants Only

Indicate how much is in force with all companies.

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

7. Additional Information

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

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

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

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

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

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

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

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

8. Ordering Requirements

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

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

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

9. Remarks

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

10. Producer's Information

Producer's Name & Firm (Please Print):

Date:

Phone Number:	Fax Number:	E-Mail Address:

BBVA Investments

VIP

Compañías

21st Century
American General Life
Allianz
Allstate
American National
AXA Equitable
Banner
Coventry
EMSI
Genworth Financial
Hartford
Indianapolis Life
ING
Integrity Life Solutions
Jefferson Pilot
John Hancock
Lincoln Benefit
Lincoln Financial
Mass Mutual
Met Life
Midland National
Mutual of Omaha
Nationwide
New York Life
North American
Northwestern Mutual
Pacific Life
Phoenix Mutual
Principal Financial
Protective
Prudential
Strategic Medical Consulting, Inc.
Sun Life
Transamerica Occidental Life Ins. Co.
United of Omaha
United States Life
US Financial
West Coast Life

Autorización para que la información de salud se pueda comunicar a la aseguradora VIP Insurance y sus compañías asociadas

La presente autorización se ajusta a la privacidad establecida por la ley de responsabilidad y portabilidad de los seguros médicos de Estados Unidos (HIPAA, por sus siglas en ingles)

Nombre del asegurado / paciente (En letras de imprenta)	Fecha de nacimiento	Numero de Seguro Social
	/ /	- -

Yo autorizo que todo proveedor de un plan de salud, médico, profesional de la salud, hospital, clínica, laboratorio, farmacia, administrador de prestaciones farmacéuticas, centro médico, compañía de seguro, organización de apoyo para compañías de seguro u otro proveedor de servicios de salud (los "Proveedores") que, en forma directa o indirecta, haya hecho un pago en mi nombre, o me haya proporcionado un tratamiento o prestado servicios, comunique a Volente Insurance Partners, LLC (la "Compañía"), asi como a sus empleados, agentes, representantes y filiales, la historia clínica completa, incluidos los informes de los exámenes personales y cualquier otra información de salud protegida. Esta autorización abarca la información sobre el diagnóstico o el tratamiento del virus de inmunodeficiencia humana (VIH) y de enfermedades de transmisión sexual. Asimismo, comprende la información sobre el diagnóstico o el tratamiento de las enfermedades mentales y del consumo de alcohol, estupefacientes y tabaco, con exclusión de las notas de las sesiones de psicoterapia.

Con su firma al pie de esta autorización, el que suscribe concluye todos los acuerdos que haya celebrado con los Proveedores para restringir la divulgación de la información de salud protegida, autorizándolos para comunicar su historia clínica completa sin limitación.

La información de salud protegida de quien suscribe se comunicará conforme a la presente Autorización, con la que la Compañía podrá: 1) transmitirla a otras compañías para que puedan proporcionarle al interesado un contrato de seguro mediante la evaluación de los requisitos, los riesgos, la emisión de la póliza y la solicitud de la cobertura; 2) procurar el reaseguro de otras compañías; 3) administrar los reclamos de seguro, así como evaluar o satisfacer la cobertura y la provisión de las prestaciones; 4)admnistrar la cobertura; y 5) llevar a cabo otras actividades permitidas por la legislación aplicable que se relacionen con la cobertura que el interesado tenga o haya solicitado en la Compañía.

Esta autorización será válida por veinticuartro meses desde su firma al pie. Por su parte, las copias de esta autorización tendrán la misma validez que el documento original. El interesado entiende que tiene el derecho de revocar la autorización en cualquier momento, por medio de una solicitud a tal fin dirigida al Ejecutivo de Privacidad HIPAA, o HIPAA Privacy Official en idioma inglés, de la Compañía, al domicilio 1200 Cottonwood Creek Trl, Cedar Park, TX 78613. La autorización también se podrá revocar enviando la solicitud mencionada a los Proveedores. La revocación no surtirá efecto cuando alguno de los Proveedores haya actuado en virtud de esta autorización ni cuando la Compañía tenga el derecho de impugnar un reclamo o la cobertura conforme a las pólizas de seguro. Por su parte, la información que se comunique conforme a esta autorización podrá quedar sujete a retransmisión por parte de sus destinatarios, caso en el que ya no contará con la protección de la normativa federal que contempla la privacidad y la confidencialidad de la información de salud (p. ej., la privacidad establecida por la ley mencionada en el encabezado).

El que suscribe entiende que si decide no firmar esta autorización, la Compañia podrá no procesar su solicitud y, en caso de que ya se haya emitido una póliza de seguro, podrá no cubrir sus prestaciones; y declara que ha recibido una copia de esta autorización.

X

Firma del asegurado / paciente o de su representante personal	Fecha

Descripción de la relación o el poder del representante personal del asegurado / paciente

NATIONWIDE LIFE INSURANCE COMPANY
NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY

ONE NATIONWIDE PLAZA
COLUMBUS, OH 43215-2220

NOTICE AND CONSENT FOR AIDS-RELATED BLOOD, URINE, OR ORAL FLUID TESTING

To evaluate your insurability, the Insurer named above (Nationwide) has requested that you provide a sample of your blood, oral fluid extracted from cheek and gum tissue, or urine for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form, you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

Pre-Testing Considerations

Many public health organizations have recommended that before taking a HIV-related test, a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

Meaning of Positive Test Result

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical 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, or for the preparation of statistical reports that do not disclose the identity of any particular person.

Notification of Test Result

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. Because a trained person should deliver that information so you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a possible positive test result:_____

Address:_____

In the event that the test is positive and you are denied coverage because of that fact and you request the reasons for the denial, the insurer may require you to name a physician at that time to receive the information.

If the test indicates a positive result, but you do not designate a private physician, the test results will be provided to you by a representative of the Texas Department of Health.

Consent

I have read and I understand this Notice and Consent for HIV-Related Testing. I voluntarily consent to the collection of a sample of blood, oral fluid extracted from cheek and gum tissue, or urine from me, the testing of that sample, and disclosure of the test results as described above. I have read the information on this form about what a test result means.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

_____ _____

Signature of Proposed Insured or Parent/Guardian Date signed

_____

Name of Proposed Insured (please print)

_____

Address

☐ Nationwide Life Insurance Company
☐ Nationwide Life and Annuity Insurance Company
P.O. Box 182835
Columbus, OH 43218-2835

FOREIGN NATIONALS OR FOREIGN TRAVEL SUPPLEMENT TO APPLICATION

I. Are you a U. S. citizen? ☐ Yes ☐ No ***(If the answer is "Yes", proceed to Part II.)***

A. If not a U. S. citizen, what is your Alien Registration Receipt Card *(green card)* number?_____
If not a U. S. citizen, advise where current citizenship is held?_____

B. If no green card, what type of Visa do you have? *(Include type, symbol and expiration date.)*_____
_____

C. When eligible, do you plan to apply for U. S. citizenship?_____

D. When eligible, do you plan to stay in the United States?_____

E. Do you own a home in the United States? ☐ Yes ☐ No
If "Yes", where? *(city and country)*_____

F. Do you own a home in a foreign country? ☐ Yes ☐ No
If "Yes", where? *(city and country)*_____

G. If married, does your family live with you? ☐ Yes ☐ No
If "No", where do they live? *(city and country)*_____

II. Do you plan to travel outside of the United States within the next year? ☐ Yes ☐ No

A. If "Yes", where? *(city and country)*_____

B. Purpose of travel? ☐ Business ☐ Pleasure

C. How often?_____

D. Average period of time for each trip._____

III. Are you fluent in reading and speaking the English language? ☐ Yes ☐ No

IV. List all trips outside of the United States in the past two years. *(Include name of cities and countries visited, length of stay, how often visited, dates, etc.)*_____
_____
_____

V. List all trips outside of the United States planned or anticipated. *(Include name of cities and countries visited, length of stay, dates, etc.)*_____
_____
_____

VI. List occupation duties performed outside the United States._____
_____
_____

I hereby represent that all the above statements and answers to all the above questions are complete and true, and I agree that they shall form a part of my application and become a part of any contract of insurance issued based on such application.

Dated at_____ this _____ day of _____, _____
City, State

_____ _____
Witness Signature of Proposed Insured

Form **W-8BEN**
(Rev. February 2006)
Department of the Treasury
Internal Revenue Service

Certificate of Foreign Status of Beneficial Owner for United States Tax Withholding

▶ Section references are to the Internal Revenue Code. ▶ See separate instructions.
▶ Give this form to the withholding agent or payer. Do not send to the IRS.

OMB No. 1545-1621

Do not use this form for:	Instead, use Form:
• A U.S. citizen or other U.S. person, including a resident alien individual	W-9
• A person claiming that income is effectively connected with the conduct of a trade or business in the United States	W-8ECI
• A foreign partnership, a foreign simple trust, or a foreign grantor trust (see instructions for exceptions)	W-8ECI or W-8IMY
• A foreign government, international organization, foreign central bank of issue, foreign tax-exempt organization, foreign private foundation, or government of a U.S. possession that received effectively connected income or that is claiming the applicability of section(s) 115(2), 501(c), 892, 895, or 1443(b) (see instructions)	W-8ECI or W-8EXP

Note: *These entities should use Form W-8BEN if they are claiming treaty benefits or are providing the form only to claim they are a foreign person exempt from backup withholding.*

• A person acting as an intermediary	W-8IMY

Note: *See instructions for additional exceptions.*

Part I Identification of Beneficial Owner (See instructions.)

1 Name of individual or organization that is the beneficial owner

2 Country of incorporation or organization

3 Type of beneficial owner: ☐ Individual ☐ Corporation ☐ Disregarded entity ☐ Partnership ☐ Simple trust
☐ Grantor trust ☐ Complex trust ☐ Estate ☐ Government ☐ International organization
☐ Central bank of issue ☐ Tax-exempt organization ☐ Private foundation

4 Permanent residence address (street, apt. or suite no., or rural route). **Do not use a P.O. box or in-care-of address.**

City or town, state or province. Include postal code where appropriate.

Country (do not abbreviate)

5 Mailing address (if different from above)

City or town, state or province. Include postal code where appropriate.

Country (do not abbreviate)

6 U.S. taxpayer identification number, if required (see instructions) ☐ SSN or ITIN ☐ EIN

7 Foreign tax identifying number, if any (optional)

8 Reference number(s) (see instructions)

Part II Claim of Tax Treaty Benefits (if applicable)

9 **I certify that (check all that apply):**

a ☐ The beneficial owner is a resident of ..... within the meaning of the income tax treaty between the United States and that country.

b ☐ If required, the U.S. taxpayer identification number is stated on line 6 (see instructions).

c ☐ The beneficial owner is not an individual, derives the item (or items) of income for which the treaty benefits are claimed, and, if applicable, meets the requirements of the treaty provision dealing with limitation on benefits (see instructions).

d ☐ The beneficial owner is not an individual, is claiming treaty benefits for dividends received from a foreign corporation or interest from a U.S. trade or business of a foreign corporation, and meets qualified resident status (see instructions).

e ☐ The beneficial owner is related to the person obligated to pay the income within the meaning of section 267(b) or 707(b), and will file Form 8833 if the amount subject to withholding received during a calendar year exceeds, in the aggregate, $500,000.

10 **Special rates and conditions** (if applicable—see instructions): The beneficial owner is claiming the provisions of Article ..... of the treaty identified on line 9a above to claim a ..... % rate of withholding on (specify type of income): .....

Explain the reasons the beneficial owner meets the terms of the treaty article: .....

Part III Notional Principal Contracts

11 ☐ I have provided or will provide a statement that identifies those notional principal contracts from which the income is not effectively connected with the conduct of a trade or business in the United States. I agree to update this statement as required.

Part IV Certification

Under penalties of perjury, I declare that I have examined the information on this form and to the best of my knowledge and belief it is true, correct, and complete. I further certify under penalties of perjury that:

1 I am the beneficial owner (or am authorized to sign for the beneficial owner) of all the income to which this form relates,

2 The beneficial owner is not a U.S. person,

3 The income to which this form relates is (a) not effectively connected with the conduct of a trade or business in the United States, (b) effectively connected but is not subject to tax under an income tax treaty, or (c) the partner's share of a partnership's effectively connected income, and

4 For broker transactions or barter exchanges, the beneficial owner is an exempt foreign person as defined in the instructions.

Furthermore, I authorize this form to be provided to any withholding agent that has control, receipt, or custody of the income of which I am the beneficial owner or any withholding agent that can disburse or make payments of the income of which I am the beneficial owner.

Sign Here ▶ Signature of beneficial owner (or individual authorized to sign for beneficial owner) | Date (MM-DD-YYYY) | Capacity in which acting

Mail To: **Nationwide Life Insurance Company**
Nationwide Life and Annuity Insurance Company
Hereinafter referred to as Nationwide
P.O. Box 182835
Columbus, OH 43218-2150
www.nationwide.com

For additional information call Nationwide's Service Center at:
Phone: 1-800-243-6295
TTD: 1-800-238-3035
Fax: 1-888-677-7393

MODIFIED ENDOWMENT CONTRACT DISCLOSURE AND AUTHORIZATION

For use with Nationwide YourLife℠ Single Premium UL

Disclosure, Acknowledgement and Authorization of Modified Endowment Contract

I understand the life insurance policy I have applied for will be considered a Modified Endowment Contract (MEC) as defined by section 7702A of the Internal Revenue Code. Distributions from a Modified Endowment Contract are subject to less favorable tax treatment than distributions taken from policies which are not Modified Endowment Contracts. Distributions include but are not limited to loans, partial surrenders and monthly charges on riders you elect that are considered Non-Qualified Additional Benefits, based on the Internal Revenue Code. I understand that for more information regarding Modified Endowment Contracts and their potential income tax implications, I should consult my personal tax advisor.

Acceptance and Signatures

Owner's Acceptance:

Print Policy Owner's Name	Policy Owner's Signature	Date Signed

Additional Owner's Acceptance (if necessary):

Print Policy Owner's Name	Policy Owner's Signature	Date Signed

Life insurance is issued by Nationwide Life Insurance Company or Nationwide Life and Annuity Insurance Company, Columbus, Ohio. In New York Only: Nationwide Life Insurance Company. In MI only: Nationwide Investment Svcs. Corporation.

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

LIFE FINANCIAL SUPPLEMENT
to Application for **BUSINESS** Life Insurance
(May be used in lieu of a copy of most recent formal financial statement.)

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

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

Occupation/Title_____

1. Name of Company_____
2. Address of Company_____
3. Organization Type: ☐ C Corporation ☐ S Corporation ☐ LLC ☐ Partnership ☐ Sole Proprietorship ☐ Other_____
4. Purpose of Organization/Type of Business_____
5. Insured's Percent of Ownership_____%
6. Insured's Annual Earned Compensation: Salary_____ Commission_____ Bonus_____ Other_____
7. Current Company Book Values: Assets $_____ Liabilities $_____ Net Worth $_____
8. CURRENT COMPANY MARKET VALUE
   Market Value $_____
   Market Value of Insured's % of Ownership $_____
9. COMPANY NET PROFIT (Before Taxes & Bonuses)
   This Year (Estimated) $_____
   Last Year (_____) $_____
   Year Before Last (_____) $_____
10. What other Stockholders, Partners, or Key Persons are also being insured in favor of the Company? (Give names and positions.)_____
11. PURPOSE OF BUSINESS INSURANCE (Indicate and furnish details.)
    - ☐ **EXECUTIVE BENEFIT PLAN FUNDING** (Indicate plan purpose and premium contribution.)
      - ☐ Deferred Compensation - Annual Contribution $_____ ☐ Bonus - Annual Contribution $_____
      - ☐ Other_____ - Annual Contribution $_____
    - ☐ **KEY PERSON** - What is the Proposed Insured's position or function in the Company? What special skills, knowledge, or abilities does he/she possess which makes the insurance necessary? How will these funds be utilized? _____
    - ☐ **STOCK REDEMPTION / BUY AND SELL**
      a. Is there a written agreement:
         ☐ In effect? (Attach a signed copy, if available.)
         ☐ Contemplated? (Give expected finalization date:_____, _____)
      b. How is the business being valued in the agreement? (Book Value? Market Value? Etc.)_____
      c. Who are other participants and their percentages?_____
    - ☐ **BUSINESS LOAN** (Include a copy of the loan agreement, if available.)
      a. Name and address of lender:_____
      b. Amount of Loan $_____ c. Date of Loan_____
      d. The repayment terms are:_____
      e. The purpose of the loan is:_____
      f. Is the lender *requiring* the insurance? ☐ Yes ☐ No g. If issued, will the policy be assigned? ☐ Yes ☐ No
      h. Any bankruptcies in the past 7 years? ☐ Yes ☐ No If "yes", give details below.
      i. Are there any suits pending or judgments against you at this time? ☐ Yes ☐ No If "yes", give details below.
      Details:_____

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

Date_____ Signature of Proposed Insured_____

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

Date_____ Signature of Witness_____

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

LIFE FINANCIAL SUPPLEMENT
to Application for **PERSONAL** Life Insurance

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

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

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

Occupation _____ Employer or Self-Employed Name _____

Employer Address _____

Type of Business _____

PERSONAL EARNED INCOME (Annual)

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

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

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

PERSONAL UNEARNED INCOME (Annual)

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

PERSONAL WORTH (Current Market Value)

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

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

PURPOSE OF PERSONAL INSURANCE

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

Explanation: _____

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

Details: _____

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

Date _____ Signature of Proposed Insured _____

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

Date _____ Signature of Witness _____

Mail To: **Nationwide Life Insurance Company**
Nationwide Life and Annuity Insurance Company
Nationwide Life Insurance Company of America
Nationwide Life and Annuity Company of America
P.O. Box 182835, Columbus, OH 43218-2835
NF: 1-800-547-7548 NFN: 1-800-688-5177
TDD # 1-800-238-3035 Fax: 1-888-677-7393
www.nationwide.com

NATIONWIDE LIFE PREMIUM PAYMENT BY ELECTRONIC FUND TRANSFER AUTHORIZATION

This form is required. Please print clearly, complete the form and provide all requested documents to avoid a delay in collecting premium. We require at least 10 business days to make the changes requested below.

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

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

Financial Institution Name: _____

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

_____

Bank Account Holder's Name(s): _____

Transit/ABA Routing Number: _____ Account Number:_____

Purpose for submitting this authorization (Check appropriate box):

☐ New Preauthorized Payment Plan ☐ Change in Bank/Checking Account ☐ Addition of New Policy to Plan

☐ Change in APD Amount to $_____ ☐ Change in ALRP Amount to $_____

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

The Total Monthly Payment is to be applied as follows:

Policy Number	Insured	Scheduled Premium	Unscheduled Premium	*Policy Loan	*Premium Deposit Fund	Total Policy Payment
	Total by each activity					

Monthly Draft Day (1st - 28th) _____ **(Monthly draft day will default to the policy issue day or the 15th for NFN policies (monthly anniversary) if blank. If policy begins with "B" or "U" (except B5) the draft day must be the 15th. 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.)**

* Only NFN eligible for this option.

Please Select One:

☐ Checking **(Requirements: Copy of Pre-printed Voided Check. Starter checks will not be accepted.)**
☐ Savings **(Requirements: Letter from the bank indicating the ABA Routing number, Account number, and the Account Holder's Name for verification.)**

- 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.

Please Start Draft: (If left blank, draft will start in first possible month.)

☐ On the Monthly Draft Day I selected, in the first possible month. **(May result in a draft in current month.)**
☐ In _____ **(We will notify you if we must draft sooner due to premium requirements.)**
(Month)

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 from me of its termination or upon policy termination, or upon debit of my last scheduled premium payment, whichever occurs first.

Bank Account Holder's Signature/Authorization*: _____Date_____

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

*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.)

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

1035 EXCHANGE PACKET

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

Submit paperwork to:

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

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

Our service to you. . .Nationwide will:

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

Top 5 Ways to Speed Up 1035 Exchanges From Relinquishing Companies

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

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

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

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

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

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

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

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

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

INTERNAL REVENUE CODE 1035 EXCHANGE FORM

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

Relinquishing Company's Name: _____ Phone Number: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

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

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

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

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

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

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

Section C – ABSOLUTE ASSIGNMENT

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

Section D – 1035 DISCLOSURE

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

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

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

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

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

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

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

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

INTERNAL REVENUE CODE SECTION 1035 EXCHANGE DISCLOSURE

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

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

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

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

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

NATIONWIDE LIFE INSURANCE COMPANY
TOBACCO USE QUESTIONNAIRE

NAME: _____

REFERENCE NUMBER: _____

1. Have you ever used any form of tobacco? (e.g. cigarettes, cigars, pipe, chewing tobacco or snuff)

   YES _____ NO _____

2. If yes, specify the type.

   _____

   Frequency of use? _____

   Date last used? _____

3. Have you ever used nicorette gum or nicotine patches?

   YES _____ NO _____

4. If yes, date last used? _____

I hereby represent, to the best of my knowledge and belief, that all answers to the above questions are complete and true.

Signed at _____ this _____ day of _____ , _____ .

_____ Signature of Insured

_____ Signature of Owner (If other than Insured)

Name of Applicant: _____

Policy Number: _____

ALCOHOL QUESTIONNAIRE

1. Date alcohol first consumed? _____
   Currently consume alcohol? _____ Yes _____ No
   If yes, amount consumed per day? _____
   If no, date alcohol last consumed? _____

2. Have you ever undergone treatment or been hospitalized for alcoholism or alcohol abuse? If Yes, please provide name(s) and addresses of hospitals, clinics and dates admitted/discharged.

3. Who treated you for alcohol abuse? Name _____
   Address _____
   Who is your personal physician? Name _____
   Address _____

4. Any nervous, circulatory, cardiovascular or gastrointestinal disorders? _____
   If yes, please provide brief details with dates, names and addresses of doctors and hospitals. _____
   _____
   _____
   _____

5. Recovered from alcohol abuse? _____
   If yes, length of time since recovery _____

6. Any relapses? _____ If yes, please provide brief details with date(s). _____
   _____
   _____

7. Any support group activity such as AA? _____
   Dates first/last attended? _____

8. Have you flown as a pilot or student pilot in the past three years or have plans to fly? (If yes, complete questionnaire.)
   _____
   _____

9. Have you participated in any sports such as auto or motorcycle racing/skin or scuba diving/snowmobiling? Parachuting/hang gliding? Skiing/bodily contact sports? Do you intend to participate in any of the above? (If yes, complete questionnaire.)

10. Do you have any driving violations? _____ If yes, please provide brief details/dates and give driver's license number. _____
    _____

11. What is your present therapy? _____
    _____
    _____
    _____

Signed at _____ on _____.

_____ _____

Proposed Insured Witness

REPORTE MEDICO

Nombre del asegurado / paciente

Nombre del Doctor

Ciudad, Estado

Fecha de Nacimiento

Estimado Doctor:

En orden para poder establecer elegibilidad para un seguro de vida de este paciente, favor de completar la forma adjunta. Estamos interesados en información relacionada a visitas de consultas de este paciente con Usted en los últimos 5 años. Si es posible, favor de incluir copias de los resultados de posibles estudios y procedimientos diagnósticos. Autorización para que Usted pueda remitir esta información acompaña esta forma.

Si requiere más espacio para completar esta información, favor de copiar la hoja adherida las veces que sea necesario. Si Usted prefiere no usar esta forma, regrésela con el reporte que usted desee mandar. Favor de enviar esta información vía fax al (512)-794-0126.

Gracias por su cooperación.

Atentamente,

REPORTE MEDICO

Nombre del asegurado / paciente _____ Ciudad, Estado _____

FECHA	QUEJAS Y DESCUBRIMIENTOS FISICOS Y ABNORMALES	DURACION DE ENFERMEDAD	DIAGNOSIS	TRATAMIENTO

- Resultados de exámenes o laboratorios (Radiografías, Electrocardiogramas, Reportes Patológicos, Etc., incluyendo fechas.) _____

_____

- Condición presente. _____

_____

- Se a consultado algún otro o cirujano? Fecha y diagnosis. _____

_____

- Favor de anotar cualquier otra información pertinente a la salud de este paciente. _____

_____

- En su conocimiento, sabe Usted si este paciente a fumado en los últimos 12 meses? _____

_____

Nombre: _____

Firma: _____ Fecha: _____