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:

***FOR THE FASTEST SERVICE USE FAX.**	**Regular Mail:**	**Express Mail:**
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

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

STOP

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:	*Proposed Additional Insured:*
Have you ordered requirements? ☐ Yes ☐ No	Have you ordered requirements? ☐ Yes ☐ No
If yes, please identify:	*If yes, please identify:*
☐ Paramed Exam ☐ Urine ☐ Blood ☐ Stress EKG ☐EKG	☐ Paramed Exam ☐ Urine ☐ Blood ☐ Stress EKG ☐ EKG
Paramed Company ordered from:_____	Paramed Company ordered from:_____
☐ APS Doctor/Facility_____	☐ 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	Integrity Life Solutions	Pacific Life
American General Life	Jefferson Pilot	Phoenix Mutual
Allianz	John Hancock	Principal Financial
Allstate	Lincoln Benefit	Protective
American National	Lincoln Financial	Prudential
AXA Equitable	Mass Mutual	Strategic Medical Consulting, Inc.
Banner	Met Life	Sun Life
Coventry	Midland National	Transamerica Occidental Life Ins. Co.
EMSI	Mutual of Omaha	United of Omaha
Genworth Financial	Nationwide	United States Life
Hartford	New York Life	US Financial
Indianapolis Life	North American	West Coast Life
ING	Northwestern Mutual	

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,

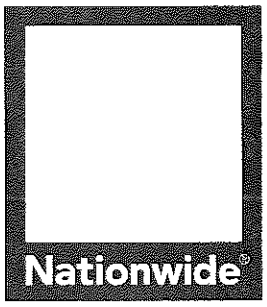
2 The beneficial owner is not a U.S. person,

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



State Specific Forms

THIS PACKET INCLUDES THE FOLLOWING FORMS:

- REPLACEMENT FORMS

AD-SSP-AO-0510

INSTRUCTION FOR REPLACEMENT FORM

Nationwide Life Insurance Company
Nationwide Life and Annuity Insurance Company
Nationwide Life Insurance Company of America
Nationwide Life and Annuity Company of America
Columbus, Ohio, 43218-2021

Your state has adopted the NAIC 2000 model for replacement regulation. The answer to the question, "Do you have existing life insurance or annuities?", which is located on the application, is required with every new business application even if the applicant does not intend to replace a life insurance policy or annuity contract. One additional replacement form may be required, depending upon responses to questions on these forms.

Step One: Please answer the question, **"Do you have existing life insurance or annuities?"** (The question is located on the signature page for Annuity applications, and in the Insurance Information section for Life Insurance applications.)

→ If the answer to this question is "No," then no additional forms or actions are needed.

→ If the answer to this question is "Yes," then please proceed to Step Two.

Step Two: complete, sign and date the enclosed "**Important Notice: Replacement of Life Insurance or Annuities**" (form APO-4860-1). *Annuities Only*: If the proposed life insurance or annuity contract is to replace existing life insurance or annuities, proceed to Step Three.

Step Three (Annuities only): Complete Transfer of Assets paperwork and submit, together with the Application and Important Notice, to Nationwide.

Nationwide Replacement Policy

We believe that replacement of an existing insurance or annuity policy must be appropriate for the customer and meet his or her needs or financial objectives. From a customer's perspective, an appropriate replacement is also one that is justified from either an economic or personal standpoint. The provision features and benefits of both the current and proposed product should be considered in relation to the client's needs, circumstances and goals. Some examples of the types of provisions that should be considered are: premium rate differences, differences in suicide and incontestability provisions for individual life insurance and pre-existing conditions, waiting periods, elimination periods, and probationary periods for health insurance policies. In addition, factors such as the age and health of the customer must be considered. Distributors are expected to provide all material information that the customer needs in order to ascertain whether replacement of an existing policy or contract is appropriate.

All replacements must be in compliance with applicable regulations and company rules. Many states require accurate written comparisons of existing and proposed contracts to be provided to the customer when proposing a replacement. Distributors are expected to know and comply with these requirements.

IMPORTANT NOTICE: Replacement of Life Insurance or Annuities

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases, this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? _____ YES _____ NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? _____ YES _____ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

Insurer Name	Contract or Policy #	Insured or Annuitant	Replaced (R) or Financed (F)

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

If you are replacing a policy or contract, upon its issuance, the policy or contract may be returned within 30 days from the date of delivery. Note that this return period may be longer than what is reflected in your policy or contract. For variable and market value adjustment policies or contracts, you will receive a payment of cash surrender value provided under the policy or contract, including any fees and other charges deducted from the gross premiums or considerations or imposed under such policy or contract. For fixed policies or contracts, you will receive a refund of your premiums paid.

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense.

(Continued on next page)

Important Notice *Continued*

PREMIUMS

Are they affordable?
Could they change?
You're older -- are premiums higher for the proposed new policy?
How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES

New policies usually take longer to build cash values and to pay dividends.
Acquisition costs for the old policy may have been paid; you will incur costs for the new one.
What surrender charges do the policies have?
What expense and sales charges will you pay on the new policy?
Does the new policy provide more insurance coverage?

INSURABILITY

If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
You may need a medical exam for a new policy.
Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY

How are premiums for both policies being paid?
How will the premiums on your existing policy be affected?
Will a loan be deducted from death benefits?
What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT

Will you pay surrender charges on your old contract?
What are the interest rate guarantees for the new contract?
Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS

What are the tax consequences of buying the new policy?
Is this a tax-free exchange? (See your tax advisor.)
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
Will the existing insurer be willing to modify the old policy?
How does the quality and financial stability of the new company compare with your existing company?

The existing policy or contract is being replaced because: _____

_____

Producer's statement: I represent that this transaction follows the Nationwide Replacement Policy, that I have used only insurer-approved sales material in connection with this sale and that copies of all sales material were left with the applicant.

All parties: I certify that the responses herein are, to the best of my knowledge, accurate:

Applicant's Signature _____ Date _____

Applicant's Printed Name _____

Joint Applicant's Signature _____ Date _____

Joint Applicant's Printed Name _____

Producer's Signature _____ Date _____

Producer's Printed Name _____

I do not want this notice read aloud to me. _____ *(Applicants must initial only if they do not want the notice read aloud.)*

NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY

VARIABLE LIFE FUND SUPPLEMENT

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

1. **Proposed Primary Insured**	Name *(First, MI, Last): (Please print)*	SSN / Tax ID #: - -
2. **Allocations**	• **For policies issued in states which require a Return of Premium to a Policy Owner exercising the Short Term Right to Cancel**—Net Premiums will be allocated to the Nationwide NVIT Money Market Fund or to the Fixed Account if selected until the end of the Right to Cancel Period. At the end of this period, the Policy Value will be allocated to the Sub-Accounts indicated below. • **For policies issued in states which require a Return of Cash Value to a Policy Owner exercising the Short Term Right to Cancel**—Net Premiums will be allocated to the Sub-Accounts at the beginning of the Short Term Right to Cancel Period. • Your selections must total 100%. Minimum initial allocation to any single Sub-Accounts is 1%. No fractional percentages are permitted. (If no allocation is selected, Policy Value will be allocated to the Nationwide NVIT Money Market Fund.)	

Sub-Accounts designated by an * may include additional restrictions and/or charges. The underlying investment options listed below are only available in variable life insurance products issued by life insurance companies or, in some cases, through participation in certain qualified pension or retirement plans. They are NOT offered to the general public directly. Please review the underlying fund prospectus carefully for information about the funds and their share classes.

AIM Variable Insurance Funds
- % Invesco V.I. Capital Development Fund

AllianceBernstein Variable Products Series Fund, Inc.
- % Small/Mid Cap Value Portfolio

American Century Variable Portfolios, Inc.
- % VP Mid Cap Value Fund

American Century Variable Portfolios II, Inc.
- % VP Inflation Protection Fund

BlackRock Variable Series Funds, Inc.
- % Global Allocation V.I. Fund

Dreyfus
- % IP Small Cap Stock Index Portfolio
- % Stock Index Fund, Inc.
- % VIF Appreciation Portfolio

Fidelity Variable Insurance Products Fund
- % VIP Energy Portfolio*
- % VIP Equity-Income Portfolio
- % VIP Freedom Fund 2010 Portfolio
- % VIP Freedom Fund 2020 Portfolio
- % VIP Freedom Fund 2030 Portfolio
- % VIP Growth Portfolio
- % VIP Investment Grade Bond Portfolio
- % VIP Mid Cap Portfolio
- % VIP Overseas Portfolio*

Franklin Templeton Variable Insurance Products Trust
- % Founding Funds Allocation Fund
- % Franklin Income Securities Fund
- % Franklin Small Cap Value Securities Fund
- % Templeton Global Bond Securities Fund

Ivy Funds Variable Insurance Portfolios, Inc.
- % Asset Strategy

Janus Aspen Series
- % Forty Portfolio
- % Global Technology Portfolio
- % Overseas Portfolio*

MFS® Variable Insurance Trust
- % Value Series

MFS® Variable Insurance Trust II
- % MFS® International Value Portfolio

Nationwide NVIT Investor Destinations Funds
- % Aggressive Fund
- % Balanced Fund
- % Capital Appreciation Fund
- % Conservative Fund
- % Moderate Fund
- % Moderately Aggressive Fund
- % Moderately Conservative Fund

Nationwide Variable Insurance Trust (NVIT)
- % American Century NVIT Multi Cap Value Fund
- % American Funds NVIT Asset Allocation Fund
- % American Funds NVIT Bond Fund
- % American Funds NVIT Global Growth Fund
- % American Funds NVIT Growth Fund
- % American Funds NVIT Growth-Income Fund
- % Federated NVIT High Income Bond Fund*
- % Gartmore NVIT International Equity Fund*
- % Gartmore NVIT Worldwide Leaders Fund
- % Neuberger Berman NVIT Multi Cap Opportunities Fund
- % Neuberger Berman NVIT Socially Responsible Fund
- % NVIT Cardinal℠ Aggressive Fund
- % NVIT Cardinal℠ Balanced Fund
- % NVIT Cardinal℠ Capital Appreciation Fund
- % NVIT Cardinal℠ Conservative Fund
- % NVIT Cardinal℠ Moderate Fund
- % NVIT Cardinal℠ Moderately Aggressive Fund
- % NVIT Cardinal℠ Moderately Conservative Fund
- % NVIT Core Bond Fund
- % NVIT Core Plus Bond Fund
- % NVIT Emerging Markets Fund*
- % NVIT Government Bond Fund
- % NVIT International Index Fund*
- % NVIT Mid Cap Index Fund
- % NVIT Money Market Fund
- % NVIT Multi-Manager International Growth Fund
- % NVIT Multi-Manager International Value Fund*
- % NVIT Multi-Manager Large Cap Growth Fund
- % NVIT Multi-Manager Large Cap Value Fund
- % NVIT Multi-Manager Mid Cap Growth Fund
- % NVIT Multi-Manager Mid Cap Value Fund
- % NVIT Multi-Manager Small Cap Growth Fund
- % NVIT Multi-Manager Small Cap Value Fund
- % NVIT Multi-Manager Small Company Fund
- % NVIT Multi Sector Bond Fund
- % NVIT Nationwide® Fund
- % NVIT Short Term Bond Fund
- % NVIT Real Estate Fund
- % Van Kampen NVIT Comstock Value Fund
- % Templeton NVIT International Value Fund

Neuberger Berman Advisers Management Trust
- % Short Duration Bond Portfolio

Oppenheimer Variable Account Funds
- % Global Securities Fund/VA*
- % Main Street® Fund/VA
- % Main Street® Small Cap Fund/VA

PIMCO Variable Insurance Trust
- % Foreign Bond Portfolio (Unhedged)
- % Low Duration Portfolio

T. Rowe Price Equity Series, Inc.
- % T. Rowe Price Health Sciences Portfolio

Wells Fargo Advantage Funds® Variable Trust
- % VT Small Cap Growth Fund

Van Eck VIP
- % Global Hard Assets Fund

Nationwide Life Insurance Co.
- % Fixed Account
- % Long Term Fixed Account**

These funds are the only available investment options IF the EDBG Rider is selected. All other investment options are unavailable with this rider.

Fidelity Variable Insurance Products Fund
- % VIP Freedom Fund 2010 Portfolio
- % VIP Freedom Fund 2020 Portfolio
- % VIP Freedom Fund 2030 Portfolio

Nationwide Variable Insurance Trust (NVIT)
- % American Funds NVIT Asset Allocation Fund
- % NVIT Cardinal℠ Aggressive Fund
- % NVIT Cardinal℠ Balanced Fund
- % NVIT Cardinal℠ Capital Appreciation Fund
- % NVIT Cardinal℠ Conservative Fund
- % NVIT Cardinal℠ Moderate Fund
- % NVIT Cardinal℠ Moderately Aggressive Fund
- % NVIT Cardinal℠ Moderately Conservative Fund

Nationwide NVIT Investor Destinations Funds
- % Aggressive Fund
- % Balanced Fund
- % Capital Appreciation Fund
- % Conservative Fund
- % Moderate Fund
- % Moderately Aggressive Fund
- % Moderately Conservative Fund

Nationwide Life Insurance Co.
- % Fixed Account

**Stringent premium and transfer restrictions are enforced for the Long Term Fixed Account, please consult the prospectus for more details on these restrictions.

3. Optional Elections

Once the policy is issued, changes to any optional election requires written instructions from Policy Owner(s).

a. **Sub-Account Monthly Deduction:**

- If the selected Sub-Account's value is not sufficient for the full monthly deduction, any portion of the monthly deduction that was not taken and all future monthly deductions will be deducted proportionately from the remaining Sub-Accounts until sufficient premium is paid into the selected Sub-Account again.
- Fixed Account(s) are not eligible for directing the monthly deduction.

Please deduct from the following Sub-Account: *(check one)*

☐ **Nationwide NVIT Money Market Fund** OR ☐ **Selected Sub-Account**_____

b. **Dollar Cost Averaging:**

- Transfers must be at least $100.
- The monthly transfer from the **FIXED ACCOUNT must be equal to or less than 1/30th of the Fixed Account value when the Dollar Cost Averaging Program is requested. Transfers to or from the Long Term Fixed Account are not available as part of Dollar Cost Averaging.
- If you choose this option, Dollar Cost Averaging will begin the 1st day available from the Policy Date.

Please transfer $_____per month from the *(check one)*

☐ **Nationwide NVIT Government Bond Fund** ☐ **Nationwide NVIT Money Market Fund**

☐ **Nationwide NVIT High Income Bond Fund (Federated)** ☐ **Nationwide Fixed Account****

Transfers from the Sub-Accounts specified above shall be transferred to the following Sub-Accounts based on the percentage allocations indicated below: (Variable Account Allocations – WHOLE % only, totaling 100%)

	SUB-ACCOUNT
_____%	_____
_____%	_____
_____%	_____
_____%	_____
_____%	_____
Total = 100%	

c. **Asset Rebalancing:**

If you choose this option, Asset Rebalancing will be the 1st day available from the Policy Date.

Rebalancing will occur: *(check one)*

☐ Quarterly ☐ Semi-Annually ☐ Annually

NOTE: UNLESS INDICATED BELOW, THE SUB-ACCOUNT ALLOCATIONS SELECTED FOR INVESTMENT IN THE ALLOCATIONS SECTION ON THIS FORM WILL BE USED. FIXED ACCOUNTS ARE NOT AN AVAILABLE SUB-ACCOUNT FOR THIS ELECTION.

	SUB-ACCOUNT
_____%	_____
_____%	_____
_____%	_____
_____%	_____
_____%	_____
_____%	_____
_____%	_____
_____%	_____
_____%	_____
_____%	_____
Total = 100%	

4. Transfer Authorization for Producer

☐ By checking this box, you have authorized and directed Nationwide to accept instructions from the Producer signing this application to execute exchanges among the Investment options available under your Policy and/or to allocate any future Premium Payments on your behalf. This power is personal to the Producer, and may be delegated by written notification to Nationwide and only to individuals employed or under control of the Producer for administrative/processing purposes. This power is not available for use by any person or organization providing any type market-timing advice or service. Nationwide may revoke the authority of the Producer to act on your behalf at any time by written notification to you.

If the box above is checked, your Producer's signature below and your signature at the end of this application represents agreement for yourselves, your heirs and the legal representatives of your estates and your successors in interest or assigns to release and hold harmless Nationwide from any and all liability in reliance on instructions given under the authority described above. You and the Producer also agree to jointly and severally indemnify Nationwide for and against any claim, liability or expense arising out of any action taken by Nationwide in reliance of such instructions.

X_____

Signature of Producer

5. Rights of Transfer for Co-Owners	If there is more than one Policy Owner or Trustee, all Policy Owners and Trustees must authorize all Sub-Account exchanges or future allocation changes, unless an option is selected below: ☐ Act Independently – Sub-Account exchanges and future allocations may be made by ***any*** Policy Owner or Trustee. ☐ Designate One – Sub-Account exchanges and future allocations may only be made by the following named Policy Owner or Trustee: _____	
6. Important Notice	**I UNDERSTAND THAT THE DEATH BENEFIT UNDER A VARIABLE LIFE INSURANCE POLICY MAY INCREASE OR DECREASE, DEPENDING ON THE INVESTMENT RETURN ON THE SUB-ACCOUNT(S) I SELECT. REGARDLESS OF INVESTMENT RETURN, THE DEATH BENEFIT CAN NEVER BE LESS THAN THE SPECIFIED AMOUNT, AS LONG AS THE POLICY IS IN FORCE. THE CASH VALUE MAY INCREASE OR DECREASE ON ANY DAY, DEPENDING ON THE INVESTMENT RETURN FOR THE POLICY. NO MINIMUM CASH VALUE IS GUARANTEED. ON REQUEST, WE WILL FURNISH ILLUSTRATIONS OF BENEFITS, INCLUDING DEATH BENEFITS AND CASH VALUES FOR A VARIABLE LIFE INSURANCE POLICY AND A FIXED LIFE INSURANCE POLICY FOR THE SAME PREMIUM.**	
7. Suitability STOP All 3 questions must be answered to issue policy.	a. Do you understand that the Death Benefit and Surrender Value may increase or decrease depending on the investment experience of the Variable Account?	☐ Yes ☐ No
	b. Do you believe that this policy will meet your insurance needs and financial objectives?	☐ Yes ☐ No
	c. Have you received a current copy of the prospectus?	☐ Yes ☐ No
8. Signatures If there are additional Owners on the policy, please attach a blank sheet with the additional signatures.	Signed on _____ (Month/Day), _____ (Year) X _____ Signature of Proposed Primary Insured *(or parent if Proposed Primary Insured is under age 15)* 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))*	

NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY

VARIABLE LIFE FUND SUPPLEMENT

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

1. Proposed Primary Insured	Name *(First, MI, Last): (Please print)*	SSN / Tax ID #: - -
2. Allocations	• **For policies issued in states which require a Return of Premium to a Policy Owner exercising the Short Term Right to Cancel**—Net Premiums will be allocated to the Nationwide NVIT Money Market Fund or to the Fixed Account if selected until the end of the Right to Cancel Period. At the end of this period, the Policy Value will be allocated to the Sub-Accounts indicated below. • **For policies issued in states which require a Return of Cash Value to a Policy Owner exercising the Short Term Right to Cancel**—Net Premiums will be allocated to the Sub-Accounts at the beginning of the Short Term Right to Cancel Period. • Your selections must total 100%. Minimum initial allocation to any single Sub-Accounts is 1%. No fractional percentages are permitted. (If no allocation is selected, Policy Value will be allocated to the Nationwide NVIT Money Market Fund.)	

Sub-Accounts designated by an * may include additional restrictions and/or charges. The underlying investment options listed below are only available in variable life insurance products issued by life insurance companies or, in some cases, through participation in certain qualified pension or retirement plans. They are NOT offered to the general public directly. Please review the underlying fund prospectus carefully for information about the funds and their share classes.

AllianceBernstein Variable Products Series Fund, Inc.
- % Small/Mid Cap Value Portfolio

American Century Variable Portfolios, Inc.
- % VP Mid Cap Value Fund

American Century Variable Portfolios II, Inc.
- % VP Inflation Protection Fund

BlackRock Variable Series Funds, Inc.
- % Global Allocation V.I. Fund

Dreyfus
- % IP Small Cap Stock Index Portfolio
- % Stock Index Fund, Inc.
- % VIF Appreciation Portfolio

Fidelity Variable Insurance Products Fund
- % VIP Energy Portfolio*
- % VIP Equity-Income Portfolio
- % VIP Freedom Fund 2010 Portfolio
- % VIP Freedom Fund 2020 Portfolio
- % VIP Freedom Fund 2030 Portfolio
- % VIP Growth Portfolio
- % VIP Investment Grade Bond Portfolio
- % VIP Mid Cap Portfolio
- % VIP Overseas Portfolio*

Franklin Templeton Variable Insurance Products Trust
- % Founding Funds Allocation Fund
- % Franklin Income Securities Fund
- % Franklin Small Cap Value Securities Fund
- % Templeton Global Bond Securities Fund

Invesco
- % Invesco V.I. Capital Development Fund

Ivy Funds Variable Insurance Portfolios, Inc.
- % Asset Strategy

Janus Aspen Series
- % Forty Portfolio
- % Global Technology Portfolio
- % Overseas Portfolio*

MFS® Variable Insurance Trust
- % Value Series

MFS® Variable Insurance Trust II
- % MFS® International Value Portfolio

Nationwide NVIT Investor Destinations Funds
- % Aggressive Fund
- % Balanced Fund
- % Capital Appreciation Fund
- % Conservative Fund
- % Moderate Fund
- % Moderately Aggressive Fund
- % Moderately Conservative Fund

Nationwide Variable Insurance Trust (NVIT)
- % American Century NVIT Growth Value Fund
- % American Century NVIT Multi Cap Value Fund
- % American Funds NVIT Asset Allocation Fund
- % American Funds NVIT Bond Fund
- % American Funds NVIT Global Growth Fund
- % American Funds NVIT Growth Fund
- % American Funds NVIT Growth-Income Fund
- % Federated NVIT High Income Bond Fund*
- % Neuberger Berman NVIT Multi Cap Opportunities Fund
- % Neuberger Berman NVIT Socially Responsible Fund
- % NVIT Cardinal[SM] Aggressive Fund
- % NVIT Cardinal[SM] Balanced Fund
- % NVIT Cardinal[SM] Capital Appreciation Fund
- % NVIT Cardinal[SM] Conservative Fund
- % NVIT Cardinal[SM] Moderate Fund
- % NVIT Cardinal[SM] Moderately Aggressive Fund
- % NVIT Cardinal[SM] Moderately Conservative Fund
- % NVIT Core Bond Fund
- % NVIT Core Plus Bond Fund
- % NVIT Emerging Markets Fund*
- % NVIT Government Bond Fund
- % NVIT International Equity Fund*
- % NVIT International Index Fund*
- % NVIT Mid Cap Index Fund
- % NVIT Money Market Fund
- % NVIT Multi-Manager International Growth Fund
- % NVIT Multi-Manager International Value Fund*
- % NVIT Multi-Manager Large Cap Growth Fund
- % NVIT Multi-Manager Large Cap Value Fund
- % NVIT Multi-Manager Mid Cap Growth Fund
- % NVIT Multi-Manager Mid Cap Value Fund
- % NVIT Multi-Manager Small Cap Growth Fund
- % NVIT Multi-Manager Small Cap Value Fund
- % NVIT Multi-Manager Small Company Fund
- % NVIT Multi Sector Bond Fund
- % NVIT Nationwide® Fund
- % NVIT Real Estate Fund
- % NVIT Short Term Bond Fund
- % Oppenheimer NVIT Large Cap Growth Fund
- % Templeton NVIT International Value Fund
- % Van Kampen NVIT Comstock Value Fund

Neuberger Berman Advisers Management Trust
- % AMT Short Duration Bond Portfolio

Oppenheimer Variable Account Funds
- % Global Securities Fund/VA*
- % Main Street® Fund/VA
- % Main Street® Small - & Mid-Cap Fund/VA

PIMCO Variable Insurance Trust
- % Foreign Bond Portfolio (Unhedged)
- % Low Duration Portfolio
- % Total Return Portfolio

T. Rowe Price Equity Series, Inc.
- % T. Rowe Price Health Sciences Portfolio

Van Eck VIP
- % Global Hard Assets Fund

Wells Fargo Advantage
- % VT Small Cap Growth Fund

Nationwide Life Insurance Co.
- % Fixed Account
- % Long Term Fixed Account**

These funds are the only available investment options IF the EDBG Rider is selected. All other investment options are unavailable with this rider.

Fidelity Variable Insurance Products Fund
- % VIP Freedom Fund 2010 Portfolio
- % VIP Freedom Fund 2020 Portfolio
- % VIP Freedom Fund 2030 Portfolio

Nationwide Variable Insurance Trust (NVIT)
- % American Funds NVIT Asset Allocation Fund
- % NVIT Cardinal[SM] Aggressive Fund
- % NVIT Cardinal[SM] Balanced Fund
- % NVIT Cardinal[SM] Capital Appreciation Fund
- % NVIT Cardinal[SM] Conservative Fund
- % NVIT Cardinal[SM] Moderate Fund
- % NVIT Cardinal[SM] Moderately Aggressive Fund
- % NVIT Cardinal[SM] Moderately Conservative Fund

Nationwide NVIT Investor Destinations Funds
- % Aggressive Fund
- % Balanced Fund
- % Capital Appreciation Fund
- % Conservative Fund
- % Moderate Fund
- % Moderately Aggressive Fund
- % Moderately Conservative Fund

Nationwide Life Insurance Co.
- % Fixed Account

**Stringent premium and transfer restrictions are enforced for the Long Term Fixed Account, please consult the prospectus for more details on these restrictions.

3. Optional Elections

Once the policy is issued, changes to any optional election requires written instructions from Policy Owner(s).

a. **Sub-Account Monthly Deduction:**

- If the selected Sub-Account's value is not sufficient for the full monthly deduction, any portion of the monthly deduction that was not taken and all future monthly deductions will be deducted proportionately from the remaining Sub-Accounts until sufficient premium is paid into the selected Sub-Account again.
- Fixed Account(s) are not eligible for directing the monthly deduction.

Please deduct from the following Sub-Account: (*check one*)

☐ **Nationwide NVIT Money Market Fund** OR ☐ **Selected Sub-Account**_____

b. **Dollar Cost Averaging:**

- Transfers must be at least $100.
- The monthly transfer from the **FIXED ACCOUNT must be equal to or less than 1/30th of the Fixed Account value when the Dollar Cost Averaging Program is requested. Transfers to or from the Long Term Fixed Account are not available as part of Dollar Cost Averaging.
- If you choose this option, Dollar Cost Averaging will begin the 1st day available from the Policy Date.

Please transfer $_____per month from the *(check one)*

☐ **Nationwide NVIT Government Bond Fund** ☐ **Nationwide NVIT Money Market Fund**

☐ **Nationwide NVIT High Income Bond Fund (Federated)** ☐ **Nationwide Fixed Account****

Transfers from the Sub-Accounts specified above shall be transferred to the following Sub-Accounts based on the percentage allocations indicated below: (Variable Account Allocations – WHOLE % only, totaling 100%)

	SUB-ACCOUNT
_____%	
_____%	
_____%	
_____%	
_____%	
Total = 100%	

c. **Asset Rebalancing:**

If you choose this option, Asset Rebalancing will be the 1st day available from the Policy Date.

Rebalancing will occur: *(check one)*

☐ Quarterly ☐ Semi-Annually ☐ Annually

NOTE: UNLESS INDICATED BELOW, THE SUB-ACCOUNT ALLOCATIONS SELECTED FOR INVESTMENT IN THE ALLOCATIONS SECTION ON THIS FORM WILL BE USED. FIXED ACCOUNTS ARE NOT AN AVAILABLE SUB-ACCOUNT FOR THIS ELECTION.

	SUB-ACCOUNT
_____%	
_____%	
_____%	
_____%	
_____%	
_____%	
_____%	
_____%	
_____%	
_____%	
Total = 100%	

4. Transfer Authorization for Producer

☐ By checking this box, you have authorized and directed Nationwide to accept instructions from the Producer signing this application to execute exchanges among the Investment options available under your Policy and/or to allocate any future Premium Payments on your behalf. This power is personal to the Producer, and may be delegated by written notification to Nationwide and only to individuals employed or under control of the Producer for administrative/processing purposes. This power is not available for use by any person or organization providing any type market-timing advice or service. Nationwide may revoke the authority of the Producer to act on your behalf at any time by written notification to you.

If the box above is checked, your Producer's signature below and your signature at the end of this application represents agreement for yourselves, your heirs and the legal representatives of your estates and your successors in interest or assigns to release and hold harmless Nationwide from any and all liability in reliance on instructions given under the authority described above. You and the Producer also agree to jointly and severally indemnify Nationwide for and against any claim, liability or expense arising out of any action taken by Nationwide in reliance of such instructions.

X_____

Signature of Producer

5. Rights of Transfer for Co-Owners	If there is more than one Policy Owner or Trustee, all Policy Owners and Trustees must authorize all Sub-Account exchanges or future allocation changes, unless an option is selected below: ☐ Act Independently – Sub-Account exchanges and future allocations may be made by ***any*** Policy Owner or Trustee. ☐ Designate One – Sub-Account exchanges and future allocations may only be made by the following named Policy Owner or Trustee: _____	
6. Important Notice	**I UNDERSTAND THAT THE DEATH BENEFIT UNDER A VARIABLE LIFE INSURANCE POLICY MAY INCREASE OR DECREASE, DEPENDING ON THE INVESTMENT RETURN ON THE SUB-ACCOUNT(S) I SELECT. REGARDLESS OF INVESTMENT RETURN, THE DEATH BENEFIT CAN NEVER BE LESS THAN THE SPECIFIED AMOUNT, AS LONG AS THE POLICY IS IN FORCE. THE CASH VALUE MAY INCREASE OR DECREASE ON ANY DAY, DEPENDING ON THE INVESTMENT RETURN FOR THE POLICY. NO MINIMUM CASH VALUE IS GUARANTEED. ON REQUEST, WE WILL FURNISH ILLUSTRATIONS OF BENEFITS, INCLUDING DEATH BENEFITS AND CASH VALUES FOR A VARIABLE LIFE INSURANCE POLICY AND A FIXED LIFE INSURANCE POLICY FOR THE SAME PREMIUM.**	
7. Suitability All 3 questions must be answered to issue policy.	a. Do you understand that the Death Benefit and Surrender Value may increase or decrease depending on the investment experience of the Variable Account?	☐ Yes ☐ No
	b. Do you believe that this policy will meet your insurance needs and financial objectives?	☐ Yes ☐ No
	c. Have you received a current copy of the prospectus?	☐ Yes ☐ No
8. Signatures If there are additional Owners on the policy, please attach a blank sheet with the additional signatures.	Signed on _____ (Month/Day), _____ (Year) X _____ Signature of Proposed Primary Insured *(or parent if Proposed Primary Insured is under age 15)* 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))*	

Nationwide
On Your Side

Nationwide Securities, LLC
P. O. Box 183137
Columbus, OH 43218-3137

CUSTOMER ACCOUNT QUESTIONNAIRE

IMPORTANT INFORMATION ABOUT PROCEDURES WHEN OPENING A NEW ACCOUNT: To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. What this means for you: When you open an account, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents. Nationwide Securities, LLC (NSLLC) adhere to Securities and Exchange Commission "Know Your Customer" regulations. The information collected in this new account application is used to determine if recommendations appropriately match your financial needs. NSLLC will retain this information, and send confirmation to you no less than every 36 months. If no changes have occurred, this information may be re-used for similar subsequent transactions.

Please select: ☐ Establish New Account ☐ Update to Existing Account Type

Section 1 - Account Types *(check only one)*

Natural Person		Joint	Fiduciary	Entities
Non-Qualified ☐ Individual *** ☐ Tenants Entirety * ☐ Community Property * ☐ 529 Plan ** * *(complete Section 2A and Section 2B)* ** *(complete Section 2A and Section 2F)* *** *(complete Section 2A)*	**Qualified** ☐ Individual Retirement Account ** ☐ Rollover IRA ** ☐ SEP IRA ** ☐ Simple IRA ** ☐ Roth IRA ** ☐ Beneficiary IRA ** ☐ Coverdell (Education) * ☐ 403(b) ** ☐ Individual/Solo 401(k) ** ** *(complete Section 2A)* * *(complete Section 2A and Section 2F)*	☐ Joint Tenant WROS ☐ Tenants in Common ***Section Guide :*** ***For natural persons complete Section 2A and Section 2B*** ***For natural person and an entity complete Section 2A and Section 2C*** ***For natural person and trust complete Section 2A and Section 2D***	☐ Guardianship * ☐ Estate ** ☐ UGMA: _____ * (State) ☐ UTMA: _____ * (State) ☐ Conservatorship * ☐ Power of Attorney * * *(complete Section 2A and Section 2F)* ** *(complete Section 2E)*	☐ Corporation * ☐ Partnership * ☐ LLC * ☐ Unincorporated Association * ☐ Non-Profit Organization * ☐ Pension Plan ** ☐ Profit Sharing Plan ** ☐ 401(k) ** ☐ Trust ** ☐ Investment Club * * *(complete Section 2C)* ** *(complete Section 2D)*

Section 2A - Natural Person (owner)

Name: *(First, Middle Initial, Last)*	Date of Birth: *(Mo./Day/Yr.)*	Social Security #:	Phone #: ( )
"Also Known As" (AKA) Name (or DBA for Sole Proprietor):	Fax #: ( )	Email Address:	
Marital Status: ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed	Citizenship: ☐ U.S. Citizen ☐ Resident Alien ☐ Non-Resident Alien	If non-U.S. citizen,must provide Country of Citizenship:	

Legal Residence:			Mailing Address (if different from Legal Residence):		
Address Line 2:			Address Line 2:		
City:	State:	Zip Code:	City:	State:	Zip Code:

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Homemaker ☐ Student ☐ Disabled
☐ Other: *(specify)*_____

Name of Employer:		Occupation:	Work Phone: ( )
Street Address:		Job Title:	Fax #: ( )
City:	State: Zip Code:		

Approximate Net Worth (excluding residence, furnishings, autos)	Liquid Net Worth (approximate investable assets)	Tax Bracket:
☐ < $50,000 ☐ $100,001 - 250,000 ☐ $50,000 - 100,000 ☐ $250,001 - 1,000,000 ☐ $250,001 - 1,000,000 ☐ > $1,000,000	☐ < $50,000 ☐ $250,001 - 1,000,000 ☐ $50,000 - 100,000 ☐ > $1,000,000 ☐ $100,001 - 250,000	☐ 0 ☐ 25 ☐ 35 ☐ 10 ☐ 28 ☐ 15 ☐ 33

Approximate Annual Salary: $	Other Household Annual Income (Including Spouse): $	Total Household Income (Annual and Other): $	Total # of Wage Earners:	Total # of Dependents:

Section 2B - Natural Person (joint owner)

Name: *(First, Middle Initial, Last)*	Date of Birth: *(Mo./Day/Yr.)*	Social Security #:	Phone #: ( )
"Also Known As" (AKA) Name (or DBA for Sole Proprietor):	Fax #: ( )	Email Address:	
Marital Status: ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed	Citizenship: ☐ U.S. Citizen ☐ Resident Alien ☐ Non-Resident Alien	If non-U.S. citizen,must provide Country of Citizenship:	
Legal Residence: ☐ Same Address as Section 2A		Mailing Address (if different from Legal Residence):	
Address Line 2:		Address Line 2:	
City: / State: / Zip Code:		City: / State: / Zip Code:	

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Homemaker ☐ Student ☐ Disabled
☐ Other: *(specify)*_____

Name of Employer:	Occupation:	Work Phone: ( )
Street Address:	Job Title:	Fax #: ( )
City: / State: / Zip Code:		

Approximate Net Worth (excluding residence, furnishings, autos)	Liquid Net Worth (approximate investable assets)	Tax Bracket:
☐ < $50,000 ☐ $50,000 - 100,000 ☐ $100,001 - 250,000 ☐ $250,001 - 1,000,000 ☐ > $1,000,000	☐ < $50,000 ☐ $50,000 - 100,000 ☐ $100,001 - 250,000 ☐ $250,001 - 1,000,000 ☐ > $1,000,000	☐ 0 ☐ 10 ☐ 15 ☐ 25 ☐ 28 ☐ 33 ☐ 35

Approximate Annual Salary: $	Other Household Annual Income (Including Spouse): $	Total Household Income (Annual and Other): $	Total # of Wage Earners:	Total # of Dependents:

Section 2C - Entity

Legal Entity Name:			Tax ID #:	# of Employees:
"Doing Business As" (DBA) Name:	Type of Business:	Main Office Phone #: ( )	Other Business #: ( )	Fax #: ( )
Principal Place of Business:			Preferred Mailing (if different from Principal Place of Business):	
Address Line 2:			Address Line 2:	
City: / State: / Zip Code:			City: / State: / Zip Code:	
Parent/Subsidiary Company: **(If yes, provide evidence of corporate heirarchy)** ☐ Yes ☐ No			Website Address:	
Authorized Persons: *(First, Middle Initial, Last)*	Title:		Authorized Persons: *(First, Middle Initial, Last)*	Title:
Authorized Persons: *(First, Middle Initial, Last)*	Title:		Authorized Persons: *(First, Middle Initial, Last)*	Title:

Annual Gross Revenue: $	Annual Net Revenue: $	Balance Sheet Information: Net Equity: $	Liabilities: $	Assets:

Required Documents Attached (Additional documents may be required to open certain Account Types)

If Corporation selected, must have a copy of Certified Articles of Incorporation and either:
☐ Board Resolution with Corporate Seal or
☐ Unanimous Consent of Shareholders Required

If Partnership selected:
☐ Co-Partnership Authorization

If Unincorporated, Non-Profit or Investment Club selected:
☐ Non-Corporate Resolution

Section 2D - Trust

Trust Description: ☐ Qualified Plans ☐ Family ☐ Living ☐ Revocable ☐ Irrevocable ☐ Testamentary

Legal Name of Trust:	Date of Trust: *(Mo., Day, Yr.)*	Tax ID #:

Trustee Name: *(First, Middle Initial, Last)*	Trustee Name: *(First, Middle Initial, Last)*	Trustee Name: *(First, Middle Initial, Last)*

Trust Address:			Preferred Mailing Address: if different from Trust Address		
Address Line 2:			Address Line 2:		
City:	State:	Zip Code:	City:	State:	Zip Code:
Trust Annual Gifts/Income Received: $			Net Worth of Trust: $		

☐ **I have attached a copy of the *required* Trust Certification form.**

Section 2E - Estate

Legal Name of Estate:	Tax ID #:
Executor or Administrator Name: *(First, Middle Initial, Last)*	Phone #:

Estate Address:			Preferred Mailing Address: if different from Estate Address		
Address Line 2:			Address Line 2:		
City:	State:	Zip Code:	City:	State:	Zip Code:
Estate Annual Income Received: $			Net Worth of Estate: $		

Required Documents Attached (Additional documents may be required to open certain Account Types)

☐ Death Certification and Court Documents Required
☐ Probated Last Will and Testament
☐ Other: _____

Section 2F - Fiduciary / 529 Beneficiary

Name: *(First, Middle Initial, Last)*	Date of Birth: *(Mo./Day/Yr.)*	Social Security #:	Phone #: ( )

"Also Known As" (AKA) Name:	Fax #: ( )	Email Address:

Marital Status: ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed	Citizenship: ☐ U.S. Citizen ☐ Resident Alien ☐ Non-Resident Alien	If non-U.S. citizen, must provide Country of Citizenship:

Legal Residence:			Mailing Address: if different from Legal Residence		
Address Line 2:			Address Line 2:		
City:	State:	Zip Code:	City:	State:	Zip Code:

Section 3 - Prior Investment Experience (for Natural Person or Person Making Investment Decision for Fiduciary or Entity Account) *(check all that apply)*

Investor Experience:

- ☐ Mutual Funds
- ☐ Variable Annuity/Life
- ☐ Stock
- ☐ Bonds
- ☐ Options
- ☐ Margin Account
- ☐ Municipal Securities
- ☐ Limited Partnership

Prior Investment Experience: ☐ 0-2 Years ☐ 3-5 Years ☐ 6-8 Years ☐ 9+ Years

Section 4 - Risk Assessment and Investment Objectives *(circle one # for each question)*

(Examples used to describe low, moderate and high assessment levels in each question are for illustrative purposes only)

1. How much risk are you willing to accept for the potential to achieve higher returns?

   Low (e.g., Savings, Money Market) — Moderate (e.g., Mutual Funds, Stocks & Bonds) — High (e.g., Speculative Investment)

   1 2 3 4 5 6 7 8 9

2. How willing are you to endure/bear fluctuations in principal?

   Low (e.g., Slight) — Moderate — High (e.g., Steep)

   1 2 3 4 5 6 7 8 9

3. How important is liquidity?

   Low (e.g., Variable Products) — Moderate (e.g., Mutual Funds, Stocks & Bonds) — High (e.g., Savings, Money Market)

   1 2 3 4 5 6 7 8 9

4. How important is current income from investable assets?

   Low (e.g., Common Stock) — Moderate (e.g., Preferred Stock/Convertible Bonds) — High (e.g., Corporate Bonds)

   1 2 3 4 5 6 7 8 9

5. How important is tax advantage/deferral?

   Low (e.g., Corporate Bonds) — Moderate (e.g., Insurance Products) — High (e.g., Triple Tax-Free Bonds)

   1 2 3 4 5 6 7 8 9

6. What is your investment time horizon?

   0-2 Years — 3-5 Years — 6-8 Years — 9+ Years

Section 5 - Insurance Needs

NOTE: If life, select from section A. If annuity, select from section B.

(A) Life and Variable Life Insurance Needs

- ☐ Survivor Income
- ☐ Estate Liquidity
- ☐ Estate Preservation
- ☐ Debt Protection
- ☐ Future Insurability
- ☐ Business Needs
- ☐ Market Opportunities
- ☐ Long Term Accumulation
- ☐ Premium Flexibility
- ☐ Retirement Supplement
- ☐ Education Funding Supplement
- ☐ Tax Advantaged Growth
- ☐ Other:

(B) Annuity and Variable Annuity Needs

- ☐ Death Benefit
- ☐ Annuitization
- ☐ Market Opportunities
- ☐ Long Term Accumulation
- ☐ Premium Flexibility
- ☐ Retirement Supplement
- ☐ Education Funding Supplement
- ☐ Tax Advantaged Growth
- ☐ Other:

Section 6 - Brokerage Account Information *(complete this section only for Brokerage Account transactions)*

Brokerage Account #:	Brokerage RR #:

1. Is this account a private banking account defined under the USA Patriot Act?	☐ Yes	☐ No
2. Is this an account for a foreign bank as defined under the USA Patriot Act?	☐ Yes	☐ No
3. This account will be used for (check all that apply):	☐ Speculation	☐ Trading

Section 7 - General Questions For All Account Types

1. Are you or anyone with an interest in this account either: (1) a senior military, governmental or political official in a non-U.S. country, or (2) closely associated with an immediate family member of such an official? If yes, please complete Section 8 below.	☐ Yes	☐ No
2. Are you a senior officer, director or 10% or more shareholder of a public company? If yes, for what company(ies) are you a senior officer, director or 10% or more shareholder? Please complete in Section 8 below.	☐ Yes	☐ No
3. Are you or anyone with an interest in this account affiliated with, an officer of, employee of, or related to an employee of the FINRA, a broker-dealer, or another financial institution? If yes, name of firm and relationship in Section 8 below.	☐ Yes	☐ No

Section 8 - Comments/Additional Information

☐ **Additional Comments Attached**

Section 9 - Signature/Verification

This document contains a pre-dispute Arbitration Agreement clause which appears below. Please review the information you provided and read the Agreement before signing.

1. **Provisions in the Event of Failure to Pay or Deliver:** Whenever the owner/customer does not, on or before the settlement date, pay in full for any security purchased for the account of the owner/customer, or deliver any security sold for such account, Nationwide Securities, LLC. (the "Company") is authorized (subject to the provisions of any applicable statute, rule or regulation) to sell any or all securities which the Company may hold for the owner/customer (either individually or jointly with others), or to buy in any or all securities required to make delivery for the account of the owner/customer, or to cancel any or all outstanding orders or commitments for the account of the owner/customer.

2. **Cancellation Provisions:** The Company is authorized, in its discretion, should the owner/customer die or should the Company for any reason whatever deem necessary for its protection, without notice, to cancel any outstanding orders in order to close out the accounts of the owner/customer, in whole or in part, or to close out any commitment made on behalf of the owner/customer.

3. **Age:** The owner/customer, if an individual, represents that he or she is of full legal age.

Section 9 - Signature/Verification *(continued)*

4. **Joint Accounts**: If this is a joint account, unless the owner/customer notifies the Company otherwise and provides such documentation as the Company requires, the brokerage account(s) shall be held by the owner/customer jointly with the rights of survivorship (payable to either or the survivor of the owner/customer). Each joint tenant irrevocably appoints the other as attorney-in-fact to take all action on his or her behalf and to represent him or her in all respects in connection with this Agreement. The Company shall be fully protected in acting but shall not be required to act upon the instructions of either of the owner(s)/customer(s). Each owner/customer shall be liable, jointly and individually, for any amounts due to the Company pursuant to this Agreement, whether incurred by either or both of the owner(s)/customer(s).

5. **Address**: Communications may be sent to the owner/customer at the current address of the owner/customer, which is on file at the Company office, or at such other address as the owner/customer may hereafter give the Company in writing. All communications so sent, whether by mail, telegraph, messenger or otherwise, shall be deemed given to the owner/customer personally, whether actually received or not.

6. **Interest in Account**: No one except the owner/customer has an interest in any of its accounts with the Company unless such interest is revealed in the title of such account and in any case the owner/customer has the interest indicated in such title.

7. **Successors**: This agreement and its provisions shall be continuous, and shall inure to the benefit of the Company's present organization, and any successor organization or assignee, and shall be binding upon the owner/customer and/or the estate, executors, administrators and assigns of the owner/customer.

8. **Force Majeure**: The Company shall not be liable for loss or delay caused directly or indirectly by war, natural disasters, government restrictions, exchange or market rulings or other conditions beyond its control.

9a. **Arbitration Disclosures: For purposes of this Section 9 the term "Person, Party or Parties" refers to each person who has signed this document and/or the entity, or individual such person represents.**

I/ We understand that this agreement contains a predispute arbitration clause. By signing an Arbitration Agreement the parties agree as follows:

a) **All parties to this agreement are giving up the right to sue each other in court, including the right to a trial by jury, except as provided by the rules of the arbitration forum in which a claim is filed.**
b) **Arbitration awards are generally final and binding; a party's ability to have a court reverse or modify an arbitration award is very limited.**
c) **The ability of the parties to obtain documents, witness statements, and other discovery is generally more limited in arbitration than in court proceedings.**
d) **The arbitrators do not have to explain the reasons(s) for their award.**
e) **The panel of arbitrators will typically include a minority of arbitrators who were or are affiliated with the securities industry.**
f) **The rules of some arbitration forums may impose time limits for bringing a claim in arbitration. In some cases, a claim that is ineligible for arbitration may be brought in court.**
g) **The rules of the arbitration forum in which the claim is filed, and any amendments thereto, shall be incorporated into this agreement.**

9b. **Arbitration Agreement: It is agreed that any controversy between the Parties that may arise concerning any transaction or any agreement among the Parties whether entered into prior, on or subsequent to the date of this Agreement, shall be submitted to arbitration conducted before the National Association of Securities Dealers, Inc. Arbitration must be commenced by service upon the other Party of a proper written demand or notice.**

No Person shall bring a putative or certified class action to arbitration, nor seek to enforce any pre-dispute arbitration agreement against any Person who has initiated in court a putative class action; or who is a member of a putative class who has not opted out of the class with respect to any claims encompassed by the putative action until:

(i) the class certification is denied; or
(ii) the class is decertified; or
(iii) the Person is excluded from the class by the court. Such forbearance to enforce an agreement to arbitrate shall not constitute a waiver of any rights under this agreement except to the extent stated herein.

The laws of the State of Pennsylvania shall govern this agreement.

10. Complaints may be reported to Nationwide Securities, LLC., Attn: Dispute Resolution, 5100 Rings Road, RR1-01-D1 Dublin, OH 43017. Telephone 888-753-7364, option 6, facsimile (302) 452-7634.

11. Contact FINRA Regulation at (800) 289-9999 or www.finra.org to learn about the FINRA BrokerCheck Program.

12. Tax Certification: Under penalties of perjury, I certify that (1) the number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), (2) I am not subject to backup withholding because (a) I am exempt from backup withholding or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, (3) I am a U.S. person (including a U.S. resident alien).
Note: You must cross out (b) above if you are currently subject to backup withholding because of underreporting interest or dividends on your tax return. For Payers Exempt from Backup Withholding (if you are unsure, ask us for a complete set of IRS instructions), write the word "Exempt" here: _____. If this is a joint account, the Social Security number of the account owner who is named FIRST in the account title MUST be used.

13. I/We hereby certify that the information provided accurately reflects my/our financial background and investment objectives.

Section 9 - Signature/Verification - **I agree that this agreement contains a predispute arbitration clause, which is located in paragraphs 9a and 9b on page 6. I/ We hereby acknowledge receipt of a copy of this agreement.**

Name of Owner (please print):	Signature of Owner:	Date:

Identification Type: ***(Must Have Unexpired Photo ID; Issue Date and Expiry Date Required for ALL ID Types)***

☐ Driver's License #________ (State ____) Issue Date: ________ Expiry Date: ________

☐ State Issued ID #________ (State ____) Issue Date: ________ Expiry Date: ________

☐ Passport #________ (Country of Issuance ________) Issue Date: ________ Expiry Date: ________

☐ Alien Green Card/Visa #________ Issue Date: ________ Expiry Date: ________

☐ Military ID SSN #________ Issue. Date: ________ Expiry Date: ________

Name of Owner (please print):	Signature of Owner:	Date:

Identification Type: ***(Must Have Unexpired Photo ID; Issue Date and Expiry Date Required for ALL ID Types)***

☐ Driver's License #________ (State ____) Issue Date: ________ Expiry Date: ________

☐ State Issued ID #________ (State ____) Issue Date: ________ Expiry Date: ________

☐ Passport #________ (Country of Issuance ________) Issue Date: ________ Expiry Date: ________

☐ Alien Green Card/Visa #________ Issue Date: ________ Expiry Date: ________

☐ Military ID SSN #________ Issue Date: ________ Expiry Date: ________

Name of Owner (please print):	Signature of Owner:	Date:

Identification Type: ***(Must Have Unexpired Photo ID; Issue Date and Expiry Date Required for ALL ID Types)***

☐ Driver's License #________ (State ____) Issue Date: ________ Expiry Date: ________

☐ State Issued ID #________ (State ____) Issue Date: ________ Expiry Date: ________

☐ Passport #________ (Country of Issuance ________) Issue Date: ________ Expiry Date: ________

☐ Alien Green Card/Visa #________ Issue Date: ________ Expiry Date: ________

☐ Military ID SSN #________ Issue Date: ________ Expiry Date: ________

My/Our signature(s) below confirm(s) that I/we have personally examined the document(s) listed in "Identification Type" and reasonably believe the information confirms the identity of the customer(s).

Documentary Verification Was Performed? ☐ Yes ☐ No	Time Known Client?	Where/How Was Account Acquired? ☐ Self ☐ Family Member ☐ Walk-In ☐ Referral ☐ Employee ☐ Prospected ☐ Existing Client

Any Related Accounts? ☐ Yes ☐ No	If yes, Name of Fund or Brokerage Firm:

Name of Registered Representative (please print):	RR Code #:	Split Code:	Signature of Registered Representative:	Date:

Name of Registered Representative (please print):	RR Code #:	Split Code:	Signature of Registered Representative:	Date:
Name of Registered Representative (please print):	RR Code #:	Split Code:	Signature of Registered Representative:	Date:
Name of Registered Representative (please print):	RR Code #:	Split Code:	Signature of Registered Representative:	Date:

Name of Field Supervisory Principal (please print):	FE #:	Signature of Field Supervisory Principal:	Date:
Name of NSLLC Home Office Principal (please print):		Signature of NSLLC Home Office Principal:	Date:

Notice to Customer

When you became a customer of NSLLC, you signed a Customer Account Questionnaire containing an arbitration agreement. This means you agree to arbitrate disputes with NSLLC and your registered representative. The exact language to which you agreed states:

Arbitration Disclosures: For purposes of this Section 9 the term "Person, Party or Parties" refers to each person who has signed this document and/or the entity, or individual such person represents.

I/ We understand that this agreement contains a predispute arbitration clause. By signing an Arbitration Agreement the parties agree as follows:

a) All parties to this agreement are giving up the right to sue each other in court, including the right to a trial by jury, except as provided by the rules of the arbitration forum in which a claim is filed.
b) Arbitration awards are generally final and binding; a party's ability to have a court reverse or modify an arbitration award is very limited.
c) The ability of the parties to obtain documents, witness statements, and other discovery is generally more limited in arbitration than in court proceedings.
d) The arbitrators do not have to explain the reasons(s) for their award.
e) The panel of arbitrators will typically include a minority of arbitrators who were or are affiliated with the securities industry.
f) The rules of some arbitration forums may impose time limits for bringing a claim in arbitration. In some cases, a claim that is ineligible for arbitration may be brought in court.
g) The rules of the arbitration forum in which the claim is filed, and any amendments thereto, shall be incorporated into this agreement.

Arbitration Agreement: It is agreed that any controversy between the Parties that may arise concerning any transaction or any agreement among the Parties whether entered into prior, on or subsequent to the date of this Agreement, shall be submitted to arbitration conducted before the Financial Industry Regulatory Authority, Inc. Arbitration must be commenced by service upon the other Party of a proper written demand or notice.

No Person shall bring a putative or certified class action to arbitration, nor seek to enforce any pre-dispute arbitration agreement against any Person who has initiated in court a putative class action; or who is a member of a putative class who has not opted out of the class with respect to any claims encompassed by the putative action until:

(i) the class certification is denied; or
(ii) the class is decertified; or
(iii) the Person is excluded from the class by the court. Such forbearance to enforce an agreement to arbitrate shall not constitute a waiver of any rights under this agreement except to the extent stated herein.

You may check the professional background of current and former FINRA registered securities firms and brokers through "FINRA BrokerCheck". A brochure from FINRA including information describing FINRA BrokerCheck is also available to investors. To obtain a report about your broker or securities firm, or for questions regarding BrokerCheck, call toll-free (800) 289-9999 Monday through Friday from 8 a.m. - 8 p.m. Eastern Time or via the web at http://www.finra.org/Investors/ToolsCalculators/BrokerCheck/index.htm.

This notice is for your records.

Nationwide® Privacy Statement

Thank you for choosing Nationwide Securities, LLC (NSLLC)

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

Confidentiality and security

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

Collecting and using your personal information

We collect information about you when you ask about or buy one of our securities products or services from a registered representative through a broker-dealer. The information comes from your applications, forms, and transactions with us. We may also collect it from other Nationwide companies, consumer reports, and publicly available sources. Please know that we only use your information to sell, service, or market products to you.

We may collect the following types of information:

- Name, address, and Social Security number
- Assets and income
- Property address and value
- Account and policy information
- Credit reports and other consumer report information
- Family member and beneficiary information
- Public Information

Sharing your information for business purposes

We share your information with other Nationwide companies and our business partners. This includes our investment companies, broker-dealers, and transfer agent affiliates. When you buy a product, we may share your information for everyday servicing purposes. Some examples include mailing your statements or processing transactions that you request. You cannot opt out of these. We also share your information with registered representatives and registered investment advisers. They use your information to manage your policy or account. We may also share your information where federal and state law requires.

Sharing your information for marketing purposes

We don't sell your information to anyone – period. We may share your information with other Nationwide companies, business partners, or agents who are under contract with us. These include the registered representative who sold you your policy or contract. They are under contract with us and may use this information to offer you a product from a nonaffiliated company. We also have joint marketing agreements with our business partners. This means that we have partnered with them to offer you a product that might interest you. They may use your personal information to market their products. If you would like to learn more about opting out, please read the Opting Out section below

Our registered representatives may decide to leave Nationwide and join another broker-dealer. When this happens, they may take your information to their new broker-dealer. If this occurs, your previous Nationwide registered representative may use your personal information to service your existing products and sell you new products offered by the new broker-dealer. In this event, if you don't want your registered representative to take your information to the new broker-dealer, follow the opt out procedures as stated within this document.

Using your medical information

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

Accessing your information

You can always ask us for a copy of your personal information. This includes any information from applications and forms that you completed when establishing an account with us. Please send your privacy inquiry to the address below and have your signature notarized. This is for your protection so we may prove your identity. We don't charge a fee for giving you a copy of your information now, but we may charge a small fee in the future.

You can change your information by calling your registered representative or producer. But we can't update information that other companies provide to us. So you'll need to contact these other companies to change your information.

We are always willing to answer any general privacy questions about our policy and can be reached at 1-877-233-3370. You may also send your privacy inquiries to the address below. Please include your name, address, and policy number. If you know it, include your producer's or agent's name and number.

Opting Out

We respect your privacy choices and how you would like us to your information. You can ask us not to share your information with the Nationwide family of companies or business partners to market products to you. Remember, these companies offer many different types of financial products and services, so you may not want to opt out.

Feel free to make your privacy choice at any time. We will follow your choice within 30 days, unless you tell us that your have changed your mind. We will apply the privacy choices to the name printed on this form. An opt out request from one joint customer will apply to all joint customers listed on your product.

To tell us your privacy choice, please do one of the following:

- Call us toll free at 1-877-233-3370. Hours of operation are Monday – Friday 8:30 a.m. to 6:00 p.m. EST.
- Log on to www.MyNFN.com
- Fax your request to 1-866-371-6834
- Mail your request to:

Nationwide Securities, LLC
Attn: Privacy
P.O. Box 183137
Columbus, OH 43218-3137

We will not share the personal information of Vermont customers with the Nationwide family of companies or third parties for marketing purposes without your consent.

Complaints may be reported to Nationwide, Attn: Dispute Resolution Unit, 5100 Rings Road, RR1-01-D1, Dublin, OH 43017, 1-888-753-7364 option 6 or fax 302-452-7634.

A parting word...

These are our privacy practices. They apply to current customers of Nationwide Securities, LLC.

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
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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: _____

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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: _____