NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY

Application for Individual Life Insurance

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

PART A – CLIENT INFORMATION

1. Proposed Primary Insured

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

Address | City

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

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

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

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

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

2. Proposed Additional Insured

If applicable, complete for either:

a) Joint Insured for Survivorship Life Plan; or

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

If additional space is required, use Special Instructions Section.

Joint/Spouse Proposed Additional Insured Information Only:

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

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

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

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

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

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

Child Proposed Additional Insured Information Only:

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

3. Owner

Complete ONLY if Owner is not the Proposed Primary Insured.

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

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

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

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

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

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

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

State | Zip Code | County | Phone # ( ) ☐AM ☐PM | E-Mail Address

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

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

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

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

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

State | Zip Code | County | Phone # ( ) ☐AM ☐PM | E-Mail Address

4. Contingent Owner

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

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

5. Secondary Addressee

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

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

Address

6. Primary Beneficiary Designations

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

If additional space is required, use Special Instructions Section.

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

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

For Proposed Primary Insured

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

For Proposed Additional Insured

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

7. Contingent Beneficiary Designations

If additional space is required, use Special Instructions Section.

For Proposed Primary Insured

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

For Proposed Additional Insured

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

8. Taxpayer ID Number

STOP

Check box, if applicable

I certify under penalties of perjury that:

- The Taxpayer Identification Number or Social Security Number listed on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and,
- I am not subject to backup withholding because
  - I have not been notified that I am subject to backup withholding as a result of a failure to report all interest or dividends, or
  - the Internal Revenue Service has notified me that I am no longer subject to backup withholding, or that I am exempt from backup withholding, and
- I am a U.S. citizen or other U.S. person, and,
- The FATCA (Foreign Account Tax Compliance Act) code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct

☐ **Check this box if you have been notified by the IRS that you are currently subject to backup withholding because of failure to report interest or dividends on your tax return.**

PLAN INFORMATION

9. Life Insurance Plan

STOP

*The Variable Life Fund Supplement **MUST** be completed if applying for a Variable Product.*

*The IUL Allocation Form **MUST** be completed if applying for an Indexed UL Product.*

Product (select one): ☐Universal Life ☐Variable Universal Life ☐Whole Life ☐Survivorship Life

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

Plan Name: _____

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

Base Specified Amount	+	Additional Term Rider/Supplemental Coverage Amount *(check plan for availability)*	=	Total Specified Amount *(including Additional Term Rider/ Supplemental Coverage)*
$ 500,000		$ _____		$ 0

10. Additional Options

STOP

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

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

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

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

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

Internal Revenue Code Life Insurance Qualification Test Option

☐ Guideline Premium/Cash Value Corridor Test

☐ Cash Value Accumulation Test

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

11. Optional Benefits

Check Plan for Availability.

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

☐ Spouse Rider ..... $_____

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

☐ Accelerated Death Benefit for Long Term Care Rider* ..... $_____

**Complete Supplement for Accelerated Death Benefit for Long Term Care Rider.*

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

☐ Extended Death Benefit/No Lapse Guarantee Rider

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

_____ Guarantee Duration *(Indicate number of years)*

☐ Extended No-Lapse Guarantee Rider**

(Available for Indexed UL Protector product only)

☐ Guarantee up to Attained Age 90

☐ Guarantee up to Attained Age 120

**This rider is not available with the Premium Waiver Rider.

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

☐ Change of Insured Rider

☐ Other Rider(s)_____

Can select only one:

☐ Premium Waiver Rider..... $ _____

☐ Waiver of Monthly Deductions Rider

Can select only one:

☐ Surrender Value Enhancement Benefit

☐ Conditional Return of Premium Rider (cannot be elected with Extended Death Benefit/No Lapse Guarantee Rider)

☐ Surrender Charge Waiver Options ☐ Full ☐ Partial

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

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

☐ Four Year Term Rider** ..... $_____

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

☐ Policy Split Option Rider

☐ Other Rider(s)_____

☐ Other Rider(s)_____

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

☐ 20 Year Spouse Rider ..... $_____

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

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

☐ Guaranteed Insurability Benefit Rider $_____

☐ Waiver of Premium Disability Benefit Rider

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

Occupation_____

Height_____

Weight_____

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

Occupation_____

Height_____

Weight_____

☐ Other Rider(s)_____

☐ Other Rider(s)_____

☐ Other Rider(s)_____

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

☐ **No, do not issue with APLO.**

FUTURE BILLING AND PREMIUM INFORMATION

12. Amount Paid With Application

Check the applicable option and indicate the premium amount being submitted with the application.

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

☐ Check/Wire amount with application ..... $_____

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

☐ Web Remittance (this option is not available for VUL products) ..... $_____

☐ Draft initial payment only (indicate initial premium amount and complete Section 14b) ..... $_____

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

13. Future Billing and Payment Options

Check the applicable billing or payment option(s) and indicate the premium amount.

Billing Options:	**Payment Options:**
☐ EFT* ..... $_____	☐ Single Premium ..... $_____
**If selected, complete Section 14, Electronic Draft Authorization.*	☐ Billing Advantage ..... $_____
☐ Quarterly ..... $_____	Account Number_____
☐ Semi-Annual ..... $_____	☐ 1035 Exchange ..... $_____
☐ Annual ..... $_____	☐ Other ..... $_____

14. Electronic Draft Authorization

14a. Electronic Draft Options:

Draft Frequency:

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

*Available for Term/Whole Life products only

Draft Day (1st –28th):_____

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

Draft Options:

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

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

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

14b. If no check or deposit slip provided, indicate below the bank information to be used:

Financial Institution Name_____ Transit/ABA Number_____

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

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

15. Payor

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

Name *(First, MI, Last)*

Address	City	State	Zip Code

INSURANCE INFORMATION

16. Replacement and Other Policy Information

STOP

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

☐ Yes ☐ No	a. Do you have any other Life Insurance or Annuities either currently in force or that has been sold to a third party? *(If "yes", list below.)*
☐ Yes ☐ No	b. Is any person here proposed for coverage now applying for Life Insurance or Annuities with any other company? *(If "yes", provide name of Company, amount applied for and purpose of coverage.)* _____
☐ Yes ☐ No	c. Will any Life Insurance or Annuities for this or any other company be replaced, discontinued, reduced or changed if insurance now applied for is issued? *(If "yes", list below and complete appropriate replacement forms. If this is an IRC Sect 1035 Exchange, attach 1035 forms.)*
☐ Yes ☐ No	d. Is any person here proposed for coverage had Life Insurance or Annuities in the past 3 years that is no longer in force? *(If "yes", provide name of Company, face amount and reason coverage is no longer in force.)* _____

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

FINANCIAL INFORMATION

17. Financial Questions

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

STOP

This section needs to be completed by each Proposed Insured and Owner/ Trustee, if other than Proposed Insured(s).

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

18. Explanation of Financial Details

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

Question Letter	Person	Dates	Details

PART B - PERSONAL AND HEALTH INFORMATION

19. Tobacco Use

All questions are to be answered by each Proposed Insured.

STOP

Be sure to answer this section.

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

20. Physical Measurements

Fill in information for the Proposed Primary Insured.

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

21. Personal Physicians

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

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

22. Personal Details

Explain all "yes" answers in Section 23 Details box below unless instructed otherwise.

All questions are to be answered by each Proposed Insured. For each yes answer, indicate the appropriate item(s) and provide details.	Proposed Primary Insured		Proposed Additional Insured		Any Child	
	Yes	No	Yes	No	Yes	No
a. Have you ever had any application for Life or Health Insurance *(or any application for reinstatement for Life or Health Insurance)* declined, postponed, rated-up or limited?	☐	☐	☐	☐	☐	☐
b. Have you ever applied for or received disability payments for any illness or injury?	☐	☐	☐	☐	☐	☐
c. In the past 3 years have you engaged in, or do you intend to engage in: flying as a pilot, student pilot, or crew member; organized racing of an automobile, motorcycle, or any type of motor-powered vehicle; scuba diving, mountain climbing, hang gliding, parachuting, sky diving, bungee jumping, soaring, or ballooning? *(If "yes", complete an Aviation/ Hazardous Activities Questionnaire.)*	☐	☐	☐	☐	☐	☐
d. Have you ever had your driver's license suspended or revoked; or ever been convicted of driving while impaired or intoxicated, or in the past 3 years been convicted of more than one moving violation?	☐	☐	☐	☐	☐	☐
e. Except as prescribed by a physician, have you ever used, or been convicted for sale or possession of cocaine or any other narcotic or illegal drug? *(If "yes", complete Drug Questionnaire.)*	☐	☐	☐	☐	☐	☐
f. Have you ever been charged with a violation of any criminal law?	☐	☐	☐	☐	☐	☐
g. In the next 12 months, do you plan to travel or reside outside of the United States or Canada? *(If "yes", complete Supplement for Foreign Nationals or Travel.)*	☐	☐	☐	☐	☐	☐
h. Do you belong to or intend to join any active or reserve military or naval organization? *(If "yes", complete Military Status Questionnaire.)*	☐	☐	☐	☐	☐	☐
i. Have you had any bankruptcies in the past 7 years or do you have any suits or judgments pending against you at this time?	☐	☐	☐	☐	☐	☐
j. To the best of your knowledge, do you have a parent or sibling who died from cancer or cardiovascular disease prior to age 60? *(If "yes", provide relationship to Proposed Insured(s), age at death, and cause of death, and if cancer, provide type.)*	☐	☐	☐	☐	☐	☐
k. Can you read and understand English?	☐	☐	☐	☐	☐	☐

23. Explanation of Personal Details

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

Question Letter	Person	Dates	Details

HEALTH INFORMATION

24. Health Questions

All questions are to be answered by each Proposed Insured.

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

To the best of your knowledge and belief, has anyone here proposed for insurance ever consulted a licensed health care provider for, been treated for, taken medication 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 received a positive result of an HIV (Human Immunodeficiency Virus) test?	☐	☐	☐	☐	☐	☐
b. Heart disease including heart attack, angina, or other chest pain, cardiomyopathy, shortness of breath, congestive heart failure, heart murmur, or other disorder of the heart?	☐	☐	☐	☐	☐	☐
c. Irregular heart beat, palpitations, high blood pressure, high cholesterol, or high triglycerides?	☐	☐	☐	☐	☐	☐
d. Aneurysm, carotid artery disease, deep venous thrombosis, phlebitis, peripheral vascular disease, any other disorder of the blood vessels, or pulmonary embolism?	☐	☐	☐	☐	☐	☐
e. Headaches, seizures, epilepsy, stroke, Alzheimer's disease, dementia, Parkinson's disease, multiple sclerosis, or any other brain or nervous disorder?	☐	☐	☐	☐	☐	☐
f. Depression, neurosis, affective disorder, psychosis, or any other mental or emotional disorder?	☐	☐	☐	☐	☐	☐
g. Asthma, emphysema, chronic bronchitis, tuberculosis, or any other disease of the lungs or respiratory system?	☐	☐	☐	☐	☐	☐
h. Colitis, ulcer, persistent diarrhea, rectal bleeding, Crohn's disease, ulcerative colitis, or any other disease or disorder of the esophagus or digestive tract?	☐	☐	☐	☐	☐	☐
i. Sugar, protein or blood in the urine, kidney stones, sexually transmitted disease, or any other disease or disorder of the kidneys, bladder, prostate, breast, urinary tract or reproductive system?	☐	☐	☐	☐	☐	☐
j. Diabetes, hepatitis, cirrhosis or any other disease of the liver, pancreas, or thyroid?	☐	☐	☐	☐	☐	☐
k. Disorder of the blood including anemia, sickle cell disorders, thalassemia, hemophilia, or any other disorder of the red blood cells, or white blood cells, platelets, or clotting factors?	☐	☐	☐	☐	☐	☐
l. Cancer, or any malignant or benign tumor or cyst, or any chronic disease of the skin or lymph glands?	☐	☐	☐	☐	☐	☐
m. Arthritis, rheumatoid arthritis, osteoporosis; or any paralysis or chronic back or muscle condition?	☐	☐	☐	☐	☐	☐
n. Alcoholism, narcotic addiction, drug use, or hallucinations?	☐	☐	☐	☐	☐	☐
o. Any disease 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:						
p. Consulted, or been examined or treated by any physician, chiropractor, psychologist or other health care practitioner or by any hospital, clinic, or other health care facility not already disclosed on this application? *(If it was for a "check up", annual physical, employment physical, etc., so state and give findings and results.)*	☐	☐	☐	☐	☐	☐
q. Had any known symptoms or known indications of any disease, disorder, injury, or operation not already disclosed on this application?	☐	☐	☐	☐	☐	☐
r. Had any x-rays, electrocardiograms, or other medical tests for reasons not already disclosed on this application?	☐	☐	☐	☐	☐	☐
s. Been medically advised to have any surgery, hospitalization, treatment or test that was not completed or results that you have not received?	☐	☐	☐	☐	☐	☐
t. Currently taking any medication other than indicated above to include prescription, over-the-counter medications for more than 5 days, dietary supplements, "natural" or herbal medications? *(Give details of dosage and frequency.)*	☐	☐	☐	☐	☐	☐
u. Used alcoholic beverages? *(If "yes", how much, what kind (beer, wine, liquor), and how often.)*	☐	☐	☐	☐	☐	☐

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

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

PART C – FRAUD STATEMENTS AND IMPORTANT NOTICES

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