

SERFF Tracking Number: NWPA-126337763 State: Arkansas
Filing Company: Nationwide Life Insurance Company State Tracking Number: 43779
Company Tracking Number: COLI-3003-E-US3
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Application for Life Insurance
Project Name/Number: /

Filing at a Glance

Company: Nationwide Life Insurance Company

Product Name: Application for Life Insurance

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: NWPA-126337763 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 43779

Co Tr Num: COLI-3003-E-US3

State Status: Approved-Closed

Authors: Sandra Davies, Dan
Gallion, Cindy Malloy, Carrie
Ruhlen, Georgia Sollars, Drema
Wallace, Leslie Hernandez

Reviewer(s): Linda Bird

Disposition Date: 10/15/2009

Date Submitted: 10/14/2009

Disposition Status: Approved-
Closed

Implementation Date Requested: 11/13/2009

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Pending

Project Number:

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 10/15/2009

Explanation for Other Group Market Type:

State Status Changed: 10/15/2009

Deemer Date:

Created By: Dan Gallion

Submitted By: Dan Gallion

Corresponding Filing Tracking Number:

Filing Description:

Re: COLI-3003-E-US3, Application for Life Insurance

COLI-3037-A, Insurance Schedule

NAIC #66869

Enclosed for filing, subject to your approval, are forms COLI-3003-E-US3, Application for Life Insurance and COLI-3037-A, Insurance Schedule. These forms will replace forms COLI-3003-E-AR, Application for Life Insurance approved by

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your Department on 02-08-07, COLI-3004-E-AR, Application for Life Insurance approved by your Department on 02-08-07 and COLI-3037, Insurance Schedule approved by your Department on 07-09-08. We would like these revisions to be effective November 13, 2009.

The following revisions were made:

COLI-3003-E-US3

1. Added Nationwide logo.
2. Updated the format of the application.
3. Removed Nationwide Life and Annuity Insurance Company.
4. Changed the address and added phone number to the front page.
5. Changed application to be used with individual and group products.
6. Revised Section 6, Plan and Specified Amount Section.
7. Added Section 7, Enhancement Benefit.
8. Revised Section 8, Optional Benefit Riders
9. Revised Section 10. Split out MEC Status into separate section.
10. Removed Special Instructions and Correction and amendments by Home Office.
11. Revised Section 13, question A2.
12. Combined Questions about Insured with Replacement Section.
13. Added Section 15, Fraud Statement Section.
14. In Part B, revised Personal and Medical Information Section.
15. In Part C, revised Personal Information Section and Medical Questions and Information Section.
16. Updated address is Important Notice Section.
17. Updated MIB address and added web address in MIB Disclosure Notice Section.
18. Removed Temporary Insurance Agreement.

COLI-3037-A

1. Updated the format of the form.
2. Added Nationwide Logo, form title, Nationwide address and phone to top of document.
3. In table changed name of Additional Protection Rider to Supplemental Insurance Rider.
4. Added Case Level Enhancement Benefit Section.
5. Revised The Employer certifies paragraph.
6. Added contact phone number for the New Business Coordinator at bottom of form.

These forms are being filed concurrently in our state of domicile. Form COLI-3003-E-US3 has been written in a readable fashion and attains a Flesch score of 53.3. Form COLI-3037-A is exempt from scoring.

Thank you in advance for your attention to this matter. Please call me if you have any questions on this filing.

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Sincerely,

Dan Gallion
 Specialist
 NF Regulatory Filings &
 Operations Team, 1-33-102
 Phone: (614) 249-8116
 Fax: (614) 249-1199
 E-Mail: galliod@nationwide.com

Company and Contact

Filing Contact Information

Dan Gallion, Compliance Specialist galliod@nationwide.com
 One Nationwide Plaza 614-249-8116 [Phone]
 1-33-102 614-249-1199 [FAX]
 Columbus, OH 43215

Filing Company Information

Nationwide Life Insurance Company CoCode: 66869 State of Domicile: Ohio
 One Nationwide Plaza Group Code: 140 Company Type:
 1-10-03 Group Name: State ID Number:
 Columbus, OH 43215 FEIN Number: 31-4156830
 (800) 882-2822 ext. [Phone]

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? Yes
 Fee Explanation: \$50.00 per filing.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Nationwide Life Insurance Company	\$50.00	10/14/2009	31281969

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	10/15/2009	10/15/2009

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Disposition

Disposition Date: 10/15/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: *NWPA-126337763* *State:* *Arkansas*
Filing Company: *Nationwide Life Insurance Company* *State Tracking Number:* *43779*
Company Tracking Number: *COLI-3003-E-US3*
TOI: *L08 Life - Other* *Sub-TOI:* *L08.000 Life - Other*
Product Name: *Application for Life Insurance*
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		No
Supporting Document	Application		No
Form	Application for Life Insurance		No
Form	Insurance Schedule		No

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Form Schedule

Lead Form Number: COLI-3003-E-US3

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment	
	COLI-3003-E-US3	Application/ Enrollment Form	Application for Life Insurance	Revised	Replaced Form #: COLI-3003-E-AR Previous Filing #: NWPA-125094883	53.300	COLI-3003-E-US3.pdf
	COLI-3037-A	Application/ Enrollment Form	Insurance Schedule	Revised	Replaced Form #: COLI-3037 Previous Filing #: NWPA-125723062	0.000	COLI-3037-A.pdf



APPLICATION FOR LIFE INSURANCE

Nationwide Life Insurance Company • Corporate Insurance Markets, 1-11-401
• One Nationwide Plaza, Columbus, Ohio 43215-2220 • 1-877-351-8808

PART I – SECTION A (COMPLETE IN ALL CASES)

Section 1 EMPLOYER INFORMATION

Employer Name: _____ Tax I.D. No.: _____
Street Address: _____ City: _____ State: _____ Zip Code: _____

Section 2 INSURED

Insured Name (First, Middle, Last): _____
Home Telephone: (____) _____ Business Telephone: (____) _____
Sex: M F Age: _____ Date of Birth: _____
MM/DD/YYYY
Birth Place: _____ Social Security No.: _____
Street Address: _____ City: _____ State: _____ Zip Code: _____
Occupation: _____ Most recent hire date: _____ County: _____
Your work location address (including zip code): _____
Driver's license no. and issue state: _____

Section 3 OWNER (Complete if other than Employer)

Name: _____ Tax I.D. No.: _____
Street Address: _____ City: _____ State: _____ Zip Code: _____

Section 4 BENEFICIARY (Complete if other than Employer)

Name: _____ Relationship: _____
Social Security No.: _____

Section 5 NAME AND ADDRESS FOR MAIL (Correspondence/Statements/Notices/Confirmations)

Name: _____ Tax I.D. No.: _____
Street Address: _____ City: _____ State: _____ Zip Code: _____

Section 6 PLAN AND SPECIFIED AMOUNT

FLEXIBLE PREMIUM VARIABLE UNIVERSAL LIFE

A. Product Name _____
B. Non-Rider Specified Amount \$ _____
C. Supplemental Insurance Rider (SIR) Specified Amount
(Enter a Specified Amount only if electing SIR in Section 7) \$ _____
D. Total Specified Amount \$ _____
E. Death Benefit Option (If no option is selected, Option 1 is elected)
 Option 1 Death Benefit equals Specified Amount
 Option 2 Death Benefit equals Specified Amount plus Cash Value
 Option 3 Death Benefit equals Specified Amount plus
Accumulated Premiums (Initial election of Option 3 is irrevocable)

COMPONENT PERCENTAGES (For Next Generation CVUL Only)

A. Component A _____ %
B. Component B _____ %
C. Component C _____ %
D. Component D _____ %
Total (must equal 100%) _____ %

The percentages entered above will impact the charges on your policy/certificate.

Section 7 ENHANCEMENT BENEFIT

Schedule A _____ Schedule B _____
Must Equal 100%

Section 8 OPTIONAL BENEFIT RIDERS

Change of Insured Rider Other _____
 Supplemental Insurance Rider (SIR) (If elected enter Specified Amount in Section 6C.)

Section 9 PREMIUM TEST

- Guideline Premium Test
- Cash Value Accumulation Test

Section 10 PLANNED PREMIUM (check one only)

- Annual \$ _____
- Other \$ _____
- Semi-Annual \$ _____
- Single Premium \$ _____
- Quarterly \$ _____

Section 11 MEC STATUS

- MEC
- Non-MEC

Section 12 SPECIAL POLICY DATE REQUESTED

Section 13 QUESTIONS ABOUT INSURED

YES NO

- A. 1. Are you actively at work full time at least 30 hours or more per week, at your usual place of employment and physically performing all your customary duties of your regular occupation? **(If "No", give details below.)**
- 2. During the past three months, have you been hospitalized or otherwise absent from work due to any illness or injury for a total of four or more days? **(If "Yes", give reason for absence and details below.)**
- 3. Are you a U.S. citizen or have a permanent U.S. resident status and currently residing of the U.S.? **(If "No", give details below --- including visa type, country of citizenship, and plans to become a U.S. citizen.)**
- B. Have you used tobacco or nicotine in any form within the past 12 months? **(If "Yes", please provide details as to types, amounts (i.e., units per week/month), and date last used.)**
- C. Will the insurance applied for replace existing Life Insurance or Annuities on any person here proposed for insurance? **(If "Yes", give details below.)**

Details: _____

Section 14 TAXPAYER IDENTIFICATION NUMBER

TAXPAYER IDENTIFICATION NUMBER Certification—Under penalties of perjury, I certify that the number indicated is my correct Taxpayer Identification Number (or am waiting for a number to be issued to me). Under the Interest and Dividend Compliance Act of 1983, persons owning insurance are required to provide the Company with certification that their taxpayer identification number is correct. (For most individuals, this is their Social Security Number.) If you do not provide us with certification of this number, you may be subject to a \$50 penalty imposed by the Internal Revenue Service. In addition, we will be required to withhold a percentage (the current rate on IRS rulings) from interest and other payments we make to you (known as backup withholding). It is not an additional tax, since the amount withheld will be applied against the tax you owe. If withholding results in an overpayment of taxes, a refund may be obtained.

- Check this box if the Internal Revenue Service has notified you that you are not subject to the provisions of this law.

Otherwise, your signature on this application is certification that the taxpayer identification number on this application is true, correct, and complete.

Section 15 FRAUD STATEMENTS

KANSAS, MONTANA, NEW HAMPSHIRE, RHODE ISLAND, WYOMING 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.

ARKANSAS only: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

COLORADO only: IMPORTANT NOTICE – IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

NEW MEXICO only: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Section 16 AGREEMENT, AUTHORIZATION, AND SIGNATURES

I have read this application. I understand each of the questions. All of the answers and statements on this form are complete and true to the best of my knowledge and belief. I understand and agree that:

This application and any amendments to it, will become a part of the Policy/Certificate. They are the basis of any insurance issued upon this application.

I have read the above questions and answers and declare that they are complete and true to the best of my knowledge and belief. I also agree that no Agent/Representative of the Company shall: have the authority to waive a complete answer to any question in this Application; transfer insurability; make or alter any contract; or, waive any of the Company's other rights or requirements. I further agree that no insurance shall take effect unless and until the Policy/Certificate has been delivered to and accepted by the Owner; and, the initial premium is paid during the lifetime and prior to any change in insurability of the Proposed Insureds.

In those states where written consent is required by statute or State Insurance Department regulation, amendments as to plan, amount, age at issue, classification, or benefits will be made only with the Owner's written consent.

I agree that such coverage may continue after I terminate my employment relationship with my Employer.

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

Signature of Proposed Insured Signature of Authorized Officer (Owner)

Signature of Agent/Registered Representative Print Name and Title of Authorized Officer

PART I – SECTION B (COMPLETE FOR SIMPLIFIED ISSUE)

Section 17 PERSONAL AND MEDICAL INFORMATION

(For each "Yes" answer check the appropriate item and provide details in Section 18.)

Insured Name (First, Middle, Last) _____ Date of Birth _____
MM/DD/YYYY

A. Height: _____ Weight: _____

B. Name, address, and phone number of Personal Physician: _____

Date last consulted, reason and results: _____

C. List any medication you are currently using: _____

D. To the best of your knowledge and belief, in the past 10 years, have you consulted a licensed health care provider for, been treated for, taken medication for, or been diagnosed as having: **YES NO**

1. Elevated blood pressure, or any disorder of the heart or blood vessels; tumor or cancer; diabetes; stroke; or any disorder of the lungs, kidneys; gastrointestinal, urinary systems?

(If "Yes", give details in Section 18.).....

2. Alcoholism, narcotic addiction, drug use, hallucination, depression or anxiety?

(If "Yes", give details in Section 18.).....

3. AIDS (Acquired Immune Deficiency Syndrome), or any other AIDS-related condition, or received a positive result of an HIV (Human Immunodeficiency Virus) test?

(If "Yes", give details in Section 18.).....

E. In the past 3 years:

1. 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.)

2. Have you 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? **(If "Yes", give details in Section 18.)**

3. Have you had any application for Life or Health Insurance (or for reinstatement for Life or Health Insurance) declined, postponed, rated-up or limited? **(If "Yes", give details in Section 18.)**

Section 18 DETAILS OF PERSONAL AND MEDICAL HISTORY

Question No. & Letter	Dates	Details (Be specific. Give full names, addresses and telephone numbers (if available) of physicians, hospitals, etc.)

Section 19 AGREEMENT, AUTHORIZATION AND SIGNATURES

I have received the pre-notice form of the Fair Credit Reporting Act of 1970 and the Medical Information Bureau disclosure form. I certify that the Social Security Number given is correct and complete.

All the statements and answers above are complete and true to the best of my knowledge and belief, whether written by my own hand or not; and I agree that they are to be the basis for any insurance issued hereon.

I authorize: any licensed physician or medical practitioner; any hospital, clinic 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, or its reinsurers. This authorization, 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.

Month Day Year

Signature of Proposed Insured

I have truly and accurately recorded all Proposed Insured's answers on this application and have witnessed his/her/their signature(s) hereon.

To the best of my knowledge, the insurance applied for will will not (check one) replace any life insurance or annuity.

Signature of Registered Representative

Print Name of Registered Representative

Firm

License ID No.

PART I – SECTION C (COMPLETE FOR MEDICAL ISSUE)

Section 17 PERSONAL INFORMATION

Insured Name (First, Middle, Last): _____ Date of Birth: _____

Total Amount of Life Insurance: _____ MM/DD/YYYY

A. In force: _____ B. Pending with other companies: _____

(For each "Yes" answer check the appropriate item and provide details in Section 19.) **YES NO**

- C. 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? **(If "Yes", give details in Section 19.)**
- D. 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 in Section 19.)**.....
- E. 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? **(If "Yes", provide details, driver's license # and state of issue in Section 19.)**.....
- F. 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.)**
- G. Do you plan to travel or reside outside of the United States or Canada? **(If "Yes", give details in Section 19.)**.....

Not required if Nationwide paramed or exam form is being completed.

Section 18 MEDICAL QUESTIONS AND INFORMATION

(For each "Yes" answer check the appropriate item and provide details in Section 19.)

A. Height: _____ Weight: _____

B. Name, address, and phone number of Personal Physician: _____

Date last consulted, reason and results: _____

C. List any medication you are currently using: _____

D. To the best of your knowledge and belief, in the past 10 years has anyone here proposed for insurance consulted a licensed health care provider for, been treated for, taken medication for, or been diagnosed as having: **YES NO**

- 1. AIDS (Acquired Immune Deficiency Syndrome), or any other AIDS-related condition, or received a positive result of an HIV (Human Immunodeficiency Virus) test?
- 2. 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?
- 3. Headaches, seizures, epilepsy, stroke, Alzheimer's disease, dementia, Parkinson's disease, multiple sclerosis, or any other brain or nervous disorder?
- 4. Depression, neurosis, affective disorder, psychosis, or any other mental or emotional disorder?
- 5. Asthma, emphysema, chronic bronchitis, tuberculosis, or any other disease of the lungs or respiratory system?.....
- 6. Colitis, ulcer, persistent diarrhea, rectal bleeding, or any other disease or disorder of the esophagus or digestive tract?
- 7. 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?
- 8. Diabetes, hepatitis, cirrhosis or any other disease of the liver, pancreas, or thyroid?
- 9. Cancer, or any malignant or benign tumor or cyst, or any chronic disease of the skin or lymph glands?.....
- 10. Arthritis, rheumatoid arthritis, osteoporosis; or any paralysis or chronic back or muscle condition?
- 11. Alcoholism, narcotic addiction, drug use, or hallucinations?
- 12. Any disease or disorder of the eyes, ears, nose or throat?

E. To the best of your knowledge and belief, in the past 5 years, has anyone here proposed for insurance:

- 1. 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 in Section 19.)
- 2. Had any disease, disorder, injury, or operation not already disclosed on this application?
- 3. Had any x-rays, electrocardiograms, or other medical tests for reasons not already disclosed on this application?
- 4. Been medically advised to have any surgery, hospitalization, treatment or test that was not completed or results that you have not received?

IMPORTANT NOTICE

DETACH AND GIVE TO PROPOSED INSURED

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 for amounts over \$5,000,000 whereby information is obtained through personal interviews with you, your employer and your financial advisor or accountant. This inquiry will include personal and financial information except as 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 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. Requests for additional information should be addressed to Nationwide Life Insurance Company, Corporate Insurance Markets, One Nationwide Plaza, 1-11-401, Columbus, Ohio 43215-2220.

MEDICAL INFORMATION BUREAU DISCLOSURE NOTICE

Information regarding your insurability will be treated as confidential. Nationwide Life 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 web address of the Bureau's information office is www.mib.com.]

Nationwide Life 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.



INSURANCE SCHEDULE FOR CORPORATE MASTER APPLICATION

Nationwide Life Insurance Company • Corporate Insurance Markets, 1-11-401
• One Nationwide Plaza, Columbus, OH 43215-2220 • 1-877-351-8808

Section 1 CORPORATION INFORMATION

Corporation Name: _____

Insurance Schedule for: _____, Owner

Section 2 INSURED INFORMATION

No.	Insured Last Name	Insured First Name	Social Security No.	Date Of Birth	Age as of (Date) MM/DD/YYYY	Sex M/F	Smoking Status (N/S)	Planned Annual Premium	Other Premium Paid at Issue	Specified Amount (Base Coverage)	Supplemental Insurance Rider (Term Coverage)	Total Coverage	Death Benefit Option (1/2/3)
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The following shall constitute a separate application and shall become a part of each policy or certificate issued on the above individuals:

- 1) This Insurance Schedule
- 2) Master Application
- 3) Variable Supplement
- 4) Consent to Insurance Forms

Case Level Enhancement Benefit

Schedule A _____

Schedule B _____

Total (must equal 100 %) _____

Policy or Certificate Date: _____

The **Policy or Certificate Owner certifies** that the above information is complete and true to the best of its knowledge and belief.

The **Employer certifies** that, as of the Policy Date and the date Nationwide receives the initial premium, all of the above individuals were actively at work full time at least 30 hours or more per week, at their usual place of employment and have not missed a total of four or more days due to illness or injury or been hospitalized in the past 90 days.

Signature of **Owner (Authorized Officer/Trustee)**

Printed Name and Title of the **Owner's Authorized Officer/Trustee**

Signed at City/State

Date

Signature of **Employer (Authorized Officer)** (if other than the Owner)

Printed Name and Title of the **Employer's Authorized Officer**

Signed at City/State

Date

In accordance with the policy provisions, the Policy Date is the effective date for all coverage. The above individuals must satisfy the Actively-at-Work criteria as of the Policy Date and the date Nationwide receives the initial premium. In the event a policy or certificate is issued on any individual who does not meet this requirement, the policy or certificate will be treated as if it were never issued. Under these circumstances, Nationwide's liability will be limited to a refund of the amount specified by the laws of the state in which the contract was issued.

SERFF Tracking Number: NWPA-126337763 State: Arkansas
Filing Company: Nationwide Life Insurance Company State Tracking Number: 43779
Company Tracking Number: COLI-3003-E-US3
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Application for Life Insurance
Project Name/Number: /

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Certification Attachment: AR CERT.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application Comments: Application filing for: COLI-3003-E-US3, Application for Life Insurance COLI-3037-A, Insurance Schedule		



ARKANSAS

Certificate of Compliance

Insurer Nationwide Life Insurance Company

Form Numbers: COLI-3003-E-US3, Application for Life Insurance
COLI-3037, Insurance Schedule

I have reviewed or supervised the review of the above forms. To the best of my knowledge and belief, they are in compliance with the rules and requirements of Regulation 19 and 49 of the Arkansas Statute, ACA 23-80-206, ACA 23-79-138, and Bulletin 11-88.

You have our assurance that any maximum cost of insurance changes and/or any minimum accumulation rates will be re-filed with the department

These forms also meet the Flesch readability requirements as explained in Title 23-80-206 of the Arkansas Insurance Code.

A handwritten signature in black ink, appearing to read "John H. Crow".

John H. Crow, ChFC, CLU, FLMI
Associate Vice President
NF Compliance
Date: 10-14-09