

SERFF Tracking Number: NWPA-126637026 State: Arkansas
 Filing Company: Nationwide Life and Annuity Insurance Company State Tracking Number: 45733
 Company Tracking Number: COLI-3000-D-AR
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: COLI Application Revision - NLAIC
 Project Name/Number: /

Filing at a Glance

Company: Nationwide Life and Annuity Insurance Company

Product Name: COLI Application Revision - NLAIC SERFF Tr Num: NWPA-126637026 State: Arkansas

TOI: L08 Life - Other

SERFF Status: Closed-Approved- Closed State Tr Num: 45733

Sub-TOI: L08.000 Life - Other

Co Tr Num: COLI-3000-D-AR

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

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

Disposition Date: 05/21/2010

Date Submitted: 05/20/2010

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Pending

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

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: 05/21/2010

Explanation for Other Group Market Type:

State Status Changed: 05/21/2010

Deemer Date:

Created By: Dan Gallion

Submitted By: Dan Gallion

Corresponding Filing Tracking Number:

Filing Description:

Re: Form COLI-3000-D-AR, Corporate Master Application

Form COLI-3001-E-US4, Corporate Enrollment Form Consent to Insurance

Form COLI-3003-F-US3, Application for Life Insurance

NAIC #92657

SERFF Tracking Number: NWPA-126637026 State: Arkansas
Filing Company: Nationwide Life and Annuity Insurance Company State Tracking Number: 45733
Company Tracking Number: COLI-3000-D-AR
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: COLI Application Revision - NLAIC
Project Name/Number: /

Enclosed for filing, subject to your approval, are forms COLI-3000-D-AR, Corporate Master Application, COLI-3001-E-US4, Corporate Enrollment Form Consent to Insurance, and COLI-3003-F-US3, Application for Life Insurance. These application forms are new forms and will not replace any previously approved forms for our Nationwide Life and Annuity Insurance Company.

These forms are currently being used with our Individual and Group Flexible Premium Variable Universal Life Insurance products for our Nationwide Life Insurance Company. We would now like to use these applications in conjunction with form NWLA-370-M2, Flexible Premium Adjustable Universal Life Insurance Policy, approved in your department on 03-11-08 (SERFF #NWPA-125518784) and form NWLA-440-M2, Flexible Premium Adjustable Variable Universal Life Insurance, approved in your department on 04-08-08 (SERFF #NWPA-125558492).

These applications will be used to provide simplified, guaranteed, or regular underwriting using the existing rates for qualified plans sold to individuals and qualified and non-qualified plans sold as part of an employee/employer case. The only revision to all forms is the addition of the Nationwide Life and Annuity Insurance Company to the top of the form. Because of this change, we are filing the revised forms concurrently for our Nationwide Life Insurance Company.

COLI-3000-D-AR and COLI-3001-E-US4 will be used when coverage is provided for a group of individuals on a Guaranteed Issue basis when the policies are to be corporate owned.

COLI-3003-G-US3 will be used for Simplified Issue and Regular Issue underwriting as well as for Guaranteed Issue underwriting when the policy is individually owned.

These forms have been written in a readable fashion and have the following Flesch scores:

COLI-3000-D-AR - 48.9
COLI-3001-E-US4 - 55.1
COLI-3003-F-US3 - 53.3

These forms have been filed concurrently in our state of domicile (Ohio).

NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY
Home Office: One Nationwide Plaza • Columbus, Ohio 43215-2220
Page Two

SERFF Tracking Number: NWPA-126637026 State: Arkansas
Filing Company: Nationwide Life and Annuity Insurance Company State Tracking Number: 45733
Company Tracking Number: COLI-3000-D-AR
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: COLI Application Revision - NLAIC
Project Name/Number: /

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

Sincerely,

Dan Gallion
Specialist
NF Regulatory Filings &
Operations Team, 1-33-102
Phone: (614) 249-8116
Fax: (614) 249-2112
E-Mail: galliod@nationwide.com

DG

Enclosures:

1. General Information
2. Certification
3. Form COLI-3000-D-AR, Corporate Master Application
4. Form COLI-3001-E-US4, Corporate Enrollment Form Consent to Insurance
5. Form COLI-3003-F-US3, Application for Life Insurance

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 and Annuity Insurance CoCode: 92657 State of Domicile: Ohio
Company
One Nationwide Plaza Group Code: 140 Company Type:
1-10-03 Group Name: State ID Number:

SERFF Tracking Number: NWPA-126637026 State: Arkansas
Filing Company: Nationwide Life and Annuity Insurance Company State Tracking Number: 45733
Company Tracking Number: COLI-3000-D-AR
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: COLI Application Revision - NLAIC
Project Name/Number: /
Columbus, OH 43215 FEIN Number: 31-1000740
(800) 882-2822 ext. [Phone]

Filing Fees

Fee Required? Yes
Fee Amount: \$150.00
Retaliatory? No
Fee Explanation: \$50.00 per form.
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Nationwide Life and Annuity Insurance Company	\$150.00	05/20/2010	36695398

SERFF Tracking Number: NWPA-126637026 State: Arkansas
Filing Company: Nationwide Life and Annuity Insurance Company State Tracking Number: 45733
Company Tracking Number: COLI-3000-D-AR
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: COLI Application Revision - NLAIC
Project Name/Number: /

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	05/21/2010	05/21/2010

SERFF Tracking Number: NWPA-126637026 State: Arkansas
Filing Company: Nationwide Life and Annuity Insurance Company State Tracking Number: 45733
Company Tracking Number: COLI-3000-D-AR
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: COLI Application Revision - NLAIC
Project Name/Number: /

Disposition

Disposition Date: 05/21/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: NWPA-126637026 State: Arkansas
 Filing Company: Nationwide Life and Annuity Insurance Company State Tracking Number: 45733
 Company Tracking Number: COLI-3000-D-AR
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: COLI Application Revision - NLAIC
 Project Name/Number: /

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Form	Corporate Master Application		Yes
Form	Corporate Enrollment Form Consent to Insurance		Yes
Form	Application for Life Insurance		Yes

SERFF Tracking Number: NWPA-126637026 State: Arkansas
 Filing Company: Nationwide Life and Annuity Insurance Company State Tracking Number: 45733
 Company Tracking Number: COLI-3000-D-AR
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: COLI Application Revision - NLAIC
 Project Name/Number: /

Form Schedule

Lead Form Number: COLI-3000-D-AR

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	COLI-3000-D-AR	Application/ Enrollment Form	Corporate Master Application	Initial		48.900	COLI-3000-D-AR.pdf
	COLI-3001-E-US4	Application/ Enrollment Form	Corporate Enrollment Form Consent to Insurance	Initial		55.100	COLI-3001-E-US4.pdf
	COLI-3003-F-US3	Application/ Enrollment Form	Application for Life Insurance	Initial		53.300	COLI-3003-F-US3.pdf



CORPORATE MASTER APPLICATION

Nationwide Life Insurance Company • Nationwide Life and Annuity Insurance Company
 • Corporate Insurance Markets, 1-11-401 • One Nationwide Plaza, Columbus, Ohio 43215-2220 • 1-877-351-8808
 Case No.: _____

Section 1 CORPORATION INFORMATION

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

Section 2 OWNER INFORMATION

Owner Name (if other than Corporation): _____
 Owner Tax I.D. No.: _____ Trust Other (specify): _____
 Owner Address: Street Address: _____
 City: _____ State: _____ Zip Code: _____
 Check this box if this is the primary mailing address. If not, complete Section 4

Section 3 BENEFICIARY INFORMATION

Beneficiary (if other than Corporation): _____

Section 4 POLICY/CERTIFICATE INFORMATION

Name and Address for Mail (correspondence/statements/notices/confirmations):
 Name: _____
 Street Address: _____ City: _____ State: _____ Zip Code: _____

Section 5 PRODUCT INFORMATION

Product Name: _____
 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 + Cash Value
 Option 3 Death Benefit equals Specified Amount + Accumulated Premiums
 Initial election of Option 3 is irrevocable.

Section 6 PREMIUM TEST

Guideline Premium Test Cash Value Accumulation Test

Section 7 PLANNED PREMIUM

Planned Premium (Check only one):
 Annual \$ _____ Semi-Annual \$ _____
 Quarterly \$ _____ Other \$ _____
 Planned Premium Payment Period - Number of years: _____

Section 8 MEC STATUS

MEC Status: MEC Non-MEC

Section 9 OPTIONAL BENEFIT RIDERS

Yes No Change of Insured Rider
 Yes No Supplemental Insurance Rider
 Yes No Other (specify) _____

If you have any questions, please contact your New Business Coordinator at 1-877-351-8808

Section 10 REPLACEMENT

Will this insurance applied for replace or cause a change in, or involve a loan under, on any life insurance proposed here or any life insurance or annuity policy owned by the Owner? Yes No

If "Yes," give the following information: Company _____

Section 11 SPECIAL POLICY/CERTIFICATE DATE REQUESTED

_____/_____/_____
MM/DD/YYYY

Insurance under this application to be applied for in accordance with the insurance schedule and request for consent to insurance forms. For all future additions, the originally completed Master Application will remain in effect for one (1) year, and all new policies will be issued with a current specified date.

Section 12 TAXPAYER IDENTIFICATION NUMBER

TAXPAYER IDENTIFICATION NUMBER Certification — Under penalties of perjury, I certify that the number shown above 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 policies are required to provide the Company with certification that their Taxpayer Identification Number is correct. 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 based 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 13 AGREEMENT, AUTHORIZATION AND SIGNATURES

I understand that the Death Benefit under a variable life insurance policy/certificate may increase or decrease, depending on the investment return of 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/Certificate is in force. The contract value may increase or decrease on any day, depending on the investment return for the policy/certificate. No minimum contract value is guaranteed.

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 agree that this Corporate Master Application and Employee consent to insurance and the insurance schedule shall form a part of any Policy/Certificate issued. 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 me; and, the initial premium is paid during the lifetime and prior to any change in insurability of the Proposed Insureds.

Changes or corrections made by the Company are ratified by the Owner upon acceptance of a contract containing this Application with the noted changes or corrections. 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.

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.

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

Signature of Applicant/Owner/Authorized Officer

Print Name and Title of Applicant/Owner/Authorized Officer

Signature of Registered Representative

Print Name of Registered Representative

List individuals authorized to sign on behalf of the Owner.

Signature

Signature

Printed Name

Printed Name

Title

Title

If you have any questions, please contact your New Business Coordinator at 1-877-351-8808



APPLICATION FOR LIFE INSURANCE

Nationwide Life Insurance Company • Nationwide Life and Annuity 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 \$ _____
- Semi-Annual \$ _____
- Quarterly \$ _____
- Other \$ _____
- Single Premium \$ _____

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 in 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, or 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.)**

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/Nationwide Life and Annuity 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/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 web 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.

SERFF Tracking Number: NWPA-126637026 State: Arkansas
Filing Company: Nationwide Life and Annuity Insurance Company State Tracking Number: 45733
Company Tracking Number: COLI-3000-D-AR
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: COLI Application Revision - NLAIC
Project Name/Number: /

Supporting Document Schedules

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

	Item Status:	Status Date:
Satisfied - Item: Application Comments: COLI-3000-D-AR, Corporate Master Application COLI-3001-E-US4, Corporate Enrollment Form Consent to Insurance COLI-3003-F-US3, Application for Life Insurance		



ARKANSAS

Certificate of Compliance

Insurer Nationwide Life and Annuity Insurance Company

Form Numbers: COLI-3000-D-AR, Corporate Master Application
COLI-3001-E-US4, Corporate Enrollment Form Consent to Insurance
COLI-3003-F-US3, Application for Life Insurance

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: 05-20-10