

SERFF Tracking Number: NWPA-127635990 State: Arkansas  
 Filing Company: Nationwide Life and Annuity Insurance Company State Tracking Number: 49890  
 Company Tracking Number: COLI-3000-E-US5; COLI-3003-G-US3; COLI-3007-C-US4; COLI-3008-B-US3 - NWLA  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: COLI-3000-E-US5; COLI-3003-G-US3; COLI-3007-C-US4; COLI-3008-B-US3 - NWLA  
 Project Name/Number: COLI-3000-E-US5; COLI-3003-G-US3; COLI-3007-C-US4; COLI-3008-B-US3 - NWLA /COLI-3000-E-US5; COLI-3003-G-US3; COLI-3007-C-US4; COLI-3008-B-US3 - NWLA

## Filing at a Glance

Company: Nationwide Life and Annuity Insurance Company

Product Name: COLI-3000-E-US5; COLI-3003- SERFF Tr Num: NWPA-127635990 State: Arkansas  
 G-US3; COLI-3007-C-US4; COLI-3008-B-US3 -  
 NWLA

TOI: L08 Life - Other

SERFF Status: Closed-Approved- State Tr Num: 49890  
 Closed

Sub-TOI: L08.000 Life - Other

Co Tr Num: COLI-3000-E-US5; State Status: Approved-Closed  
 COLI-3003-G-US3; COLI-3007-C-  
 US4; COLI-3008-B-US3 - NWLA

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Amy Burchette, Sandra  
 Davies, Dan Gallion, Cindy Malloy,  
 Clara Pollard, Carrie Ruhlen,  
 Georgia Sollars, Darcy L. Spangler,  
 Drema Wallace, Leslie Hernandez,  
 Darcy Spangler

Date Submitted: 09/27/2011

Disposition Status: Approved-  
 Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: COLI-3000-E-US5; COLI-3003-G-US3; COLI-3007-C- Status of Filing in Domicile: Pending  
 US4; COLI-3008-B-US3 - NWLA

Project Number: COLI-3000-E-US5; COLI-3003-G-US3; COLI-3007-C- Date Approved in Domicile:  
 US4; COLI-3008-B-US3 - NWLA

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 10/04/2011

State Status Changed: 10/04/2011

Deemer Date:

Created By: Carrie Ruhlen

SERFF Tracking Number: NWPA-127635990 State: Arkansas  
Filing Company: Nationwide Life and Annuity Insurance Company State Tracking Number: 49890  
Company Tracking Number: COLI-3000-E-US5; COLI-3003-G-US3; COLI-3007-C-US4; COLI-3008-B-US3 - NWLA  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: COLI-3000-E-US5; COLI-3003-G-US3; COLI-3007-C-US4; COLI-3008-B-US3 - NWLA  
Project Name/Number: COLI-3000-E-US5; COLI-3003-G-US3; COLI-3007-C-US4; COLI-3008-B-US3 - NWLA /COLI-3000-E-US5; COLI-3003-G-US3;  
COLI-3007-C-US4; COLI-3008-B-US3 - NWLA

Submitted By: Carrie Ruhlen

Corresponding Filing Tracking Number: COLI-3000-E-US5; COLI-3003-G-US3; COLI-3007-C-US4; COLI-3008-B-US3 - NWLA

Filing Description:

Re: COLI-3000-E-US5 Corporate Master Application  
COLI-3003-G-US3 Corporate Application for Life Insurance  
COLI-3007-C-US4 Corporate Application for Policy/Certificate Change  
COLI-3008-B-US3 Corporate Master Application Change Form  
NAIC #92657

Enclosed for filing, subject to your approval, are forms COLI-3000-E-US5, Corporate Master Application, COLI-3003-G-US3, Corporate Application for Life Insurance, COLI-3007-C-US4, Corporate Application for Policy/Certificate Change, and COLI-3008-B-US3, Corporate Master Application Change Form.

EXISTING FORM APPROVAL DATE SERFF # NEW FORM

COLI-3000-D-AR 05-21-2010 NWPA-126637026  
State Tr #45733 COLI-3000-E-US5  
COLI-3003-F-US3 05-21-2010 NWPA-126637026  
State Tr #45733 COLI-3003-G-US3  
COLI-3007-B-AR 02-09-2007 NWPA-125094882  
State Tr #35002 COLI-3007-C-US4  
COLI-3015-B-AR 02-08-2007 NWPA-125094401  
State Tr #35001 COLI-3007-C-US4  
COLI-3008-A-AR 02-09-2007 NWPA-125094882  
State Tr #35002 COLI-3008-B-US3  
COLI-3016-B 02-08-2007 NWPA-125094401  
State Tr #35001 COLI-3008-B-US3

The following revisions were made:

COLI-3000-E-US5

1. Bracketed the address.
2. Changed name of Department from Corporate Insurance Markets to Nationwide Business Solutions Group.
3. In Section 9, added Overloan Protection Rider.
4. In Section 10, added 2 new financial questions. Re-arranged section.
5. In Section 9, added to title line (Subject to Availability).

SERFF Tracking Number: NWPA-127635990 State: Arkansas  
Filing Company: Nationwide Life and Annuity Insurance Company State Tracking Number: 49890  
Company Tracking Number: COLI-3000-E-US5; COLI-3003-G-US3; COLI-3007-C-US4; COLI-3008-B-US3 - NWLA  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: COLI-3000-E-US5; COLI-3003-G-US3; COLI-3007-C-US4; COLI-3008-B-US3 - NWLA  
Project Name/Number: COLI-3000-E-US5; COLI-3003-G-US3; COLI-3007-C-US4; COLI-3008-B-US3 - NWLA /COLI-3000-E-US5; COLI-3003-G-US3;  
COLI-3007-C-US4; COLI-3008-B-US3 - NWLA

#### COLI-3003-G-US3

1. Bracketed Nationwide's address and phone number and the MIB address and phone number.
2. Changed name of Department from Corporate Insurance Markets to Nationwide Business Solutions Group.
3. In Section 4, added Beneficiary Address.
4. In Section 6, removed Component Percentages section and moved it to Section 7.
5. In Section 7, added a section for Future Executive Universal Life.
6. In Section 8, added to title line (For Future Corporate Variable Universal Life Only).
7. In Section 9, added to title line (Subject to Availability).
8. In Section 9, added Overloan Protection Rider.
9. In Section 16, adjusted states available.
10. In Part A, Section 14, Part B, Section 18, and Part C, Section 18, added 2 new financial questions.
11. In Part B, Section 20 and Part C, Section 21, updated the I authorize paragraph to be HIPAA Compliant.
12. Added Company name and address to the top of the last page.
13. Replaced all Medical Information Bureau and Bureau wording with MIB, Inc.

#### COLI-3007-C-US4

1. Added Nationwide logo.
2. Updated the format of the application.
3. Added the address and added phone number to the front page.
4. Bracketed Nationwide's address and phone number and the MIB address and phone number.
5. Changed application to be used with individual and group products.
6. In Part B, Section 9E, updated AIDS question.
7. In Part B, Section 9 and Part C, Section 11, added 2 new financial questions.
8. In Part B, Section 11 and Part C, Section 13, updated the I authorize paragraph to be HIPAA Compliant.
9. Added Company name and address to the top of the last page.
10. Added page numbers.
11. Replaced all Medical Information Bureau and Bureau wording with MIB, Inc.

#### COLI-3008-B-US3

1. Added Nationwide logo.
2. Updated the format of the application.
3. Bracketed Nationwide's address and phone number.
4. Changed application to be used with individual and group products.
5. Removed Section 4.
6. Moved Section 3 to Section 4.
7. Added new Section 3 Representations, which adds 2 new financial questions.
8. The New Business Coordinator phone number was placed at the bottom of page 3A and 3B.

SERFF Tracking Number: NWPA-127635990 State: Arkansas  
 Filing Company: Nationwide Life and Annuity Insurance Company State Tracking Number: 49890  
 Company Tracking Number: COLI-3000-E-US5; COLI-3003-G-US3; COLI-3007-C-US4; COLI-3008-B-US3 - NWLA  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: COLI-3000-E-US5; COLI-3003-G-US3; COLI-3007-C-US4; COLI-3008-B-US3 - NWLA  
 Project Name/Number: COLI-3000-E-US5; COLI-3003-G-US3; COLI-3007-C-US4; COLI-3008-B-US3 - NWLA /COLI-3000-E-US5; COLI-3003-G-US3;  
 COLI-3007-C-US4; COLI-3008-B-US3 - NWLA

- 9. Added the address and phone number to the front page, and page 3A and 3B.
- 10. Updated titles in Section 1 on page 3A and 3B.
- 11. Added page numbers.

These forms are being filed concurrently in our state of domicile. Form COLI-3000-E-US5, COLI-3003-G-US3, COLI-3007-C-US4, and COLI-3008-B-US3 have been written in a readable fashion and attain Flesch scores of 48.9, 46.9, 44.3, and 52.0.

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

## Company and Contact

### Filing Contact Information

Carrie Ruhlen, Compliance Specialist ruhlenc@nationwide.com  
 One Nationwide Plaza 614-249-8042 [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:  
 Columbus, OH 43215 FEIN Number: 31-1000740  
 (800) 882-2822 ext. [Phone]

-----

## Filing Fees

Fee Required? Yes  
 Fee Amount: \$200.00  
 Retaliatory? Yes  
 Fee Explanation: \$50 per form x 4 = \$200  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Nationwide Life and Annuity Insurance	\$200.00	09/27/2011	52175869

SERFF Tracking Number: NWPA-127635990 State: Arkansas  
Filing Company: Nationwide Life and Annuity Insurance Company State Tracking Number: 49890  
Company Tracking Number: COLI-3000-E-US5; COLI-3003-G-US3; COLI-3007-C-US4; COLI-3008-B-US3 - NWLA  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: COLI-3000-E-US5; COLI-3003-G-US3; COLI-3007-C-US4; COLI-3008-B-US3 - NWLA  
Project Name/Number: COLI-3000-E-US5; COLI-3003-G-US3; COLI-3007-C-US4; COLI-3008-B-US3 - NWLA /COLI-3000-E-US5; COLI-3003-G-US3;  
COLI-3007-C-US4; COLI-3008-B-US3 - NWLA

**Company**

SERFF Tracking Number: NWPA-127635990 State: Arkansas  
Filing Company: Nationwide Life and Annuity Insurance Company State Tracking Number: 49890  
Company Tracking Number: COLI-3000-E-US5; COLI-3003-G-US3; COLI-3007-C-US4; COLI-3008-B-US3 - NWLA  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: COLI-3000-E-US5; COLI-3003-G-US3; COLI-3007-C-US4; COLI-3008-B-US3 - NWLA  
Project Name/Number: COLI-3000-E-US5; COLI-3003-G-US3; COLI-3007-C-US4; COLI-3008-B-US3 - NWLA /COLI-3000-E-US5; COLI-3003-G-US3;  
COLI-3007-C-US4; COLI-3008-B-US3 - NWLA

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	10/04/2011	10/04/2011

SERFF Tracking Number: NWPA-127635990 State: Arkansas  
Filing Company: Nationwide Life and Annuity Insurance Company State Tracking Number: 49890  
Company Tracking Number: COLI-3000-E-US5; COLI-3003-G-US3; COLI-3007-C-US4; COLI-3008-B-US3 - NWLA  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: COLI-3000-E-US5; COLI-3003-G-US3; COLI-3007-C-US4; COLI-3008-B-US3 - NWLA  
Project Name/Number: COLI-3000-E-US5; COLI-3003-G-US3; COLI-3007-C-US4; COLI-3008-B-US3 - NWLA /COLI-3000-E-US5; COLI-3003-G-US3;  
COLI-3007-C-US4; COLI-3008-B-US3 - NWLA

## Disposition

Disposition Date: 10/04/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: NWPA-127635990 State: Arkansas  
 Filing Company: Nationwide Life and Annuity Insurance Company State Tracking Number: 49890  
 Company Tracking Number: COLI-3000-E-US5; COLI-3003-G-US3; COLI-3007-C-US4; COLI-3008-B-US3 - NWLA  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: COLI-3000-E-US5; COLI-3003-G-US3; COLI-3007-C-US4; COLI-3008-B-US3 - NWLA  
 Project Name/Number: COLI-3000-E-US5; COLI-3003-G-US3; COLI-3007-C-US4; COLI-3008-B-US3 - NWLA /COLI-3000-E-US5; COLI-3003-G-US3;  
 COLI-3007-C-US4; COLI-3008-B-US3 - NWLA

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Statement of Variability		Yes
Form	Corporate Master Application		Yes
Form	Corporate Application for Life Insurance		Yes
Form	Corporate Application for Policy/Certificate Change		Yes
Form	Corporate Master Application Change From		Yes

SERFF Tracking Number: NWPA-127635990 State: Arkansas  
 Filing Company: Nationwide Life and Annuity Insurance Company State Tracking Number: 49890  
 Company Tracking Number: COLI-3000-E-US5; COLI-3003-G-US3; COLI-3007-C-US4; COLI-3008-B-US3 - NWLA  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: COLI-3000-E-US5; COLI-3003-G-US3; COLI-3007-C-US4; COLI-3008-B-US3 - NWLA  
 Project Name/Number: COLI-3000-E-US5; COLI-3003-G-US3; COLI-3007-C-US4; COLI-3008-B-US3 - NWLA /COLI-3000-E-US5; COLI-3003-G-US3;  
 COLI-3007-C-US4; COLI-3008-B-US3 - NWLA

## Form Schedule

### Lead Form Number: COLI-3000-E-US5

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	COLI-3000-E-US5	Application/Corporate Enrollment Form	Master Application	Revised	Replaced Form #: COLI-3000-D-AR Previous Filing #: 45733	48.900	COLI-3000-E-US5 JD.pdf
	COLI-3003-G-US3	Application/Corporate Enrollment Form	Application for Life Insurance	Revised	Replaced Form #: COLI-3003-F-US3 Previous Filing #: 45733	46.900	COLI-3003-G-US3 JD.pdf
	COLI-3007-C-US4	Application/Corporate Enrollment Form	Application for Policy/Certificate Change	Revised	Replaced Form #: COLI-3007-B-AR; COLI-3015-B-AR Previous Filing #: 35002 & 35001	44.300	COLI-3007-C-US4 JD.pdf
	COLI-3008-B-US3	Application/Corporate Enrollment Form	Master Application Change From	Revised	Replaced Form #: COLI-3008-A-AR; COLI-3016-A-AR Previous Filing #: 35002 & 35001	52.000	COLI-3008-B-US3 JD.pdf



# CORPORATE MASTER APPLICATION

Nationwide Life Insurance Company •  Nationwide Life and Annuity Insurance Company  
[• Nationwide Business Solutions Group, 1-11-401 • One Nationwide Plaza, Columbus, Ohio 43215-2220 • 1-877-351-8808]

Case No.: \_\_\_\_\_

## Section 1 CORPORATION INFORMATION

Corporation Name: Any Corporation Corporation Tax I.D. No.: 00-0000000

Corporation Address: Street Address: One Any Street

City: Any City State: Any State Zip Code: Any Zip

## Section 2 OWNER INFORMATION

Owner Name (if other than Corporation): John Doe

Owner Tax I.D. No.: 00-0000000  Trust  Other (specify): \_\_\_\_\_

Owner Address: Street Address: One Any Street

City: Any City State: Any State Zip Code: Any Zip

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 (Subject to Availability)

- Yes  No Change of Insured Rider
- Yes  No Overloan Protection Rider
- Yes  No Supplemental Insurance Rider (SIR)
- Yes  No Other (specify) \_\_\_\_\_

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

**Section 10 REPRESENTATIONS**

**Replacement**

1. 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 \_\_\_\_\_

**Secondary Market**

1. 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? **YES** **NO**  
 (If "Yes", give details below.) .....
2. Have you ever sold any life insurance policy to a life settlement company, trust, limited liability corporation, viatical, or other secondary market purchaser? (If "Yes", give details below.) .....
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**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.

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

**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 Any Place on January 3, 2011  
City State Month Day Year

John Doe  
Signature of Applicant/Owner/Authorized Officer

John Doe  
Print Name and Title of Applicant/Owner/Authorized Officer

Any Representative  
Signature of Registered Representative

Any Officer CEO  
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  
[ Nationwide Business Solutions Group, 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: Any Employer Tax I.D. No.: 00-0000000  
Street Address: One Any Street City: Any City State: Any State Zip Code: Any Zip

### Section 2 INSURED

Insured Name (First, Middle, Last): John Doe  
Home Telephone: ( 000 ) 000-0000 Business Telephone: ( 000 ) 000-0000  
Sex:  M  F Age: 35 Date of Birth: 02/07/65  
MM/DD/YYYY  
Birth Place: Any Place Social Security No.: 000-00-0000  
Street Address: One Any Street City: Any City State: Any State Zip Code: Any Zip  
Occupation: President of Any Employer Most recent hire date: 07/01/1965 County: Any County  
Your work location address (including zip code): 00000-0000  
Driver's license no. and issue state: GL00000 Any 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.: \_\_\_\_\_  
Beneficiary Address: \_\_\_\_\_

### 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

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)

**Section 7 COMPONENT PERCENTAGES**

**For Next Generation CVUL Only**

- A. Component A \_\_\_\_\_
- B. Component B \_\_\_\_\_
- C. Component C \_\_\_\_\_
- D. Component D \_\_\_\_\_

Total (must equal 100%) \_\_\_\_\_

**For Future Executive Universal Life Only**

- A. Component A \_\_\_\_\_
- B. Component B \_\_\_\_\_
- Total (must equal 100%) \_\_\_\_\_

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

**Section 8 ENHANCEMENT BENEFIT (For Future Corporate Variable Universal Life Only)**

Schedule A \_\_\_\_\_ Schedule B \_\_\_\_\_  
Must Equal 100%

**Section 9 OPTIONAL BENEFIT RIDERS (Subject to Availability)**

- Yes  No Change of Insured Rider
- Yes  No Overloan Protection Rider
- Yes  No Supplemental Insurance Rider
- Yes  No Other (specify) \_\_\_\_\_

**Section 10 PREMIUM TEST**

- Guideline Premium Test
- Cash Value Accumulation Test

**Section 11 PLANNED PREMIUM (check one only)**

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

**Section 12 MEC STATUS**

- MEC
- Non-MEC

**Section 13 SPECIAL POLICY DATE REQUESTED**

**Section 14 REPRESENTATIONS**

- |                                                                                                                                                                                                                                                                     |                                     | 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? <b>(If "No", give details below.)</b> .....                          | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |
| 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? <b>(If "Yes", give reason for absence and details below.)</b> .....                                        | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you a U.S. citizen or have a permanent U.S. resident status and currently residing in the U.S.? <b>(If "No", give details below — including visa type, country of citizenship, and plans to become a U.S. citizen.)</b> .....                                | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |
| B. Have you used tobacco or nicotine in any form within the past 12 months? <b>(If "Yes", please provide details as to types, amounts (i.e., units per week/month), and date last used.)</b> .....                                                                  | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| C. Will the insurance applied for replace existing Life Insurance or Annuities on any person here proposed for insurance? <b>(If "Yes", give details below.)</b> .....                                                                                              | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| D. 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? <b>(If "Yes", give details below.)</b> ..... | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| E. Have you ever sold any life insurance policy to a life settlement company, trust, limited liability corporation, viatical, or other secondary market purchaser? <b>(If "Yes", give details below.)</b> .....                                                     | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

**Details:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Section 15 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 16 FRAUD STATEMENTS**

**KANSAS and 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 and RHODE ISLAND 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 17 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 Any Place on January 3, 2001  
City State Month Day Year

John Doe  
Signature of Proposed Insured

Any Officer  
Signature of Authorized Officer (Owner)

Any Agent  
Signature of Agent/Registered Representative

Any Officer CEO  
Print Name and Title of Authorized Officer

**PART I – SECTION B (COMPLETE FOR SIMPLIFIED ISSUE)**

**Section 18 PERSONAL AND MEDICAL INFORMATION**

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

Insured Name *(First, Middle, Last)* John Doe Date of Birth 02/07/65  
MM/DD/YYYY

A. Height: 6 ft. 1 in. Weight: 190

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 19.)**.....

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

**(If "Yes", give details in Section 19.)**.....

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 19.)**.....

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 19.)**.....

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 19.)** ....

F. 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? **(If "Yes", give details in Section 19.)**.....

G. Have you ever sold any life insurance policy to a life settlement company, trust, limited liability corporation, viatical, or other secondary market purchaser? **(If "Yes", give details in Section 19.)** .....

**Section 19 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 20 AGREEMENT, AUTHORIZATION AND SIGNATURES**

I have received the pre-notice form of the Fair Credit Reporting Act of 1970 and the MIB, Inc. 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, any pharmacy or pharmacy benefit managers, and other sources who maintain prescription drug records and related information, or other medical or medically related facility; any insurance company; MIB, Inc.; or any other organization, institution, or person, to disclose any information concerning me, including, but not limited to, my entire medical/health record to the Medical Director of Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company or its affiliates, including, but not limited to, RSA Medical, 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; pharmacy or pharmacy benefit managers; medical facility, or other health care provider to release and disclose my entire medical/health 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 any time, by sending a written request for revocation to Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company, [Nationwide Business Solutions Group, 1-11-401, One Nationwide Plaza, Columbus, Ohio 43215-2220.] 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 records, or, if I revoke this authorization before a policy is issued, 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.

January 3	2001	John Doe
_____	_____	_____
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.

John Doe  
\_\_\_\_\_  
Signature of Registered Representative

Any Firm  
\_\_\_\_\_  
Firm

Any Representative  
\_\_\_\_\_  
Print Name of Registered Representative

A00-00000  
\_\_\_\_\_  
License ID No.

PART I – SECTION C (COMPLETE FOR MEDICAL ISSUE)

Section 18 PERSONAL INFORMATION

Insured Name (First, Middle, Last): John Doe Date of Birth: 02/07/65

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 20.) 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 20.)

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 20.)

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 20.)

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 20.)

H. 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? (If "Yes", give details in Section 20.)

I. Have you ever sold any life insurance policy to a life settlement company, trust, limited liability corporation, viatical, or other secondary market purchaser? (If "Yes", give details in Section 20.)

Section 19 MEDICAL QUESTIONS AND INFORMATION

(For each "Yes" answer check the appropriate item and provide details in Section 20.)

- A. Height: 6 ft. 1 in. Weight: 190
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:

Table with 2 columns: YES, NO. Rows 1-12 listing various medical conditions like AIDS, heart disease, depression, asthma, etc.

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

Table with 2 columns: YES, NO. Rows 1-4 listing insurance-related questions like 'Consulted, or been examined or treated by any physician...', 'Had any disease, disorder, injury, or operation...', etc.



**Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company**

[Nationwide Business Solutions Group, 1-11-401  
One Nationwide Plaza, Columbus, Ohio 43215-2220 • 1-877-351-8808]

**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, [Nationwide Business Solutions Group, One Nationwide Plaza, 1-11-401, Columbus, Ohio 43215-2220]

**MIB, INC. 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 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.

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 web address of the MIB, Inc. information office is [www.mib.com](http://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.



# APPLICATION FOR POLICY/CERTIFICATE CHANGE

Nationwide Life Insurance Company  Nationwide Life and Annuity Insurance Company  
[• Nationwide Business Solutions Group, 1-11-401 • One Nationwide Plaza, Columbus, Ohio 43215-2220 • 1-877-351-8808]

## PART A

### Section 1 POLICY/CERTIFICATE OWNER/CORPORATION INFORMATION *(Must be completed by all applicants.)*

Owner Name: Any Corporation Tax I.D. No.: 00-0000000  
Owner Address: One Any Street City: Any City State: Any State Zip Code: Any Zip  
Corporation/Employer Name (if other than Owner): \_\_\_\_\_  
Corporation Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

### Section 2 LIFE INSURED INFORMATION *(Proposed Insured for Change of Insured.)*

Name of Life Insured: John Doe Policy/Certificate Number: N000000000  
Social Security No.: 000-00-0000 Date of Birth (MM/DD/YYYY): 02/07/1965  
State of Residence: Any State State of Birth: Any City  
Occupation: President of Any Employer Employer: Any Corporation

### Section 3 CHANGE REQUEST *(Please indicate the change desired.)*

- Increase Specified Amount to: \_\_\_\_\_
- Decrease Specified Amount to: \_\_\_\_\_
- Change Death Benefit Option to: \_\_\_\_\_
- Rate Reconsideration
- Change of Smoker Status *(Complete Section 5)*
- Change of Insured (old): \_\_\_\_\_ to (new): \_\_\_\_\_
- Other: \_\_\_\_\_

### Section 4 ACTIVELY AT WORK STATUS

- A. 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.)*  Yes  No
- B. During the past three months, have you (i) been absent from work for a total of four or more days for any illness or injury, or (ii) been hospitalized? *(If "Yes", give reason and details below.)* .....  Yes  No
- C. Details: *(If additional space is needed, an additional blank sheet may be attached.)* \_\_\_\_\_  
\_\_\_\_\_

### Section 5 CHANGE FROM SMOKER TO NON-SMOKER STATUS *(Urine Specimen is required.)*

- A. Have you used tobacco or nicotine supplements in any form in the past 12 months? .....  Yes  No
- B. Please provide the date you last used tobacco or nicotine supplements in any form. Type: \_\_\_\_\_  
Amount of Usage: \_\_\_\_\_ Date of last usage (MM/DD/YYYY): \_\_\_\_\_
- C. Details: *(If additional space is needed, an additional blank sheet may be attached.)* \_\_\_\_\_  
\_\_\_\_\_

### Section 6 REPLACEMENT

- A. Will the insurance applied for replace existing Life Insurance or Annuities on any person proposed for coverage? *(If "Yes", give details below.)* .....  Yes  No
- B. Details: *(If additional space is needed, an additional blank sheet may be attached.)* \_\_\_\_\_  
\_\_\_\_\_

**Section 7 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 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 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 8 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 any policy/certificate change herein applied for will not be in effect until this application is approved by the Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company in its Home Office in Columbus, Ohio; that any additional premium cost resulting from this change will be added to the premium due; that this application and any medical exam(s) taken for it will become a part of the policy/certificate contract.

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

<u>Any Officer</u> Signature of Life Insured	<u>John Doe</u> Print Name of Life Insured	<u>January 3, 2009</u> Date
-------------------------------------------------	-----------------------------------------------	--------------------------------

<u>Any Officer</u> Signature of Owner (Authorized Officer/Trustee)	<u>Any Officer</u> Print Name and Title of Owner	<u>January 3, 2009</u> Date
-----------------------------------------------------------------------	-----------------------------------------------------	--------------------------------

<u>Signature of Assignee (if applicable)</u>	<u>Print Name and Entity of Assignee</u>	<u>Date</u>
----------------------------------------------	------------------------------------------	-------------

<u>Any Agent</u> Signature of Agent/Registered Representative	<u>January 3, 2009</u> Date
------------------------------------------------------------------	--------------------------------

**PART B (COMPLETE FOR SIMPLIFIED ISSUE)**

**Section 9 PERSONAL AND MEDICAL INFORMATION**

*(For each "Yes" answer check the appropriate item and provide details below.)*

Life Insured Name *(First, Middle, Last)* John Doe Date of Birth 02/07/1965  
MM/DD/YYYY

A. Height: 6 ft. 1 in. Weight: 190

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

Date last consulted, reason and results: \_\_\_\_\_

C. List any medication you are currently using: \_\_\_\_\_

D. In the past 10 years, have you consulted a physician, been examined or treated for: **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 10.)* .....

2. Alcoholism, narcotic addiction, drug use, hallucination, depression, or anxiety?  
*(If "Yes", give details in Section 10.)* .....

E. In the past 10 years, have you been diagnosed by a doctor or by a member of the medical profession as having AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS-Related Complex), or any other AIDS related condition, or received a positive result of an HIV (Human Immunodeficiency Virus) test?  
*(If "Yes", give details in Section 10.)* .....

F. In the past 3 years:  
 1. Have you flown as a pilot, co-pilot, or crew member; or engaged in the racing of an automobile, motorcycle or motor powered vehicle; or performed any scuba diving, mountain climbing, parachuting, sky diving, bungee jumping; or any type of life-threatening activity? *(If "Yes", complete an Aviation/Hazardous Activities Questionnaire.)* .....

2. Have you been convicted of driving while impaired or intoxicated? *(If "Yes", give details in Section 10.)* .....

3. Have you been rated or declined for Life or Disability Insurance? *(If "Yes", give details in Section 10.)* .....

G. 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?  
*(If "Yes", give details in Section 10.)* .....

H. Have you ever sold any life insurance policy to a life settlement company, trust, limited liability corporation, viatical, or other secondary market purchaser? *(If "Yes", give details in Section 10.)* .....

**Section 10 DETAILS OF PERSONAL AND MEDICAL INFORMATION**

*(If more space is needed, an additional blank sheet may be attached.)*

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

**Section 11 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 any policy/certificate change herein applied for will not be in effect until this application is approved by the Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company in its Home Office in Columbus, Ohio; that any additional premium cost resulting from this change will be added to the premium due; that this application and any medical exam(s) taken for it will become a part of the policy/certificate contract.

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

I have received the Pre-Notice form of the Fair Credit Reporting Act of 1970 and the MIB, Inc. Disclosure form.

I authorize: any licensed physician or medical practitioner, any hospital, clinic, any pharmacy or pharmacy benefit managers, and other sources who maintain prescription drug records and related information, or other medical or medically related facility; any insurance company; MIB, Inc.; or any other organization, institution, or person, to disclose any information concerning me, including, but not limited to, my entire medical/health record to the Medical Director of Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company or its affiliates, including, but not limited to, RSA Medical, 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; pharmacy or pharmacy benefit managers; medical facility, or other health care provider to release and disclose my entire medical/health 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 any time, by sending a written request for revocation to Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company, [Nationwide Business Solutions Group, 1-11-401, One Nationwide Plaza, Columbus, Ohio 43215-2220.] 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 records, or, if I revoke this authorization before a policy is issued, 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. 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.

Any Officer	John Doe	January 3, 2009
Signature of Life Insured	Print Name of Life Insured	Date

Any Officer	Any Officer	January 3, 2009
Signature of Owner (Authorized Officer/Trustee)	Print Name and Title of Owner	Date

<i>Signature of Assignee (if applicable)</i>	Print Name and Entity of Assignee	Date
----------------------------------------------	-----------------------------------	------

Any Agent	January 3, 2009	Date
Signature of Agent/Registered Representative		

**PART C (COMPLETE FOR MEDICAL ISSUE)**

**Section 9**

**MEDICAL INFORMATION**

(For each "Yes" answer check the appropriate item and provide details below.)

**YES NO**

- A. To the best of your knowledge and belief, in the past 10 years, have you consulted, been examined or been treated for any of the following:
1. Heart attack, angina, chest pain, high blood pressure, shortness of breath, palpitations, heart murmur, or any other disorder of the heart or blood vessels? .....
  2. Headaches, seizures, epilepsy, stroke, Alzheimer's disease, Parkinson's disease, multiple sclerosis; or depression, neurosis, psychosis, or any other brain, nervous or mental disorder? .....
  3. Asthma, emphysema, tuberculosis, chronic bronchitis, or any other disease of the lungs or respiratory system? .....
  4. Any disease or disorder of the eyes, ears, nose or throat? .....
  5. Colitis, ulcer, persistent diarrhea, rectal bleeding, or any other disease or disorder of the digestive tract? .....
  6. Kidney stones, nephritis, sugar, protein or blood in the urine; sexually transmitted diseases, or any other disease of the urinary tract or reproductive system? .....
  7. Diabetes, hepatitis, cirrhosis; or any other disease of the liver, pancreas, or thyroid? .....
  8. Cancer, or any malignant or benign tumor or cyst; or any chronic disease of the skin or lymph glands? .....
  9. Arthritis or any paralysis; or chronic back or muscle condition? .....
  10. Alcoholism, alcohol use, narcotic addiction, drug use, or hallucinations? .....
  11. AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS-Related Complex), or any other AIDS-related condition, or received a positive result of an HIV (Human Immunodeficiency Virus) test? .....
- B. Within the past five years, has anyone here proposed for insurance:
1. Consulted, or been examined or treated by any physician, chiropractor, or other medical practitioner or by any hospital, clinic, or other medical facility not previously mentioned? (If it was for a "check up", annual physical, employment physical, etc., so state and give findings and results below.) .....
  2. Had any disease, disorder, injury, or operation not previously mentioned? .....
  3. Had any x-rays, electrocardiograms, or other medical tests for reasons not covered above? .....
  4. Been advised to have any surgery, hospitalization, treatment or test that was not completed? .....

**Section 10**

**DETAILS OF MEDICAL INFORMATION (If more space is needed, an additional blank sheet may be attached.)**

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

**Section 11 PERSONAL INFORMATION**

*(For each "Yes" answer check the appropriate item and provide details below.)*

**YES NO**

- A. In the past 3 years, have you been rated or declined for Life or Disability Insurance? .....
- B. Do you have a family history of cardiovascular disease or death prior to age 60 or family history of cancer, kidney disease, or diabetes? *(If "Yes", provide relationship to Life Insured, age if living, age at death and cause of death below.)* .....
- C. In the past 5 years, have you been convicted of more than one moving violation or been convicted of driving while impaired or intoxicated? *(If "Yes", provide details, driver's license number and state of issue below.)* .....
- D. In the past 3 years, have you flown as a pilot, co-pilot or crew member; or engaged in the racing of an automobile, motorcycle or motor powered vehicle; or performed any scuba diving, mountain climbing, parachuting, sky diving, bungee jumping; or any type of life-threatening activity? *(If "Yes", complete an Aviation/Hazardous Activities Questionnaire.)* .....
- E. Do you plan to reside outside the United States? *(If "Yes", give details below.)* .....
- F. Are you actively at full-time work and physically performing all the duties of your usual employment, at least 30 hours per week, at your regular place of employment? *(If "No", give details below.)* .....
- G. During the past three months, have you (i) been absent from work for a total of four or more days for any illness or injury, or (ii) been hospitalized? *(If "Yes", give reason and details below.)* .....
- H. 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? *(If "Yes", give reason and details below.)*.....
- I. Have you ever sold any life insurance policy to a life settlement company, trust, limited liability corporation, viatical, or other secondary market purchaser? *(If "Yes", give reason and details below.)* .....

**Section 12 DETAILS OF PERSONAL INFORMATION**

*(If more space is needed, an additional blank sheet may be attached.)*

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

**Section 13 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 any policy/certificate change herein applied for will not be in effect until this application is approved by the Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company in its Home Office in Columbus, Ohio; that any additional premium cost resulting from this change will be added to the premium due; that this application and any medical exam(s) taken for it will become a part of the policy/certificate contract.

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

I have received the Pre-Notice form of the Fair Credit Reporting Act of 1970 and the MIB, Inc. Disclosure form.

I authorize: any licensed physician or medical practitioner, any hospital, clinic, any pharmacy or pharmacy benefit managers, and other sources who maintain prescription drug records and related information, or other medical or medically related facility; any insurance company; MIB, Inc.; or any other organization, institution, or person, to disclose any information concerning me, including, but not limited to, my entire medical/health record to the Medical Director of Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company or its affiliates, including, but not limited to, RSA Medical, 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; pharmacy or pharmacy benefit managers; medical facility, or other health care provider to release and disclose my entire medical/health 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 any time, by sending a written request for revocation to Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company, [Nationwide Business Solutions Group, 1-11-401, One Nationwide Plaza, Columbus, Ohio 43215-2220.] 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 records, or, if I revoke this authorization before a policy is issued, 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. 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.

<u>John Doe</u>	<u>John Doe</u>	<u>January 3, 2009</u>
Signature of Life Insured	Print Name of Life Insured	Date
<u>Any Officer</u>	<u>Any Officer</u>	<u>January 3, 2009</u>
Signature of Owner (Authorized Officer/Trustee)	Print Name and Title of Owner	Date
<u>Signature of Assignee (if applicable)</u>	<u>Print Name and Entity of Assignee</u>	<u>Date</u>
<u>Any Agent</u>	<u>January 3, 2009</u>	
Signature of Agent/Registered Representative	Date	

# Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company

[Nationwide Business Solutions Group, 1-11-401  
One Nationwide Plaza, Columbus, Ohio 43215-2220 • 1-877-351-8808]

## 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:

1. 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
2. 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, [Nationwide Business Solutions Group, One Nationwide Plaza, Columbus, Ohio 43215-2220.]

### MIB, INC. 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 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.

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 web address of the MIB, Inc. information office is [www.mib.com](http://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.



# CORPORATE MASTER APPLICATION CHANGE FORM

Nationwide Life Insurance Company  Nationwide Life and Annuity Insurance Company

• Nationwide Business Solutions Group, 1-11-401 • One Nationwide Plaza, Columbus, Ohio 43215-2220 • 1-877-351-8808

Any changes should be initialed by the Owner

## Section 1 POLICY/CERTIFICATE OWNER INFORMATION

Owner Name: Any Corporation

Street Address: One Any Street City: Any City State: State Zip Code: 00000

Corporation/Employer Name (if other than Owner): \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## Section 2 CHANGE REQUEST

- Increase Specified Amount
- Decrease Specified Amount
- Change Death Benefit Option
- Change of Insured
- Other: \_\_\_\_\_

\*\* Changes under this application to be requested in accordance with the attached insurance schedule.

## Section 3 REPRESENTATIONS

### Secondary Market

- |                                                                                                                                                                                                                                                              |                          |                                     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------|
| 1. 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? (If "Yes", give details below.) ..... | YES                      | NO                                  |
|                                                                                                                                                                                                                                                              | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Have you ever sold any life insurance policy to a life settlement company, trust, limited liability corporation, viatical, or other secondary market purchaser? (If "Yes", give details below.) .....                                                     | YES                      | NO                                  |
|                                                                                                                                                                                                                                                              | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

## Section 4 ADDITIONAL INSTRUCTIONS

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Section 5 TAXPAYER IDENTIFICATION NUMBER

Taxpayer Identification Number of the Owner: \_\_\_\_\_

- Partnership
- Corporation
- Trustee
- Other: \_\_\_\_\_

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 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 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 6 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 any policy/certificate change here applied for will not be in effect until this application is approved by the Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company in its Home Office in Columbus, Ohio; that any additional premium cost resulting from this change will be added to the premium due; that this application, insurance schedule, and any medical exam(s) taken for it will become a part of the policy/certificate contract. 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.

<u>Any Officer</u>	<u>Any Officer</u>	<u>1-3-2002</u>
Signature of Owner (Authorized Officer/Trustee)	Print Name and Title of Owner	Date

<u>Signature of Assignee (if applicable)</u>	<u>Print Name and Entity of Assignee</u>	<u>Date</u>
----------------------------------------------	------------------------------------------	-------------

<u>Any Agent</u>	<u>1-3-2002</u>
Signature of Agent/Registered Representative	Date



# INSURANCE SCHEDULE FOR CHANGE OF INSUREDS

Nationwide Life Insurance Company  Nationwide Life and Annuity Insurance Company

[• Nationwide Business Solutions Group, 1-11-401 • One Nationwide Plaza, Columbus, OH 43215-2220 • 1-877-351-8808]

ANY CHANGES SHOULD BE INITIALED BY THE OWNER (Please type or print.)

## Section 1 INSURED INFORMATION

New Insured Information		Insured Being Replaced										
Policy/ Certificate Number	Insured Last Name	Insured First Name	Social Security No.	Date Of Birth MM/DD/YYYY	Age	Sex M/F	Smoking Status (N/S)	Insured Last Name	Insured First Name	New Rider Coverage	New Total Coverage	New Estimated Annual Premium

## Section 2 EMPLOYER CERTIFICATION

The Employer certifies that all participants insured under the above policies/certificates as per attached schedule are presently employed with the above employer. All the lives under the schedule are actively at work, full time, and physically performing all for the duties of their usual employment of at least 30 hours per week at their regular place of employment. Furthermore, in the past three months, the participants have not (i) been absent from work for a total of four or more days for any illness or injury, or (ii) been hospitalized.

This Insurance Schedule, Master Change Application and the above statement shall constitute separate application for change in coverage to the individual policies/certificates in force and will be part of each policy/certificate. I certify the above information is complete and true to the best of my knowledge and belief.

*Any Officer, Vice President* \_\_\_\_\_ Any Officer, Vice President 1-3-2002  
 Signature of Owner (Authorized Officer/Trustee) \_\_\_\_\_ Date  
*Authorized Officer* \_\_\_\_\_ Authorized Officer 1-3-2002  
 Signature of Employer's Authorized Officer (if other than the Owner) \_\_\_\_\_ Date  
 Signature of Assignee (if applicable) \_\_\_\_\_ Date  
*Joe Agent* \_\_\_\_\_  
 Signature of Agent/Registered Representative \_\_\_\_\_



# INSURANCE SCHEDULE FOR POLICY/CERTIFICATE CHANGES

Nationwide Life Insurance Company  Nationwide Life and Annuity Insurance Company

1 Nationwide Business Solutions Group, 1-11-401 • One Nationwide Plaza, Columbus, OH 43215-2220 • 1-877-351-8808]

ANY CHANGES SHOULD BE INITIALED BY THE OWNER (Please type or print.)

## Section 1 INSURED INFORMATION

Policy/ Certificate Number	Insured Last Name	Insured First Name	Social Security No.	Date Of Birth MM/DD/YYYY	Age	Sex M/F	Smoking Status (N/S)	Total			New Estimated Annual Premium	
								Current Base Coverage Amount	Current Rider Coverage Amount	New Base Coverage Amount		

## Section 2 EMPLOYER CERTIFICATION

The Employer certifies that all participants insured under the above policies/certificates as per attached schedule are presently employed with the above employer. All the lives under the schedule are actively at work, full time, and physically performing all for the duties of their usual employment for at least 30 hours per week at their regular place of employment. Furthermore, in the past three months, the participants have not (i) been absent from work for a total of four or more days for any illness or injury, or (ii) been hospitalized.

This Insurance Schedule, Master Change Application and the above statement shall constitute separate application for change in coverage to the individual policies/certificates in force and will be part of each policy/certificate. I certify the above information is complete and true to the best of my knowledge and belief.

<i>Any Officer, Vice President</i>	Any Officer, Vice President	1-3-2002
Signature of Owner (Authorized Officer/Trustee)	Printed Name and Title of Owner	Date
<i>Authorized Officer</i>	Authorized Officer	1-3-2002
Signature of Employer's Authorized Officer (if other than the Owner)	Print Name and Title of Employer	Date
Signature of Assignee (if applicable)	Printed Name and Entity of Assignee	Date
<i>Joe Agent</i>	1-3-2002	Date
Signature of Agent/Registered Representative	Date	

SERFF Tracking Number: NWPA-127635990 State: Arkansas  
 Filing Company: Nationwide Life and Annuity Insurance Company State Tracking Number: 49890  
 Company Tracking Number: COLI-3000-E-US5; COLI-3003-G-US3; COLI-3007-C-US4; COLI-3008-B-US3 - NWLA  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: COLI-3000-E-US5; COLI-3003-G-US3; COLI-3007-C-US4; COLI-3008-B-US3 - NWLA  
 Project Name/Number: COLI-3000-E-US5; COLI-3003-G-US3; COLI-3007-C-US4; COLI-3008-B-US3 - NWLA /COLI-3000-E-US5; COLI-3003-G-US3;  
 COLI-3007-C-US4; COLI-3008-B-US3 - NWLA

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> <b>Attachment:</b> AR CERT NWLA.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application <b>Comments:</b> This is an application filing. The forms and dates are in the General Description.		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Statement of Variability <b>Comments:</b> <b>Attachment:</b> Statement of Variability-AR.pdf		



ARKANSAS

Certificate of Compliance

Insurer Nationwide Life and Annuity Insurance Company

Form Numbers: COLI-3000-E-US5, Corporate Master Application  
COLI-3003-G-US3, Corporate Application for Life Insurance  
COLI-3007-C-US4, Corporate Application for Policy/Certificate Change  
COLI-3008-B-US3, Corporate Master Application Change Form

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.

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 that reads "James J. Rabenstine". The signature is written in a cursive style.

---

James J. Rabenstine  
Vice President  
NF Compliance  
Date: 09-20-2011

**NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY  
(09/2011)**

**STATEMENT OF VARIABILITY FOR FORMS:**

**COLI-3000-E-US5, CORPORATE MASTER APPLICATION  
COLI-3003-G-US3, CORPORATE APPLICATION FOR LIFE INSURANCE  
COLI-3007-C-US4, CORPORATE APPLICATION FOR POLICY/CERTIFICATE CHANGE  
COLI-3008-B-US3, CORPORATE MASTER APPLICATION CHANGE FORM**

Bracketed items in the above captioned forms indicate variability as follows:

**COLI-3000-E-US5; COLI-3003-G-US3; COLI-3007-C-US4; COLI-3008-B-US3**

Nationwide's Business Group Name, Address, and Phone Number	Nationwide's Business Group Name, address and/or telephone information is bracketed throughout each application in case they change in the future.
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------

**COLI-3003-G-US3; COLI-3007-C-US4**

Medical Information Bureau Disclosure Notice	The Medical Information Bureau's address and/or telephone information is bracketed in case either change in the future.
----------------------------------------------	-------------------------------------------------------------------------------------------------------------------------