

SERFF Tracking Number: NWPA-127334583 State: Arkansas
 Filing Company: Nationwide Life and Annuity Insurance Company State Tracking Number: 49421
 Company Tracking Number: LAA-0111M1; LAA-0112M1; LAA-0113M1, APPLICATIONS FOR INDIVIDUAL LIFE INSURANCE
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: LAA-0111M1, Application for Individual Life Insurance
 Project Name/Number: LAA-0111M1, Application for Individual Life Insurance/LAA-0111M1, Application for Individual Life Insurance

Filing at a Glance

Company: Nationwide Life and Annuity Insurance Company

Product Name: LAA-0111M1, Application for Individual Life Insurance SERFF Tr Num: NWPA-127334583 State: Arkansas

Individual Life Insurance

TOI: L08 Life - Other

SERFF Status: Closed-Approved- Closed State Tr Num: 49421

Sub-TOI: L08.000 Life - Other

Co Tr Num: LAA-0111M1; LAA-0112M1; LAA-0113M1, APPLICATIONS FOR INDIVIDUAL LIFE INSURANCE State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

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

Disposition Date: 08/05/2011

Date Submitted: 07/28/2011

Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: LAA-0111M1, Application for Individual Life Insurance

Status of Filing in Domicile: Pending

Project Number: LAA-0111M1, Application for Individual Life Insurance

Date Approved in Domicile:

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: 08/05/2011

State Status Changed: 08/05/2011

Deemer Date:

Created By: Carrie Ruhlen

Submitted By: Carrie Ruhlen

Corresponding Filing Tracking Number: LAA-0111M1, Application for Individual Life Insurance

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Filing Description:

Re: LAA-0111M1, Application for Individual Life Insurance
LAA-0112M1, Application for Individual Life Insurance
LAA-0113M1, Application for Individual Life Insurance
NAIC #92657

Enclosed for filing, subject to your approval, are forms LAA-0111M1, LAA-0112M1, and LAA-0113M1, Applications for Individual Life Insurance. These are new forms and will replace the following forms:

LAA-0107M1, Application for Life Insurance, Approved 08-12-2008, SERFF #NWPA-125762706, State Tracking #39886
LAA-0109M1.1, Application for Life Insurance, Approved 06-15-2009, SERFF #NWPA-126182312, State Tracking #42652

The forms in this filing will be used with our Traditional, Universal Life, Variable Life and Variable Universal Life Products. Other forms that will be used with this application are:

VLOB-0186-03-A, Supplemental Application for Long Term Care Rider, Approved 12-10-2003
VLS-0113AO.1, Variable Life Fund Supplement, Approved 06-03-2009, SERFF #NWPA-126167674, State Tracking #42529
VLS-0114AO.1, Variable Life Fund Supplement, Approved 06-03-2009, SERFF #NWPA-126167674, State Tracking #42529
VLS-0115AO.1, Variable Life Fund Supplement, Approved 06-03-2009, SERFF #NWPA-126167674, State Tracking #42529

The intended purpose of forms LAA-0111M1, LAA-0112M1, and LAA-0113M1, Applications for Life Insurance, is to update our multi applications to provide an easier application process for our producers and customers. These 3 applications are exactly the same except for the products in Section 8, the Life Insurance Plan Section. This section is determined by the distribution channel. The forms will be completed by the Agent/Broker in their entirety in paper form only. We have plans to use these forms electronically at a later date.

Nationwide's application is used in paper and electronic format. To verify the authenticity, Nationwide and its producers collect personal information from the applicant as part of the application process and the identity of the applicant is verified through this process. When collecting electronic signatures on applications and other documents, Nationwide will then send an email to the applicant's private email account, which is provided to Nationwide or its producers during the application process. The email contains a web link to our third-party electronic signature application. After clicking on the link, the applicant must provide their 4-digit pin, which is a secret number that the applicant provides Nationwide or its producers during the application process. They must also consent to an e-signature statement, which contains the notices and consents required by law for a binding electronic signature. For added security, the web link is only

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active for five days, after which time the applicant must contact Nationwide or the producer for another email message with a new web link.

Forms LAA-0111M1, LAA-0112M1, and LAA-0113M1 have been written in a readable fashion and attain a Flesch score of 48.4 each, however, when combined with the policy the scores are greater than 50.

We will begin using the approved forms on the latter of November 4, 2011 or upon approval.

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

Enclosures:

1. Certification
2. Form LAA-0111M1, Application for Life Insurance
3. Form LAA-0112M1, Application for Life Insurance
4. Form LAA-0113M1, Application for Life Insurance

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: \$150.00
Retaliatory? Yes

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 Fee Explanation: \$50.00 per form = \$150.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Nationwide Life and Annuity Insurance Company	\$150.00	07/28/2011	50168686

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	08/05/2011	08/05/2011

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Application for Individual Life Insurance	Carrie Ruhlen	08/02/2011	08/02/2011
Form	Application for Individual Life Insurance	Carrie Ruhlen	08/02/2011	08/02/2011
Form	Application for Individual Life Insurance	Carrie Ruhlen	08/02/2011	08/02/2011

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Disposition

Disposition Date: 08/05/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Statement of Variability		Yes
Form (revised)	Application for Individual Life Insurance		Yes
Form	Application for Individual Life Insurance	Replaced	Yes
Form (revised)	Application for Individual Life Insurance		Yes
Form	Application for Individual Life Insurance	Replaced	Yes
Form (revised)	Application for Individual Life Insurance		Yes
Form	Application for Individual Life Insurance	Replaced	Yes

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Amendment Letter

Submitted Date: 08/02/2011

Comments:

Nationwide is writing to inform your Department of errors discovered in the Application forms (LAA-0111M1; LAA-0112M1; and LAA-0113M1), submitted to your Department on 07/28/2011.

On Page 4, the Note section on Item 13a was corrected to read: "(Note: Monthly Draft Day will be determined based upon policy effective date unless a day is requested above.)" The word "below" was corrected to "above."

On Page 6, question 21j was inadvertently left off. We have now added this question and it reads: "j. To the best of your knowledge, do you have a parent or sibling who died from cancer or cardiovascular disease prior to age 60? (If "yes", provide relationship to Proposed Insured(s), age at death, and cause of death, and if cancer, provide type.)"

We have changed the revision date at the bottom right hand corner to (07/2011).

Please be advised that no other changes have been made to this filing.

Thank you for your attention to this filing. Please feel free to call me at 1-800-882-2822 (ext. 98042) if you have any questions.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
LAA-0111M1	Application/Enrollment Form	Application for Individual Life Insurance	Initial				48.400	LAA-0111M1.pdf
LAA-0112M1	Application/Enrollment Form	Application for Individual Life Insurance	Initial				48.400	LAA-0112M1.pdf
LAA-0113M1	Application/Enrollment Form	Application for Individual Life Insurance	Initial				48.400	LAA-0113M1.pdf

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Form Life Insurance

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Form Schedule

Lead Form Number: LAA-0111M1

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	LAA-0111M1	Application/ Enrollment Form Individual Life Insurance	Initial		48.400	LAA-0111M1.pdf
	LAA-0112M1	Application/ Enrollment Form Individual Life Insurance	Initial		48.400	LAA-0112M1.pdf
	LAA-0113M1	Application/ Enrollment Form Individual Life Insurance	Initial		48.400	LAA-0113M1.pdf

NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY

Application for Individual Life Insurance

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

PART A – CLIENT INFORMATION

1. Proposed Primary Insured	Name <i>(First, MI, Last)</i> John D. Doe				SSN / Tax ID # 000 - 00 - 0000	
	Address One Any Street			City Any City		
	State Any State	Zip Code 00000	County Any County	Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	Former Name	
	Marital Status <input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other _____			Age 35	Date of Birth <i>(mm/dd/yyyy)</i> 02/07/1973	State of Birth OH
	E-Mail Address JDDOE@YAHOO.COM				Phone # (000) 000-0000	<input type="checkbox"/> AM <input checked="" type="checkbox"/> PM
	Driver's License # / State of Issue RL000000 OH		Annual Income		Net Worth	
	Occupation	Employer		Citizenship <i>(If other, submit Foreign Supplement.)</i> <input type="checkbox"/> U.S. <input type="checkbox"/> Canada <input type="checkbox"/> Other, how long have you lived in the U.S.? _____		

	Name of Additional Insured(s)	Birth Date	Birth State	Sex	Height	Weight	SSN / Tax ID #	Relationship to Primary Insured	
2. Proposed Additional Insured <i>If applicable, complete for either:</i> a) <i>Joint Insured for Survivorship Life Plan; or</i> b) <i>Term Rider on Another Covered Person (i.e., Spouse/Children)</i> <i>If additional space is required, use Special Instructions Section.</i>									
	Joint/Spouse Proposed Additional Insured Information Only								
	Former Name		Address <input type="checkbox"/> <i>(Check box if same as Proposed Primary Insured)</i>						
	City		State	Zip Code		County			
	E-Mail Address				Phone # ()		<input type="checkbox"/> AM <input type="checkbox"/> PM		
	Driver's License # / State of Issue		Annual Income		Net Worth				
	Occupation	Employer		Citizenship <i>(If other, submit Foreign Supplement.)</i> <input type="checkbox"/> U.S. <input type="checkbox"/> Canada <input type="checkbox"/> Other, how long have you lived in the U.S.? _____					

3. Owner <i>Complete ONLY if Owner is not the Proposed Primary Insured.</i> <i>Unless indicated the Proposed Primary Insured (Joint Insureds in the case of Survivorship) will own the policy.</i> <i>If more than two Owners are requested, use Special Instructions Section.</i> <i>TRUST - Submit a copy of first and signature pages of Trust document.</i>	Name <i>(First, MI, Last)</i>				SSN / Tax ID #		
	Address <input type="checkbox"/> <i>(Check box if same as Proposed Primary Insured)</i>			City			
	State	Zip Code	County	Date of Birth <i>(mm/dd/yyyy)</i>	Phone # ()		
	Type of Owner <input type="checkbox"/> Individual <input type="checkbox"/> Employer <input type="checkbox"/> Trust <input type="checkbox"/> Rabbi Trust <input type="checkbox"/> Other _____		Relationship to Insured	E-Mail Address			
	<i>If more than one Owner the following will be applicable: 1) Ownership will be vested jointly with right of survivorship, otherwise to the Executor or Administrator of the last owner's estate. 2) All notices will be mailed to the one address listed above unless otherwise instructed. 3) For tax reporting purposes, only one Social Security Number can be used. The SSN shown above will be used unless otherwise instructed.</i>						
	Joint Owner <i>(First, MI, Last)</i>				SSN / Tax ID #		
	Address <input type="checkbox"/> <i>(Check box if same as Proposed Primary Insured)</i>			City			
	State	Zip Code	County	Date of Birth <i>(mm/dd/yyyy)</i>	Phone # ()		
	Type of Owner <input type="checkbox"/> Individual <input type="checkbox"/> Employer <input type="checkbox"/> Trust <input type="checkbox"/> Rabbi Trust <input type="checkbox"/> Other _____		Relationship to Insured	E-Mail Address			
	Exact Name of Trust		Trust Tax ID Number	Current Trustee(s)		Date of Trust	



4. Contingent Owner <i>Complete this section to name an alternative Owner in the event the Insured survives the Owner.</i>	Name (First, MI, Last)				SSN / Tax ID #	
	Address <input type="checkbox"/> (Check box if same as Proposed Primary Insured)				City	
	State	Zip Code	County	Relationship to Insured	Date of Birth (mm/dd/yyyy)	

5. Primary Beneficiary Designations <i>If Survivorship Life Plan, the Proposed Insureds may not be named as Beneficiary.</i> <i>If additional space is required, use Special Instructions Section.</i>	<i>When more than one Beneficiary is designated, payments will be made in equal shares to the Beneficiaries surviving the Insured, or in full to the last surviving Beneficiary, unless some other distribution of proceeds is provided.</i>					
	<input type="checkbox"/> <i>Check this box if Trust named in the Owner section is to be the Primary Beneficiary. If a different Trust is named as Primary Beneficiary or Trust is named as Contingent Beneficiary, provide the Trust information below.</i>					
	For Proposed Primary Insured					
	Primary Beneficiary(ies) Name(s) or Trust and Trustee(s)	Share %	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID #	Address
	Jane S. Doe	100	Wife	10/08/1975	000-00-0000	One Any Street Any City, Any State 00000
	For Proposed Additional Insured					
	Primary Beneficiary(ies) Name(s) or Trust and Trustee(s)	Share %	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID #	Address

6. Contingent Beneficiary Designations <i>If additional space is required, use Special Instructions Section.</i>	For Proposed Primary Insured					
	Contingent Beneficiary(ies) Name(s) or Trust and Trustee(s)	Share %	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID #	Address
	For Proposed Additional Insured					
	Contingent Beneficiary(ies) Name(s) or Trust and Trustee(s)	Share %	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID #	Address

7. Taxpayer ID Number  <i>Check box, if applicable</i>	I certify under penalties of perjury that:
	<ul style="list-style-type: none"> • The number shown on this form is my correct taxpayer identification number and, • I am not subject to backup withholding because <ul style="list-style-type: none"> ♦ I have not been notified that I am subject to backup withholding as a result of a failure to report all interest or dividends, or ♦ the Internal Revenue Service has notified me that I am no longer subject to backup withholding, or that I am exempt from backup withholding, and • I am a U.S. person (including a U.S. resident alien). <input type="checkbox"/> Check this box if you have been notified by the IRS that you are currently subject to backup withholding because of failure to report interest or dividends on your tax return. <p>The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.</p>



PLAN INFORMATION

8. Life Insurance Plan



*The Variable Life Fund Supplement MUST be completed if applying for a Variable Product.
The IUL Allocation Form MUST be completed if applying for an Index UL Product.*

- | | |
|---|--|
| <input type="checkbox"/> Nationwide YourLife® 10-year Term
<input type="checkbox"/> Nationwide YourLife® 15-year Term
<input type="checkbox"/> Nationwide YourLife® 20-year Term
<input type="checkbox"/> Nationwide YourLife® 30-year Term
<input type="checkbox"/> Nationwide YourLife® 20-Pay WL
<input type="checkbox"/> Nationwide YourLife® WL 100
<input type="checkbox"/> Nationwide YourLife® Current Assumption UL
<input type="checkbox"/> Nationwide YourLife® No-Lapse Guarantee UL | <input type="checkbox"/> Nationwide YourLife® Indexed UL
<input type="checkbox"/> Nationwide YourLife® SUL
<input type="checkbox"/> Nationwide YourLife® No-Lapse Guarantee SUL II
<input type="checkbox"/> Nationwide YourLife® Protection VUL
<input type="checkbox"/> Nationwide YourLife® Accumulation VUL
<input type="checkbox"/> Nationwide YourLife® Survivorship VUL
<input type="checkbox"/> Other _____ |
|---|--|

Base Specified Amount	+	Additional Term Rider/Supplemental Coverage Amount (check plan for availability)	=	Total Specified Amount (including Additional Term Rider/Supplemental Coverage)
\$ 250,000.00		\$ _____		\$ 250,000.00

9. Additional Options



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

- Death Benefit Option (If no option is selected here, Option 1 is elected.)**
- Option 1(The Specified Amount, or a multiple of the Cash/Accumulated Value, whichever is greater.)
- Option 2(The Specified Amount, plus the Cash/Accumulated Value, or a multiple of the Cash/Accumulated Value, whichever is greater.)
- Option 3(The Specified Amount, plus the Accumulated Premium Account at _____%* interest or a multiple of the Cash/Accumulated Value, whichever is greater.) *Enter a percentage up to 12% maximum, **ONLY** if the Owner is a business entity. If nothing is entered or the Owner is not a business entity, 0% will apply.
- Internal Revenue Code Life Insurance Qualification Test Option**
- Guideline Premium/Cash Value Corridor Test
- Cash Value Accumulation Test
- (If no selection is made here, the Guideline Premium/Cash Value Corridor Test is elected.)*

10. Optional Benefits

Check Plan for Availability.

- Variable or Universal Life Plans Only (Subject to Plan availability.)**
- | | |
|--|---|
| <input type="checkbox"/> Spouse Rider..... \$ _____
<input type="checkbox"/> Children's Term Insurance Rider..... \$ _____
<input type="checkbox"/> Long Term Care Rider* \$ _____
*Complete Supplement for Long Term Care Rider.
<input type="checkbox"/> Accidental Death Benefit Rider..... \$ _____
<input type="checkbox"/> Adjusted Sales Load Rider _____%
(in whole percentages only) waived for _____ years
<input type="checkbox"/> Extended Death Benefit Guarantee Rider
_____ Guarantee Percentage (Indicate percentage of specified amount)
_____ Guarantee Duration (Indicate number of years) | <input type="checkbox"/> Change of Insured Rider
<input type="checkbox"/> Other Rider(s) _____
<input type="checkbox"/> Other Rider(s) _____
Can select only one:
<input type="checkbox"/> Premium Waiver Rider \$ _____
<input type="checkbox"/> Waiver of Monthly Deductions Rider
Can select only one:
<input type="checkbox"/> Surrender Value Enhancement Benefit
<input type="checkbox"/> Conditional Return of Premium Rider (cannot be elected with Extended Death Benefit Guarantee Rider) |
|--|---|
- Survivorship Variable or Survivorship Universal Life Plans Only (Subject to Plan availability.)**
- | | |
|--|--|
| <input type="checkbox"/> Four Year Term Rider** \$ _____
**If the No Charge Four Year Term Insurance has been illustrated you should NOT select this rider. | <input type="checkbox"/> Policy Split Option Rider
<input type="checkbox"/> Other Rider(s) _____
<input type="checkbox"/> Other Rider(s) _____ |
|--|--|
- Whole or Term Life Plans Only (Subject to Plan availability.)**
- | | |
|---|---|
| <input type="checkbox"/> 20 Year Spouse Rider \$ _____
<input type="checkbox"/> Children's Term Insurance Rider..... \$ _____
<input type="checkbox"/> Accidental Death Benefit Rider..... \$ _____
<input type="checkbox"/> Guaranteed Insurability Benefit Rider \$ _____
<input type="checkbox"/> Waiver of Premium Disability Benefit Rider
<input type="checkbox"/> Owner's Waiver of Premium Death Benefit Rider (Complete Part B for the Owner)
Occupation _____
Height _____
Weight _____
State of Birth _____ | <input type="checkbox"/> Owner's Waiver of Premium Death or Disability Benefit Rider (Complete Part B for the Owner)
Occupation _____
Height _____
Weight _____
State of Birth _____
<input type="checkbox"/> Other Rider(s) _____
<input type="checkbox"/> Other Rider(s) _____
<input type="checkbox"/> Other Rider(s) _____ |
|---|---|

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

No, do not issue with APL.



FUTURE BILLING AND PREMIUM INFORMATION

11. Amount Paid With Application
Check the applicable option and indicate the premium amount being submitted with the application.

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

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

(NOTE: Make all checks payable to NATIONWIDE.)

Web Remittance \$ _____

Draft initial payment only (indicate initial premium amount and complete Section 13b)..... \$ _____

Draft initial payment and future payments (indicate initial premium amount and complete Sections 12 & 13) \$ _____

12. Future Billing and Payment Options
Check the applicable billing or payment option(s) and indicate the premium amount.

Billing Options:	Payment Options:
<input type="checkbox"/> Monthly EFT* \$ _____ <i>*If selected, complete Section 13, Monthly Electronic Draft Authorization.</i>	<input type="checkbox"/> Single Premium \$ _____
<input type="checkbox"/> Quarterly \$ _____	<input type="checkbox"/> Billing Advantage \$ _____ Account Number _____
<input type="checkbox"/> Semi-Annual \$ _____	<input type="checkbox"/> 1035 Exchange \$ _____
<input type="checkbox"/> Annual \$ _____	<input type="checkbox"/> Other \$ _____

13. Electronic Draft Authorization

13a. Monthly Electronic Draft Options:

Monthly Draft Day (1st – 28th): _____

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

Draft Options:

*Checking - Use information on the initial premium check.

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

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

13b. If no check or deposit slip provided, indicate below the bank information to be used:

Financial Institution Name _____	Transit/ABA Number _____
Account Number _____	Type of Account: <input type="checkbox"/> *Checking <input type="checkbox"/> *Savings

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

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

Name (First, MI, Last) _____

Address _____	City _____	State _____	Zip Code _____
---------------	------------	-------------	----------------

INSURANCE INFORMATION

15. Replacement and Other Policy Information

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

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

Insured	Company	Policy Number	Amount Of Coverage	Year Issued	To Be Replaced	1035 Exch	Lapsed/ Surrendered/ Sold	Nationwide Term Conversion
			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>		<input type="checkbox"/>
			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>		<input type="checkbox"/>
			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>		<input type="checkbox"/>
			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>		<input type="checkbox"/>



FINANCIAL INFORMATION

<p>16. Financial Questions Explain all "yes" answers in Section 17 Details box below unless instructed otherwise.</p> <p style="text-align: center;">STOP</p> <p><i>This section needs to be completed by each Proposed Insured and Owner/Trustee, if other than Proposed Insured(s).</i></p>	All questions must be answered by each Proposed Insured and Owner/Trustee, if other than Proposed Insured(s). For each yes answer, indicate the appropriate item(s) and provide details.				Proposed Primary Insured		Proposed Additional Insured		Owner/Trustee if other than Proposed Insured(s)	
					Yes	No	Yes	No	Yes	No
	a. Is this policy being purchased for the purpose of selling or assigning this policy to a life settlement company, trust, limited liability corporation, viatical, or other secondary market purchaser?				<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b. Have you entered into any agreement, or made arrangements, for the sale or assignment of this policy to a life settlement company, trust, limited liability corporation, viatical, or other secondary market purchaser?				<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c. Have you been involved in any communication about the possible sale or assignment of this policy to a life settlement company, trust, limited liability corporation, viatical, or other secondary market purchaser?				<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d. Have you ever sold any life insurance policy to a life settlement company, trust, limited liability corporation, viatical, or other secondary market purchaser?				<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	e. Will any portion of the current or future premium for this policy be financed?				<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Will any Insured or Policy Owner receive any payment in connection with the insurance issued on the basis of this application?				<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

<p>17. Explanation of Financial Details If more space is needed, an additional blank sheet may be attached. Any Proposed Insured(s) or Owner(s) should sign and date additional pages.</p>	Question Letter	Person	Dates	Details

PART B - PERSONAL AND HEALTH INFORMATION

<p>18. Tobacco Use All questions are to be answered by each Proposed Insured.</p> <p style="text-align: center;">STOP</p> <p><i>Be sure to answer this section.</i></p>	Have you used tobacco or nicotine in any form?		Proposed Primary Insured		Proposed Additional Insured	
	1. In the last 12 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", date last used: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", date last used: _____	
	2. In the last 5 years?		<input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", date last used: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", date last used: _____	
	3. If "yes", check all forms of tobacco or nicotine products used.		<input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Other Tobacco <input type="checkbox"/> Nicotine Products (gum, patch, etc.)	<input type="checkbox"/> Cigars <input type="checkbox"/> Pipe <input type="checkbox"/> Snuff	<input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Other Tobacco <input type="checkbox"/> Nicotine Products (gum, patch, etc.)	<input type="checkbox"/> Cigars <input type="checkbox"/> Pipe <input type="checkbox"/> Snuff

<p>19. Physical Measurements Fill in information for the Proposed Primary Insured.</p>	Height	Current Weight	Weight 1 Year Ago	Reason for Weight Gain or Loss

<p>20. Personal Physicians If Child Rider coverage is requested, use Special Instructions Section to add Personal Physician information for each child.</p>	Proposed Primary Insured		Proposed Additional Insured		Any Child
	Name of Personal Physician:				
	Address:				
	Telephone Number:				
	Date last consulted:				
	Reason last consulted:				
Treatment given or medication prescribed:					



HEALTH INFORMATION

23. Health Questions	To the best of your knowledge and belief, has anyone here proposed for insurance ever consulted a licensed health care provider for, been treated for, taken medication for, or been diagnosed as having:	Proposed Primary Insured		Proposed Additional Insured		Any Child	
		Yes	No	Yes	No	Yes	No
<i>All questions are to be answered by each Proposed Insured.</i> <i>Explain all "yes" answers in Section 24 Details box unless instructed otherwise.</i>	a. AIDS (Acquired Immune Deficiency Syndrome), or any other AIDS-related condition, or received a positive result of an HIV (Human Immunodeficiency Virus) test?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b. Heart disease including heart attack, angina, or other chest pain, cardiomyopathy, shortness of breath, congestive heart failure, heart murmur, or other disorder of the heart?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c. Irregular heart beat, palpitations, high blood pressure, high cholesterol, or high triglycerides?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d. Aneurysm, carotid artery disease, deep venous thrombosis, phlebitis, peripheral vascular disease, any other disorder of the blood vessels, or pulmonary embolism?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	e. Headaches, seizures, epilepsy, stroke, Alzheimer's disease, dementia, Parkinson's disease, multiple sclerosis, or any other brain or nervous disorder?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	f. Depression, neurosis, affective disorder, psychosis, or any other mental or emotional disorder?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	g. Asthma, emphysema, chronic bronchitis, tuberculosis, or any other disease of the lungs or respiratory system?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	h. Colitis, ulcer, persistent diarrhea, rectal bleeding, Crohn's disease, ulcerative colitis, or any other disease or disorder of the esophagus or digestive tract?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	i. Sugar, protein or blood in the urine, kidney stones, sexually transmitted disease, or any other disease or disorder of the kidneys, bladder, prostate, breast, urinary tract or reproductive system?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	j. Diabetes, hepatitis, cirrhosis or any other disease of the liver, pancreas, or thyroid?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	k. Disorder of the blood including anemia, sickle cell disorders, thalassemia, hemophilia, or any other disorder of the red blood cells, or white blood cells, platelets, or clotting factors?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	l. Cancer, or any malignant or benign tumor or cyst, or any chronic disease of the skin or lymph glands?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	m. Arthritis, rheumatoid arthritis, osteoporosis; or any paralysis or chronic back or muscle condition?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	n. Alcoholism, narcotic addiction, drug use, or hallucinations?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	o. Any disease or disorder of the eyes, ears, nose or throat?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
To the best of your knowledge and belief, in the past 5 years, has anyone here proposed for insurance:							
p. Consulted, or been examined or treated by any physician, chiropractor, psychologist or other health care practitioner or by any hospital, clinic, or other health care facility not already disclosed on this application? <i>(If it was for a "check up", annual physical, employment physical, etc., so state and give findings and results.)</i>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
q. Had any disease, disorder, injury, or operation not already disclosed on this application?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
r. Had any x-rays, electrocardiograms, or other medical tests for reasons not already disclosed on this application?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
s. Been medically advised to have any surgery, hospitalization, treatment or test that was not completed or results that you have not received?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
t. Currently taking any medication other than indicated above to include prescription, over-the-counter medications for more than 5 days, dietary supplements, "natural" or herbal medications? <i>(Give details of dosage and frequency.)</i>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
u. Used alcoholic beverages? <i>(If yes, how much, what kind (beer, wine, liquor), and how often?)</i>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



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

25. Special Instructions Section	<i>If more space is needed, an additional blank sheet may be attached. Any Proposed Insured(s) or Owner(s) should sign and date additional pages.</i>			
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PART C – FRAUD STATEMENTS AND IMPORTANT NOTICES

RHODE ISLAND 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 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.
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: <ul style="list-style-type: none"> • An investigative consumer report may be made whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. This inquiry will include information as to character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation, with respect to you, members of your family, and others having an interest in or closely connected with the insurance transaction; and • You may elect to be interviewed if an investigative consumer report is prepared in connection with this application. You are entitled to receive a copy of any investigative consumer report by submitting your request in writing. • Upon your written request, made within a reasonable time after you receive this notice, additional information as to the nature and scope of the investigation, if one is made, will be provided. You may send corrections and requests for additional information addressed to Nationwide Life and Annuity Insurance Company, [P.O. Box 182835, Columbus, Ohio 43218-2835]. In the event of an adverse decision, you will be notified in writing.
Medical Information Bureau Disclosure Notice	Information regarding your insurability will be treated as confidential. Nationwide Life and Annuity Insurance Company, or its reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is [50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734, telephone number 866-692-6901 (TTY 866-346-3642).] The e-mail address of the Bureau's information office is www.mib.com. Nationwide Life 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.



TEMPORARY INSURANCE AGREEMENT

NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY, COLUMBUS, OH

This Agreement provides a limited amount of Life Insurance coverage, for a limited period of time, subject to the terms of this Agreement.

HEALTH QUESTION

 Question must be answered by each Proposed Insured(s).	Proposed Primary Insured		Proposed Additional Insured		Any Child		Has anyone here proposed for insurance: To the best of your knowledge and belief, within the past 10 years, been treated for, consulted a licensed health care provider, or been diagnosed by a licensed health care provider as having: angina, or chest pain or discomfort; heart attack, heart murmur, or any other heart disorder; epilepsy, stroke or diabetes; AIDS (Acquired Immune Deficiency Syndrome), any AIDS-related disorder or positive HIV (Human Immunodeficiency Virus) test result; any brain, nervous, or mental disorder, any drug or alcohol addiction; any kidney disorder (other than kidney stones); or any cancer or other malignancy?
	Yes	No	Yes	No	Yes	No	
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

If the above question is answered YES or LEFT BLANK, NO COVERAGE will take effect under this Agreement and no representative of Nationwide Life and Annuity Insurance Company is authorized to accept money, and/or provide a temporary insurance receipt to the applicant.

TERMS AND CONDITIONS

Amount of Coverage <i>[\$1,000,000] overall maximum for all applications or agreements.</i>	Temporary Insurance under this Agreement will commence on the date of the application if the full first premium for the mode selected has been paid and accepted by Nationwide or authorized by Electronic Funds Transfer as advance payment for an application for Life Insurance. If any Proposed Insured dies while this temporary insurance is in effect, Nationwide will pay to the designated Beneficiary the lesser of: <ul style="list-style-type: none"> the amount of death benefits, if any, which would be payable under the policy and its riders if issued as applied for, excluding any accidental death benefits, or [\$1,000,000] This total benefit limit applies to all insurance applied for under this and any other current applications to Nationwide and any other Temporary Insurance Agreements for Life Insurance whether applied for on the life or lives of one or more Proposed Insureds.
Date Coverage Terminates <i>60 DAYS maximum coverage.</i>	Temporary Life Insurance under this Agreement will terminate automatically on the earliest of: <ul style="list-style-type: none"> 60 days from the date of this signed Agreement, or the date any policy is offered or issued to the Proposed Insured in connection with the above application, or the date Nationwide mails notice of termination of coverage and refund of the advance payment to the Proposed Insured, or the Owner, if different than the Proposed Insured.
Limitations	<ul style="list-style-type: none"> Fraud or material misrepresentation in the application or in the answers to the Health question of this Agreement invalidates this Agreement and Nationwide's only liability is for refund of any payment made. This Agreement does not provide coverage for Proposed Insured's who are under 15 days of age or over the age of 70 on the date of the Agreement. If any Proposed Insured dies by suicide, while sane or insane, Nationwide's liability under this Agreement is limited to a refund of the payment made. There is no coverage under this Agreement if the check submitted as payment is not honored by the bank on first presentation or if the Electronic Funds Transfer is not processed by the bank. No one is authorized to waive or modify any of the provisions of this Agreement.

SIGNATURES

Proposed Insured(s) and Owner Signatures	I HAVE RECEIVED A COPY OF AND HAVE READ THIS AGREEMENT AND DECLARE THAT THE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND AND AGREE TO ALL ITS TERMS. Dated (mm/dd/yyyy) <u>July 28, 2008</u> X <u>John D. Doe</u> Signature of Proposed Primary Insured (or parent if Proposed Primary Insured is under age 15) X _____ X _____ Signature of Applicant/Owner (if other than the Proposed Insured(s)) Signature of Proposed Additional Insured (if to be Insured)
Initial Premium Receipt and Producer's Signature  Be sure to include the amount of the initial premium payment.	An initial premium payment in the amount of \$ _____ has been submitted with this application. I have advised the Applicant/Owner that additional premium may need to be submitted at time of delivery. X <u>Sam A. Producer</u> _____ <u>Any Firm</u> _____ <u>02-A000000</u> Signature of Producer Firm Producer's Nationwide #



NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY

Application for Individual Life Insurance

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

PART A – CLIENT INFORMATION

1. Proposed Primary Insured	Name <i>(First, MI, Last)</i> John D. Doe						SSN / Tax ID # 000 - 00 - 0000		
	Address One Any Street					City Any City			
	State Any State	Zip Code 00000	County Any County		Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	Former Name			
	Marital Status <input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other _____				Age 35	Date of Birth <i>(mm/dd/yyyy)</i> 02/07/1973	State of Birth OH		
	E-Mail Address JDDOE@YAHOO.COM					Phone # (000) 000-0000		<input type="checkbox"/> AM <input checked="" type="checkbox"/> PM	
	Driver's License # / State of Issue RL000000 OH			Annual Income		Net Worth			
	Occupation		Employer		Citizenship <i>(If other, submit Foreign Supplement.)</i> <input type="checkbox"/> U.S. <input type="checkbox"/> Canada <input type="checkbox"/> Other, how long have you lived in the U.S.? _____				
	2. Proposed Additional Insured <i>If applicable, complete for either:</i> a) <i>Joint Insured for Survivorship Life Plan; or</i> b) <i>Term Rider on Another Covered Person (i.e., Spouse/Children)</i> <i>If additional space is required, use Special Instructions Section.</i>								
Name of Additional Insured(s)		Birth Date	Birth State	Sex	Height	Weight	SSN / Tax ID #	Relationship to Primary Insured	
Joint/Spouse Proposed Additional Insured Information Only Former Name _____ Address <input type="checkbox"/> <i>(Check box if same as Proposed Primary Insured)</i>									
City		State	Zip Code		County				
E-Mail Address					Phone # ()		<input type="checkbox"/> AM <input type="checkbox"/> PM		
Driver's License # / State of Issue			Annual Income		Net Worth				
Occupation		Employer		Citizenship <i>(If other, submit Foreign Supplement.)</i> <input type="checkbox"/> U.S. <input type="checkbox"/> Canada <input type="checkbox"/> Other, how long have you lived in the U.S.? _____					
3. Owner <i>Complete ONLY if Owner is not the Proposed Primary Insured.</i> <i>Unless indicated the Proposed Primary Insured (Joint Insureds in the case of Survivorship) will own the policy.</i> <i>If more than two Owners are requested, use Special Instructions Section.</i> <i>TRUST - Submit a copy of first and signature pages of Trust document.</i>	Name <i>(First, MI, Last)</i>						SSN / Tax ID #		
	Address <input type="checkbox"/> <i>(Check box if same as Proposed Primary Insured)</i>					City			
	State	Zip Code	County		Date of Birth <i>(mm/dd/yyyy)</i>		Phone # ()		<input type="checkbox"/> AM <input type="checkbox"/> PM
	Type of Owner <input type="checkbox"/> Individual <input type="checkbox"/> Employer <input type="checkbox"/> Trust <input type="checkbox"/> Rabbi Trust <input type="checkbox"/> Other _____			Relationship to Insured		E-Mail Address			
	<i>If more than one Owner the following will be applicable: 1) Ownership will be vested jointly with right of survivorship, otherwise to the Executor or Administrator of the last owner's estate. 2) All notices will be mailed to the one address listed above unless otherwise instructed. 3) For tax reporting purposes, only one Social Security Number can be used. The SSN shown above will be used unless otherwise instructed.</i>								
	Joint Owner <i>(First, MI, Last)</i>						SSN / Tax ID #		
	Address <input type="checkbox"/> <i>(Check box if same as Proposed Primary Insured)</i>					City			
	State	Zip Code	County		Date of Birth <i>(mm/dd/yyyy)</i>		Phone # ()		<input type="checkbox"/> AM <input type="checkbox"/> PM
	Type of Owner <input type="checkbox"/> Individual <input type="checkbox"/> Employer <input type="checkbox"/> Trust <input type="checkbox"/> Rabbi Trust <input type="checkbox"/> Other _____			Relationship to Insured		E-Mail Address			
	Exact Name of Trust			Trust Tax ID Number		Current Trustee(s)		Date of Trust	



4. Contingent Owner <i>Complete this section to name an alternative Owner in the event the Insured survives the Owner.</i>	Name (First, MI, Last)				SSN / Tax ID #	
	Address <input type="checkbox"/> (Check box if same as Proposed Primary Insured)				City	
	State	Zip Code	County	Relationship to Insured	Date of Birth (mm/dd/yyyy)	
5. Primary Beneficiary Designations <i>If Survivorship Life Plan, the Proposed Insureds may not be named as Beneficiary.</i> <i>If additional space is required, use Special Instructions Section.</i>	<i>When more than one Beneficiary is designated, payments will be made in equal shares to the Beneficiaries surviving the Insured, or in full to the last surviving Beneficiary, unless some other distribution of proceeds is provided.</i>					
	<input type="checkbox"/> <i>Check this box if Trust named in the Owner section is to be the Primary Beneficiary. If a different Trust is named as Primary Beneficiary or Trust is named as Contingent Beneficiary, provide the Trust information below.</i>					
	For Proposed Primary Insured					
	Primary Beneficiary(ies) Name(s) or Trust and Trustee(s)	Share %	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID #	Address
	Jane S. Doe	100	Wife	10/08/1975	000-00-0000	One Any Street Any City, Any State 00000
	For Proposed Additional Insured					
	Primary Beneficiary(ies) Name(s) or Trust and Trustee(s)	Share %	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID #	Address
6. Contingent Beneficiary Designations <i>If additional space is required, use Special Instructions Section.</i>	For Proposed Primary Insured					
	Contingent Beneficiary(ies) Name(s) or Trust and Trustee(s)	Share %	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID #	Address
	For Proposed Additional Insured					
	Contingent Beneficiary(ies) Name(s) or Trust and Trustee(s)	Share %	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID #	Address
7. Taxpayer ID Number  <i>Check box, if applicable</i>	I certify under penalties of perjury that: <ul style="list-style-type: none"> • The number shown on this form is my correct taxpayer identification number and, • I am not subject to backup withholding because <ul style="list-style-type: none"> ♦ I have not been notified that I am subject to backup withholding as a result of a failure to report all interest or dividends, or ♦ the Internal Revenue Service has notified me that I am no longer subject to backup withholding, or that I am exempt from backup withholding, and • I am a U.S. person (including a U.S. resident alien). <input type="checkbox"/> Check this box if you have been notified by the IRS that you are currently subject to backup withholding because of failure to report interest or dividends on your tax return.					
	The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.					



PLAN INFORMATION

8. Life Insurance Plan



*The Variable Life Fund Supplement MUST be completed if applying for a Variable Product.
The IUL Allocation Form MUST be completed if applying for an Index UL Product.*

- Waddell & Reed Protection VUL
- Waddell & Reed Accumulation VUL
- Waddell & Reed Survivorship Universal Life
- Nationwide YourLife® 10-year Term
- Nationwide YourLife® 15-year Term
- Nationwide YourLife® 20-year Term
- Nationwide YourLife® 30-year Term
- Nationwide YourLife® 20-Pay WL
- Nationwide YourLife® WL 100

- Nationwide YourLife® Indexed UL
- Nationwide YourLife® Current Assumption UL
- Nationwide YourLife® No-Lapse Guarantee UL
- Nationwide YourLife® SUL
- Nationwide YourLife® No-Lapse Guarantee SUL II
- Nationwide YourLife® Protection VUL
- Nationwide YourLife® Accumulation VUL
- Nationwide YourLife® Survivorship VUL
- Other _____

Base Specified Amount	+	Additional Term Rider/Supplemental Coverage Amount (check plan for availability)	=	Total Specified Amount (including Additional Term Rider/Supplemental Coverage)
\$ 250,000.00		\$ _____		\$ 250,000.00

9. Additional Options



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

- Death Benefit Option (If no option is selected here, Option 1 is elected.)**
- Option 1(The Specified Amount, or a multiple of the Cash/Accumulated Value, whichever is greater.)
 - Option 2(The Specified Amount, plus the Cash/Accumulated Value, or a multiple of the Cash/Accumulated Value, whichever is greater.)
 - Option 3(The Specified Amount, plus the Accumulated Premium Account at _____%* interest or a multiple of the Cash/Accumulated Value, whichever is greater.) *Enter a percentage up to 12% maximum, ONLY if the Owner is a business entity. If nothing is entered or the Owner is not a business entity, 0% will apply.
- Internal Revenue Code Life Insurance Qualification Test Option**
- Guideline Premium/Cash Value Corridor Test
 - Cash Value Accumulation Test
- (If no selection is made here, the Guideline Premium/Cash Value Corridor Test is elected.)*

10. Optional Benefits

Check Plan for Availability.

- Variable or Universal Life Plans Only (Subject to Plan availability.)**
- | | |
|--|---|
| <input type="checkbox"/> Spouse Rider \$ _____ | <input type="checkbox"/> Change of Insured Rider |
| <input type="checkbox"/> Children's Term Insurance Rider \$ _____ | <input type="checkbox"/> Other Rider(s) _____ |
| <input type="checkbox"/> Long Term Care Rider* \$ _____ | <input type="checkbox"/> Other Rider(s) _____ |
| *Complete Supplement for Long Term Care Rider. | |
| <input type="checkbox"/> Accidental Death Benefit Rider \$ _____ | Can select only one:
<input type="checkbox"/> Premium Waiver Rider \$ _____
<input type="checkbox"/> Waiver of Monthly Deductions Rider |
| <input type="checkbox"/> Adjusted Sales Load Rider _____ %
<i>(in whole percentages only) waived for _____ years</i> | |
| <input type="checkbox"/> Extended Death Benefit Guarantee Rider
_____ Guarantee Percentage (Indicate percentage of specified amount)
_____ Guarantee Duration (Indicate number of years) | Can select only one:
<input type="checkbox"/> Surrender Value Enhancement Benefit
<input type="checkbox"/> Conditional Return of Premium Rider (cannot be elected with Extended Death Benefit Guarantee Rider) |

- Survivorship Variable or Survivorship Universal Life Plans Only (Subject to Plan availability.)**
- | | |
|--|--|
| <input type="checkbox"/> Four Year Term Rider** \$ _____ | <input type="checkbox"/> Policy Split Option Rider |
| **If the No Charge Four Year Term Insurance has been illustrated you should NOT select this rider. | <input type="checkbox"/> Other Rider(s) _____ |
| | <input type="checkbox"/> Other Rider(s) _____ |

- Whole or Term Life Plans Only (Subject to Plan availability.)**
- | | |
|--|--|
| <input type="checkbox"/> 20 Year Spouse Rider \$ _____ | <input type="checkbox"/> Owner's Waiver of Premium Death or Disability Benefit Rider (Complete Part B for the Owner)
Occupation _____
Height _____
Weight _____
State of Birth _____ |
| <input type="checkbox"/> Children's Term Insurance Rider \$ _____ | |
| <input type="checkbox"/> Accidental Death Benefit Rider \$ _____ | <input type="checkbox"/> Other Rider(s) _____
<input type="checkbox"/> Other Rider(s) _____
<input type="checkbox"/> Other Rider(s) _____ |
| <input type="checkbox"/> Guaranteed Insurability Benefit Rider \$ _____ | |
| <input type="checkbox"/> Waiver of Premium Disability Benefit Rider | |
| <input type="checkbox"/> Owner's Waiver of Premium Death Benefit Rider (Complete Part B for the Owner)
Occupation _____
Height _____
Weight _____
State of Birth _____ | |

Policy will be issued with Automatic Premium Loan Option (APL) for Whole Life Plans only, if available, unless the box below is checked.
 No, do not issue with APL.



FUTURE BILLING AND PREMIUM INFORMATION

11. Amount Paid With Application
Check the applicable option and indicate the premium amount being submitted with the application.

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

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

(NOTE: Make all checks payable to NATIONWIDE.)

Web Remittance \$ _____

Draft initial payment only (indicate initial premium amount and complete Section 13b)..... \$ _____

Draft initial payment and future payments (indicate initial premium amount and complete Sections 12 & 13) \$ _____

12. Future Billing and Payment Options
Check the applicable billing or payment option(s) and indicate the premium amount.

Billing Options:	Payment Options:
<input type="checkbox"/> Monthly EFT* \$ _____ <i>*If selected, complete Section 13, Monthly Electronic Draft Authorization.</i>	<input type="checkbox"/> Single Premium \$ _____
<input type="checkbox"/> Quarterly \$ _____	<input type="checkbox"/> Billing Advantage \$ _____ Account Number _____
<input type="checkbox"/> Semi-Annual \$ _____	<input type="checkbox"/> 1035 Exchange \$ _____
<input type="checkbox"/> Annual \$ _____	<input type="checkbox"/> Other \$ _____

13. Electronic Draft Authorization

13a. Monthly Electronic Draft Options:

Monthly Draft Day (1st – 28th): _____

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

Draft Options:

*Checking - Use information on the initial premium check.

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

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

13b. If no check or deposit slip provided, indicate below the bank information to be used:

Financial Institution Name _____	Transit/ABA Number _____
Account Number _____	Type of Account: <input type="checkbox"/> *Checking <input type="checkbox"/> *Savings

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

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

Name (First, MI, Last) _____

Address _____	City _____	State _____	Zip Code _____
---------------	------------	-------------	----------------

INSURANCE INFORMATION

15. Replacement and Other Policy Information

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

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

Insured	Company	Policy Number	Amount Of Coverage	Year Issued	To Be Replaced	1035 Exch	Lapsed/ Surrendered/ Sold	Nationwide Term Conversion
			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>		<input type="checkbox"/>
			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>		<input type="checkbox"/>
			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>		<input type="checkbox"/>
			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>		<input type="checkbox"/>



FINANCIAL INFORMATION

<p>16. Financial Questions Explain all "yes" answers in Section 17 Details box below unless instructed otherwise.</p> <p style="text-align: center;">STOP</p> <p><i>This section needs to be completed by each Proposed Insured and Owner/Trustee, if other than Proposed Insured(s).</i></p>	All questions must be answered by each Proposed Insured and Owner/Trustee, if other than Proposed Insured(s). For each yes answer, indicate the appropriate item(s) and provide details.				Proposed Primary Insured		Proposed Additional Insured		Owner/Trustee if other than Proposed Insured(s)	
					Yes	No	Yes	No	Yes	No
	a. Is this policy being purchased for the purpose of selling or assigning this policy to a life settlement company, trust, limited liability corporation, viatical, or other secondary market purchaser?				<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b. Have you entered into any agreement, or made arrangements, for the sale or assignment of this policy to a life settlement company, trust, limited liability corporation, viatical, or other secondary market purchaser?				<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c. Have you been involved in any communication about the possible sale or assignment of this policy to a life settlement company, trust, limited liability corporation, viatical, or other secondary market purchaser?				<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d. Have you ever sold any life insurance policy to a life settlement company, trust, limited liability corporation, viatical, or other secondary market purchaser?				<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	e. Will any portion of the current or future premium for this policy be financed?				<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Will any Insured or Policy Owner receive any payment in connection with the insurance issued on the basis of this application?				<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

<p>17. Explanation of Financial Details If more space is needed, an additional blank sheet may be attached. Any Proposed Insured(s) or Owner(s) should sign and date additional pages.</p>	Question Letter	Person	Dates	Details

PART B - PERSONAL AND HEALTH INFORMATION

<p>18. Tobacco Use All questions are to be answered by each Proposed Insured.</p> <p style="text-align: center;">STOP</p> <p><i>Be sure to answer this section.</i></p>	Have you used tobacco or nicotine in any form?		Proposed Primary Insured		Proposed Additional Insured	
	1. In the last 12 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", date last used: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", date last used: _____	
	2. In the last 5 years?		<input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", date last used: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", date last used: _____	
	3. If "yes", check all forms of tobacco or nicotine products used.		<input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Other Tobacco <input type="checkbox"/> Nicotine Products (gum, patch, etc.)	<input type="checkbox"/> Cigars <input type="checkbox"/> Pipe <input type="checkbox"/> Snuff	<input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Other Tobacco <input type="checkbox"/> Nicotine Products (gum, patch, etc.)	<input type="checkbox"/> Cigars <input type="checkbox"/> Pipe <input type="checkbox"/> Snuff

<p>19. Physical Measurements Fill in information for the Proposed Primary Insured.</p>	Height	Current Weight	Weight 1 Year Ago	Reason for Weight Gain or Loss

<p>20. Personal Physicians If Child Rider coverage is requested, use Special Instructions Section to add Personal Physician information for each child.</p>	Proposed Primary Insured		Proposed Additional Insured		Any Child
	Name of Personal Physician:				
	Address:				
	Telephone Number:				
	Date last consulted:				
	Reason last consulted:				
Treatment given or medication prescribed:					



HEALTH INFORMATION

23. Health Questions	To the best of your knowledge and belief, has anyone here proposed for insurance ever consulted a licensed health care provider for, been treated for, taken medication for, or been diagnosed as having:	Proposed Primary Insured		Proposed Additional Insured		Any Child	
		Yes	No	Yes	No	Yes	No
<i>All questions are to be answered by each Proposed Insured.</i> <i>Explain all "yes" answers in Section 24 Details box unless instructed otherwise.</i>	a. AIDS (Acquired Immune Deficiency Syndrome), or any other AIDS-related condition, or received a positive result of an HIV (Human Immunodeficiency Virus) test?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b. Heart disease including heart attack, angina, or other chest pain, cardiomyopathy, shortness of breath, congestive heart failure, heart murmur, or other disorder of the heart?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c. Irregular heart beat, palpitations, high blood pressure, high cholesterol, or high triglycerides?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d. Aneurysm, carotid artery disease, deep venous thrombosis, phlebitis, peripheral vascular disease, any other disorder of the blood vessels, or pulmonary embolism?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	e. Headaches, seizures, epilepsy, stroke, Alzheimer's disease, dementia, Parkinson's disease, multiple sclerosis, or any other brain or nervous disorder?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	f. Depression, neurosis, affective disorder, psychosis, or any other mental or emotional disorder?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	g. Asthma, emphysema, chronic bronchitis, tuberculosis, or any other disease of the lungs or respiratory system?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	h. Colitis, ulcer, persistent diarrhea, rectal bleeding, Crohn's disease, ulcerative colitis, or any other disease or disorder of the esophagus or digestive tract?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	i. Sugar, protein or blood in the urine, kidney stones, sexually transmitted disease, or any other disease or disorder of the kidneys, bladder, prostate, breast, urinary tract or reproductive system?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	j. Diabetes, hepatitis, cirrhosis or any other disease of the liver, pancreas, or thyroid?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	k. Disorder of the blood including anemia, sickle cell disorders, thalassemia, hemophilia, or any other disorder of the red blood cells, or white blood cells, platelets, or clotting factors?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	l. Cancer, or any malignant or benign tumor or cyst, or any chronic disease of the skin or lymph glands?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	m. Arthritis, rheumatoid arthritis, osteoporosis; or any paralysis or chronic back or muscle condition?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	n. Alcoholism, narcotic addiction, drug use, or hallucinations?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	o. Any disease or disorder of the eyes, ears, nose or throat?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
To the best of your knowledge and belief, in the past 5 years, has anyone here proposed for insurance:							
p. Consulted, or been examined or treated by any physician, chiropractor, psychologist or other health care practitioner or by any hospital, clinic, or other health care facility not already disclosed on this application? <i>(If it was for a "check up", annual physical, employment physical, etc., so state and give findings and results.)</i>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
q. Had any disease, disorder, injury, or operation not already disclosed on this application?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
r. Had any x-rays, electrocardiograms, or other medical tests for reasons not already disclosed on this application?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
s. Been medically advised to have any surgery, hospitalization, treatment or test that was not completed or results that you have not received?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
t. Currently taking any medication other than indicated above to include prescription, over-the-counter medications for more than 5 days, dietary supplements, "natural" or herbal medications? (Give details of dosage and frequency.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
u. Used alcoholic beverages? <i>(If yes, how much, what kind (beer, wine, liquor), and how often?)</i>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



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

25. Special Instructions Section	<i>If more space is needed, an additional blank sheet may be attached. Any Proposed Insured(s) or Owner(s) should sign and date additional pages.</i>			
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PART C – FRAUD STATEMENTS AND IMPORTANT NOTICES

RHODE ISLAND 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 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.
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: <ul style="list-style-type: none"> • An investigative consumer report may be made whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. This inquiry will include information as to character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation, with respect to you, members of your family, and others having an interest in or closely connected with the insurance transaction; and • You may elect to be interviewed if an investigative consumer report is prepared in connection with this application. You are entitled to receive a copy of any investigative consumer report by submitting your request in writing. • Upon your written request, made within a reasonable time after you receive this notice, additional information as to the nature and scope of the investigation, if one is made, will be provided. You may send corrections and requests for additional information addressed to Nationwide Life and Annuity Insurance Company, [P.O. Box 182835, Columbus, Ohio 43218-2835]. In the event of an adverse decision, you will be notified in writing.
Medical Information Bureau Disclosure Notice	Information regarding your insurability will be treated as confidential. Nationwide Life and Annuity Insurance Company, or its reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is [50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734, telephone number 866-692-6901 (TTY 866-346-3642).] The e-mail address of the Bureau's information office is www.mib.com. Nationwide Life and Annuity Insurance Company or its reinsurer(s) may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.



PART D – AGREEMENT, AUTHORIZATION AND SIGNATURE

<p>Agreement</p>	<p>I understand and agree that:</p> <ul style="list-style-type: none"> • This application, any amendments to it, and any related medical examination(s) will become a part of the Policy and are the basis of any insurance issued upon this application. • The Proposed Insured or Owner has a right to cancel this application at any time by contacting their producer or Nationwide in writing. No producer, medical examiner or other representative of Nationwide may accept risks or make or change any contract; or waive or change any of the Company's rights or requirements. • If the full first premium is made in exchange for a Temporary Insurance Agreement, Nationwide will only be liable to the extent set forth in that Agreement. • If the full first premium is not paid with this application, then insurance will only take effect when (1) a policy is issued by Nationwide and accepted by me; and (2) the full first premium is paid; and (3) all the answers and statements made on the application, medical examination(s) and amendments are true to the best of my knowledge and belief when (1) and (2) have occurred.
<p>Authorization</p>	<p>I authorize: any licensed physician or medical practitioner; any hospital, clinic, any pharmacy benefit managers, and other sources who maintain prescription drug records and related information, or other medical or medically related facility; any insurance company; the Medical Information Bureau; or any other organization, institution, or person to disclose my entire medical record and any other protected health information concerning me to the Medical Director of the 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. By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this form; and I instruct any physician; health care professional; hospital; clinic; medical facility; or other health care provider to release and disclose my entire medical record without restriction. I understand that any information that is disclosed pursuant to this form may be redisclosed and no longer be covered by federal rules governing privacy and confidentiality of health information. This form, or a copy of it, will be valid for a period of not more than two years (24 months) from the date it was signed. I understand that I have the right to revoke this form in writing, at anytime, by sending a written request for revocation to Nationwide Life and Annuity Insurance Company, [Attention: Underwriting, P.O. Box 182835, Columbus, Ohio 43218-2835]. I understand that a revocation is not effective to the extent that any of my providers have relied on this form; or to the extent that Nationwide Life and Annuity Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I further understand that if I refuse to sign this form to release my complete medical records, Nationwide Life 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.</p>
<p>Proposed Insured(s) and Owner/Trustee Signatures</p> <p style="text-align: center;"></p> <p><i>All Financial questions in Section 16 (a through f) are required to be answered for both the Proposed Insured(s) and Owner, if not Proposed Insured(s).</i></p>	<p>I HAVE READ THIS APPLICATION AND AGREEMENT AND DECLARE THAT THE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND AND AGREE TO ALL ITS TERMS.</p> <p>Signed at _____, on _____, _____, 2008 Any City, Any State July 28 2008 City/State Month/Day Year</p> <p>_____ X _____ John D. Doe John D. Doe Full Name of Proposed Primary Insured (print) Signature of Proposed Primary Insured (or parent if Proposed Primary Insured is under age 15)</p> <p>_____ X _____ Full Name of Proposed Additional Insured (print) Signature of Proposed Additional Insured (if to be Insured)</p> <p>X _____ X _____ Signature of Applicant/Owner Signature of Applicant/Owner (if other than the Proposed Insured(s)) (if other than the Proposed Insured(s))</p>

PART E - PRODUCER'S CERTIFICATION

<p>Producer's Certification</p> <p style="text-align: center;"></p> <p><i>Be sure to answer all three questions.</i></p>	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Will <input checked="" type="checkbox"/> Will Not</p>	<p>a. I have truly and accurately recorded all Proposed Insureds' answers on this application.</p> <p>b. I have witnessed his/her/their signature(s) hereon. <i>(If "no", provide details in Special Instructions Section.)</i></p> <p>c. To the best of my knowledge, the insurance applied for will or will not replace any Life Insurance, and/or Annuities.</p>
	<p>_____ X _____ Sam A. Producer Sam A. Producer Producer's Name (print) Signature of Producer</p> <p>_____ _____ Any Firm 02-A000000 Firm Producer's Nationwide #</p>	



TEMPORARY INSURANCE AGREEMENT

NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY, COLUMBUS, OH

This Agreement provides a limited amount of Life Insurance coverage, for a limited period of time, subject to the terms of this Agreement.

HEALTH QUESTION

 Question must be answered by each Proposed Insured(s).	Proposed Primary Insured		Proposed Additional Insured		Any Child		Has anyone here proposed for insurance: To the best of your knowledge and belief, within the past 10 years, been treated for, consulted a licensed health care provider, or been diagnosed by a licensed health care provider as having: angina, or chest pain or discomfort; heart attack, heart murmur, or any other heart disorder; epilepsy, stroke or diabetes; AIDS (Acquired Immune Deficiency Syndrome), any AIDS-related disorder or positive HIV (Human Immunodeficiency Virus) test result; any brain, nervous, or mental disorder, any drug or alcohol addiction; any kidney disorder (other than kidney stones); or any cancer or other malignancy?
	Yes	No	Yes	No	Yes	No	
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

If the above question is answered YES or LEFT BLANK, NO COVERAGE will take effect under this Agreement and no representative of Nationwide Life and Annuity Insurance Company is authorized to accept money, and/or provide a temporary insurance receipt to the applicant.

TERMS AND CONDITIONS

Amount of Coverage [\$1,000,000] overall maximum for all applications or agreements.	Temporary Insurance under this Agreement will commence on the date of the application if the full first premium for the mode selected has been paid and accepted by Nationwide or authorized by Electronic Funds Transfer as advance payment for an application for Life Insurance. If any Proposed Insured dies while this temporary insurance is in effect, Nationwide will pay to the designated Beneficiary the lesser of: <ul style="list-style-type: none"> the amount of death benefits, if any, which would be payable under the policy and its riders if issued as applied for, excluding any accidental death benefits, or [\$1,000,000] This total benefit limit applies to all insurance applied for under this and any other current applications to Nationwide and any other Temporary Insurance Agreements for Life Insurance whether applied for on the life or lives of one or more Proposed Insureds.
Date Coverage Terminates 60 DAYS maximum coverage.	Temporary Life Insurance under this Agreement will terminate automatically on the earliest of: <ul style="list-style-type: none"> 60 days from the date of this signed Agreement, or the date any policy is offered or issued to the Proposed Insured in connection with the above application, or the date Nationwide mails notice of termination of coverage and refund of the advance payment to the Proposed Insured, or the Owner, if different than the Proposed Insured.
Limitations	<ul style="list-style-type: none"> Fraud or material misrepresentation in the application or in the answers to the Health question of this Agreement invalidates this Agreement and Nationwide's only liability is for refund of any payment made. This Agreement does not provide coverage for Proposed Insured's who are under 15 days of age or over the age of 70 on the date of the Agreement. If any Proposed Insured dies by suicide, while sane or insane, Nationwide's liability under this Agreement is limited to a refund of the payment made. There is no coverage under this Agreement if the check submitted as payment is not honored by the bank on first presentation or if the Electronic Funds Transfer is not processed by the bank. No one is authorized to waive or modify any of the provisions of this Agreement.

SIGNATURES

Proposed Insured(s) and Owner Signatures	I HAVE RECEIVED A COPY OF AND HAVE READ THIS AGREEMENT AND DECLARE THAT THE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND AND AGREE TO ALL ITS TERMS. Dated (mm/dd/yyyy) <u>July 28, 2008</u> X <u>John D. Doe</u> Signature of Proposed Primary Insured (or parent if Proposed Primary Insured is under age 15) X _____ X _____ Signature of Applicant/Owner (if other than the Proposed Insured(s)) Signature of Proposed Additional Insured (if to be Insured)
Initial Premium Receipt and Producer's Signature  Be sure to include the amount of the initial premium payment.	An initial premium payment in the amount of \$ _____ has been submitted with this application. I have advised the Applicant/Owner that additional premium may need to be submitted at time of delivery. X <u>Sam A. Producer</u> _____ <u>Any Firm</u> _____ <u>02-A000000</u> Signature of Producer Firm Producer's Nationwide #



NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY

Application for Individual Life Insurance

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

PART A – CLIENT INFORMATION

1. Proposed Primary Insured	Name <i>(First, MI, Last)</i> John D. Doe						SSN / Tax ID # 000 - 00 - 0000		
	Address One Any Street					City Any City			
	State Any State	Zip Code 00000	County Any County		Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	Former Name			
	Marital Status <input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other _____				Age 35	Date of Birth <i>(mm/dd/yyyy)</i> 02/07/1973	State of Birth OH		
	E-Mail Address JDDOE@YAHOO.COM					Phone # (000) 000-0000		<input type="checkbox"/> AM <input checked="" type="checkbox"/> PM	
	Driver's License # / State of Issue RL000000 OH			Annual Income		Net Worth			
	Occupation		Employer		Citizenship <i>(If other, submit Foreign Supplement.)</i> <input type="checkbox"/> U.S. <input type="checkbox"/> Canada <input type="checkbox"/> Other, how long have you lived in the U.S.? _____				
	2. Proposed Additional Insured If applicable, complete for either: a) Joint Insured for Survivorship Life Plan; or b) Term Rider on Another Covered Person (i.e., Spouse/Children) If additional space is required, use Special Instructions Section.								
Name of Additional Insured(s)		Birth Date	Birth State	Sex	Height	Weight	SSN / Tax ID #	Relationship to Primary Insured	
Joint/Spouse Proposed Additional Insured Information Only Former Name _____ Address <input type="checkbox"/> <i>(Check box if same as Proposed Primary Insured)</i>									
City		State	Zip Code		County				
E-Mail Address					Phone # ()		<input type="checkbox"/> AM <input type="checkbox"/> PM		
Driver's License # / State of Issue			Annual Income		Net Worth				
Occupation		Employer		Citizenship <i>(If other, submit Foreign Supplement.)</i> <input type="checkbox"/> U.S. <input type="checkbox"/> Canada <input type="checkbox"/> Other, how long have you lived in the U.S.? _____					
3. Owner Complete ONLY if Owner is not the Proposed Primary Insured. Unless indicated the Proposed Primary Insured (Joint Insureds in the case of Survivorship) will own the policy. If more than two Owners are requested, use Special Instructions Section. TRUST - Submit a copy of first and signature pages of Trust document.	Name <i>(First, MI, Last)</i>						SSN / Tax ID #		
	Address <input type="checkbox"/> <i>(Check box if same as Proposed Primary Insured)</i>					City			
	State	Zip Code	County		Date of Birth <i>(mm/dd/yyyy)</i>		Phone # ()		<input type="checkbox"/> AM <input type="checkbox"/> PM
	Type of Owner <input type="checkbox"/> Individual <input type="checkbox"/> Employer <input type="checkbox"/> Trust <input type="checkbox"/> Rabbi Trust <input type="checkbox"/> Other _____			Relationship to Insured		E-Mail Address			
	If more than one Owner the following will be applicable: 1) Ownership will be vested jointly with right of survivorship, otherwise to the Executor or Administrator of the last owner's estate. 2) All notices will be mailed to the one address listed above unless otherwise instructed. 3) For tax reporting purposes, only one Social Security Number can be used. The SSN shown above will be used unless otherwise instructed.								
	Joint Owner <i>(First, MI, Last)</i>						SSN / Tax ID #		
	Address <input type="checkbox"/> <i>(Check box if same as Proposed Primary Insured)</i>					City			
	State	Zip Code	County		Date of Birth <i>(mm/dd/yyyy)</i>		Phone # ()		<input type="checkbox"/> AM <input type="checkbox"/> PM
	Type of Owner <input type="checkbox"/> Individual <input type="checkbox"/> Employer <input type="checkbox"/> Trust <input type="checkbox"/> Rabbi Trust <input type="checkbox"/> Other _____			Relationship to Insured		E-Mail Address			
	Exact Name of Trust			Trust Tax ID Number		Current Trustee(s)		Date of Trust	



4. Contingent Owner <i>Complete this section to name an alternative Owner in the event the Insured survives the Owner.</i>	Name (First, MI, Last)				SSN / Tax ID #	
	Address <input type="checkbox"/> (Check box if same as Proposed Primary Insured)				City	
	State	Zip Code	County	Relationship to Insured	Date of Birth (mm/dd/yyyy)	

5. Primary Beneficiary Designations <i>If Survivorship Life Plan, the Proposed Insureds may not be named as Beneficiary.</i> <i>If additional space is required, use Special Instructions Section.</i>	<i>When more than one Beneficiary is designated, payments will be made in equal shares to the Beneficiaries surviving the Insured, or in full to the last surviving Beneficiary, unless some other distribution of proceeds is provided.</i>					
	<input type="checkbox"/> <i>Check this box if Trust named in the Owner section is to be the Primary Beneficiary. If a different Trust is named as Primary Beneficiary or Trust is named as Contingent Beneficiary, provide the Trust information below.</i>					
	For Proposed Primary Insured					
	Primary Beneficiary(ies) Name(s) or Trust and Trustee(s)	Share %	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID #	Address
	Jane S. Doe	100	Wife	10/08/1975	000-00-0000	One Any Street Any City, Any State 00000
For Proposed Additional Insured						
Primary Beneficiary(ies) Name(s) or Trust and Trustee(s)	Share %	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID #	Address	

6. Contingent Beneficiary Designations <i>If additional space is required, use Special Instructions Section.</i>	For Proposed Primary Insured					
	Contingent Beneficiary(ies) Name(s) or Trust and Trustee(s)	Share %	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID #	Address
For Proposed Additional Insured						
Contingent Beneficiary(ies) Name(s) or Trust and Trustee(s)	Share %	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID #	Address	

7. Taxpayer ID Number  <i>Check box, if applicable</i>	I certify under penalties of perjury that:
	<ul style="list-style-type: none"> • The number shown on this form is my correct taxpayer identification number and, • I am not subject to backup withholding because <ul style="list-style-type: none"> ♦ I have not been notified that I am subject to backup withholding as a result of a failure to report all interest or dividends, or ♦ the Internal Revenue Service has notified me that I am no longer subject to backup withholding, or that I am exempt from backup withholding, and • I am a U.S. person (including a U.S. resident alien). <input type="checkbox"/> Check this box if you have been notified by the IRS that you are currently subject to backup withholding because of failure to report interest or dividends on your tax return.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.



PLAN INFORMATION

8. Life Insurance Plan



The Variable Life Fund Supplement MUST be completed if applying for a Variable Product.
The IUL Allocation Form MUST be completed if applying for an Index UL Product.

- | | |
|---|---|
| <input type="checkbox"/> Nationwide Marathon SM Performance VUL - Protection | <input type="checkbox"/> Nationwide YourLife [®] SUL |
| <input type="checkbox"/> Nationwide Marathon SM Performance VUL - Accumulation | <input type="checkbox"/> Nationwide YourLife [®] No-Lapse Guarantee SUL II |
| <input type="checkbox"/> Nationwide Marathon SM No Lapse Guarantee UL | <input type="checkbox"/> Nationwide YourLife [®] 20-Pay WL |
| <input type="checkbox"/> Nationwide Marathon SM Indexed UL | <input type="checkbox"/> Nationwide YourLife [®] WL 100 |
| <input type="checkbox"/> Nationwide YourLife [®] Protection VUL | <input type="checkbox"/> Nationwide YourLife [®] 10-year Term |
| <input type="checkbox"/> Nationwide YourLife [®] Accumulation VUL | <input type="checkbox"/> Nationwide YourLife [®] 15-year Term |
| <input type="checkbox"/> Nationwide YourLife [®] Survivorship VUL | <input type="checkbox"/> Nationwide YourLife [®] 20-year Term |
| <input type="checkbox"/> Nationwide YourLife [®] Current Assumption UL | <input type="checkbox"/> Nationwide YourLife [®] 30-year Term |
| <input type="checkbox"/> Nationwide YourLife [®] No-Lapse Guarantee UL | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Nationwide YourLife [®] Indexed UL | |

Base Specified Amount	+	Additional Term Rider/Supplemental Coverage Amount (check plan for availability)	=	Total Specified Amount (including Additional Term Rider/Supplemental Coverage)
\$ 250,000.00		\$ _____		\$ 250,000.00

9. Additional Options



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

- Death Benefit Option (If no option is selected here, Option 1 is elected.)**
- Option 1(The Specified Amount, or a multiple of the Cash/Accumulated Value, whichever is greater.)
- Option 2(The Specified Amount, plus the Cash/Accumulated Value, or a multiple of the Cash/Accumulated Value, whichever is greater.)
- Option 3(The Specified Amount, plus the Accumulated Premium Account at _____%* interest or a multiple of the Cash/Accumulated Value, whichever is greater.) *Enter a percentage up to 12% maximum, ONLY if the Owner is a business entity. If nothing is entered or the Owner is not a business entity, 0% will apply.
- Internal Revenue Code Life Insurance Qualification Test Option**
- Guideline Premium/Cash Value Corridor Test
- Cash Value Accumulation Test
- (If no selection is made here, the Guideline Premium/Cash Value Corridor Test is elected.)*

10. Optional Benefits

Check Plan for Availability.

- Variable or Universal Life Plans Only (Subject to Plan availability.)**
- | | |
|--|--|
| <input type="checkbox"/> Spouse Rider..... \$ _____ | <input type="checkbox"/> Change of Insured Rider |
| <input type="checkbox"/> Children's Term Insurance Rider..... \$ _____ | <input type="checkbox"/> Other Rider(s) _____ |
| <input type="checkbox"/> Long Term Care Rider* \$ _____ | <input type="checkbox"/> Other Rider(s) _____ |
| <i>*Complete Supplement for Long Term Care Rider.</i> | |
| <input type="checkbox"/> Accidental Death Benefit Rider..... \$ _____ | Can select only one: |
| <input type="checkbox"/> Adjusted Sales Load Rider _____% | <input type="checkbox"/> Premium Waiver Rider \$ _____ |
| <i>(in whole percentages only) waived for _____ years</i> | <input type="checkbox"/> Waiver of Monthly Deductions Rider |
| <input type="checkbox"/> Extended Death Benefit Guarantee Rider | Can select only one: |
| _____ Guarantee Percentage (Indicate percentage of specified amount) | <input type="checkbox"/> Surrender Value Enhancement Benefit |
| _____ Guarantee Duration (Indicate number of years) | <input type="checkbox"/> Conditional Return of Premium Rider (cannot be elected with Extended Death Benefit Guarantee Rider) |

- Survivorship Variable or Survivorship Universal Life Plans Only (Subject to Plan availability.)**
- | | |
|---|--|
| <input type="checkbox"/> Four Year Term Rider** \$ _____ | <input type="checkbox"/> Policy Split Option Rider |
| <i>**If the No Charge Four Year Term Insurance has been illustrated you should NOT select this rider.</i> | <input type="checkbox"/> Other Rider(s) _____ |
| | <input type="checkbox"/> Other Rider(s) _____ |

- Whole or Term Life Plans Only (Subject to Plan availability.)**
- | | |
|--|--|
| <input type="checkbox"/> 20 Year Spouse Rider \$ _____ | <input type="checkbox"/> Owner's Waiver of Premium Death or Disability Benefit Rider (Complete Part B for the Owner) |
| <input type="checkbox"/> Children's Term Insurance Rider..... \$ _____ | Occupation _____ |
| <input type="checkbox"/> Accidental Death Benefit Rider..... \$ _____ | Height _____ |
| <input type="checkbox"/> Guaranteed Insurability Benefit Rider \$ _____ | Weight _____ |
| <input type="checkbox"/> Waiver of Premium Disability Benefit Rider | State of Birth _____ |
| <input type="checkbox"/> Owner's Waiver of Premium Death Benefit Rider (Complete Part B for the Owner) | <input type="checkbox"/> Other Rider(s) _____ |
| Occupation _____ | <input type="checkbox"/> Other Rider(s) _____ |
| Height _____ | <input type="checkbox"/> Other Rider(s) _____ |
| Weight _____ | |
| State of Birth _____ | |

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

No, do not issue with APL.



FUTURE BILLING AND PREMIUM INFORMATION

11. Amount Paid With Application
Check the applicable option and indicate the premium amount being submitted with the application.

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

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

(NOTE: Make all checks payable to NATIONWIDE.)

Web Remittance \$ _____

Draft initial payment only (indicate initial premium amount and complete Section 13b)..... \$ _____

Draft initial payment and future payments (indicate initial premium amount and complete Sections 12 & 13) \$ _____

12. Future Billing and Payment Options
Check the applicable billing or payment option(s) and indicate the premium amount.

Billing Options:	Payment Options:
<input type="checkbox"/> Monthly EFT* \$ _____ <i>*If selected, complete Section 13, Monthly Electronic Draft Authorization.</i>	<input type="checkbox"/> Single Premium \$ _____
<input type="checkbox"/> Quarterly \$ _____	<input type="checkbox"/> Billing Advantage \$ _____ Account Number _____
<input type="checkbox"/> Semi-Annual \$ _____	<input type="checkbox"/> 1035 Exchange \$ _____
<input type="checkbox"/> Annual \$ _____	<input type="checkbox"/> Other \$ _____

13. Electronic Draft Authorization

13a. Monthly Electronic Draft Options:

Monthly Draft Day (1st – 28th): _____

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

Draft Options:

*Checking - Use information on the initial premium check.

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

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

13b. If no check or deposit slip provided, indicate below the bank information to be used:

Financial Institution Name _____	Transit/ABA Number _____
Account Number _____	Type of Account: <input type="checkbox"/> *Checking <input type="checkbox"/> *Savings

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

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

Name (First, MI, Last) _____

Address _____	City _____	State _____	Zip Code _____
---------------	------------	-------------	----------------

INSURANCE INFORMATION

15. Replacement and Other Policy Information

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

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

Insured	Company	Policy Number	Amount Of Coverage	Year Issued	To Be Replaced	1035 Exch	Lapsed/ Surrendered/ Sold	Nationwide Term Conversion
			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>		<input type="checkbox"/>
			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>		<input type="checkbox"/>
			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>		<input type="checkbox"/>
			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>		<input type="checkbox"/>



FINANCIAL INFORMATION

<p>16. Financial Questions Explain all "yes" answers in Section 17 Details box below unless instructed otherwise.</p> <p style="text-align: center;">STOP</p> <p><i>This section needs to be completed by each Proposed Insured and Owner/Trustee, if other than Proposed Insured(s).</i></p>	All questions must be answered by each Proposed Insured and Owner/Trustee, if other than Proposed Insured(s). For each yes answer, indicate the appropriate item(s) and provide details.				Proposed Primary Insured		Proposed Additional Insured		Owner/Trustee if other than Proposed Insured(s)	
					Yes	No	Yes	No	Yes	No
	a. Is this policy being purchased for the purpose of selling or assigning this policy to a life settlement company, trust, limited liability corporation, viatical, or other secondary market purchaser?				<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b. Have you entered into any agreement, or made arrangements, for the sale or assignment of this policy to a life settlement company, trust, limited liability corporation, viatical, or other secondary market purchaser?				<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c. Have you been involved in any communication about the possible sale or assignment of this policy to a life settlement company, trust, limited liability corporation, viatical, or other secondary market purchaser?				<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d. Have you ever sold any life insurance policy to a life settlement company, trust, limited liability corporation, viatical, or other secondary market purchaser?				<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	e. Will any portion of the current or future premium for this policy be financed?				<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Will any Insured or Policy Owner receive any payment in connection with the insurance issued on the basis of this application?				<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

<p>17. Explanation of Financial Details If more space is needed, an additional blank sheet may be attached. Any Proposed Insured(s) or Owner(s) should sign and date additional pages.</p>	Question Letter	Person	Dates	Details

PART B - PERSONAL AND HEALTH INFORMATION

<p>18. Tobacco Use All questions are to be answered by each Proposed Insured.</p> <p style="text-align: center;">STOP</p> <p><i>Be sure to answer this section.</i></p>	Have you used tobacco or nicotine in any form?		Proposed Primary Insured		Proposed Additional Insured	
	1. In the last 12 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", date last used: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", date last used: _____	
	2. In the last 5 years?		<input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", date last used: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", date last used: _____	
	3. If "yes", check all forms of tobacco or nicotine products used.		<input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Other Tobacco <input type="checkbox"/> Nicotine Products (gum, patch, etc.)	<input type="checkbox"/> Cigars <input type="checkbox"/> Pipe <input type="checkbox"/> Snuff	<input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Other Tobacco <input type="checkbox"/> Nicotine Products (gum, patch, etc.)	<input type="checkbox"/> Cigars <input type="checkbox"/> Pipe <input type="checkbox"/> Snuff

<p>19. Physical Measurements Fill in information for the Proposed Primary Insured.</p>	Height	Current Weight	Weight 1 Year Ago	Reason for Weight Gain or Loss

<p>20. Personal Physicians If Child Rider coverage is requested, use Special Instructions Section to add Personal Physician information for each child.</p>	Proposed Primary Insured		Proposed Additional Insured		Any Child
	Name of Personal Physician:				
	Address:				
	Telephone Number:				
	Date last consulted:				
	Reason last consulted:				
Treatment given or medication prescribed:					



HEALTH INFORMATION

23. Health Questions	To the best of your knowledge and belief, has anyone here proposed for insurance ever consulted a licensed health care provider for, been treated for, taken medication for, or been diagnosed as having:	Proposed Primary Insured		Proposed Additional Insured		Any Child	
		Yes	No	Yes	No	Yes	No
<i>All questions are to be answered by each Proposed Insured.</i> <i>Explain all "yes" answers in Section 24 Details box unless instructed otherwise.</i>	a. AIDS (Acquired Immune Deficiency Syndrome), or any other AIDS-related condition, or received a positive result of an HIV (Human Immunodeficiency Virus) test?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b. Heart disease including heart attack, angina, or other chest pain, cardiomyopathy, shortness of breath, congestive heart failure, heart murmur, or other disorder of the heart?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c. Irregular heart beat, palpitations, high blood pressure, high cholesterol, or high triglycerides?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d. Aneurysm, carotid artery disease, deep venous thrombosis, phlebitis, peripheral vascular disease, any other disorder of the blood vessels, or pulmonary embolism?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	e. Headaches, seizures, epilepsy, stroke, Alzheimer's disease, dementia, Parkinson's disease, multiple sclerosis, or any other brain or nervous disorder?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	f. Depression, neurosis, affective disorder, psychosis, or any other mental or emotional disorder?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	g. Asthma, emphysema, chronic bronchitis, tuberculosis, or any other disease of the lungs or respiratory system?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	h. Colitis, ulcer, persistent diarrhea, rectal bleeding, Crohn's disease, ulcerative colitis, or any other disease or disorder of the esophagus or digestive tract?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	i. Sugar, protein or blood in the urine, kidney stones, sexually transmitted disease, or any other disease or disorder of the kidneys, bladder, prostate, breast, urinary tract or reproductive system?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	j. Diabetes, hepatitis, cirrhosis or any other disease of the liver, pancreas, or thyroid?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	k. Disorder of the blood including anemia, sickle cell disorders, thalassemia, hemophilia, or any other disorder of the red blood cells, or white blood cells, platelets, or clotting factors?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	l. Cancer, or any malignant or benign tumor or cyst, or any chronic disease of the skin or lymph glands?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	m. Arthritis, rheumatoid arthritis, osteoporosis; or any paralysis or chronic back or muscle condition?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	n. Alcoholism, narcotic addiction, drug use, or hallucinations?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	o. Any disease or disorder of the eyes, ears, nose or throat?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
To the best of your knowledge and belief, in the past 5 years, has anyone here proposed for insurance:							
p. Consulted, or been examined or treated by any physician, chiropractor, psychologist or other health care practitioner or by any hospital, clinic, or other health care facility not already disclosed on this application? <i>(If it was for a "check up", annual physical, employment physical, etc., so state and give findings and results.)</i>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
q. Had any disease, disorder, injury, or operation not already disclosed on this application?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
r. Had any x-rays, electrocardiograms, or other medical tests for reasons not already disclosed on this application?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
s. Been medically advised to have any surgery, hospitalization, treatment or test that was not completed or results that you have not received?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
t. Currently taking any medication other than indicated above to include prescription, over-the-counter medications for more than 5 days, dietary supplements, "natural" or herbal medications? (Give details of dosage and frequency.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
u. Used alcoholic beverages? <i>(If yes, how much, what kind (beer, wine, liquor), and how often?)</i>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



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

25. Special Instructions Section	<i>If more space is needed, an additional blank sheet may be attached. Any Proposed Insured(s) or Owner(s) should sign and date additional pages.</i>			
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PART C – FRAUD STATEMENTS AND IMPORTANT NOTICES

RHODE ISLAND 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 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.
Pre-Notice of Procedures as Required by The Fair Credit Reporting Act of 1970	<p>This notice is to inform you that as part of our normal underwriting procedures in connection with an application for insurance:</p> <ul style="list-style-type: none"> • An investigative consumer report may be made whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. This inquiry will include information as to character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation, with respect to you, members of your family, and others having an interest in or closely connected with the insurance transaction; and • You may elect to be interviewed if an investigative consumer report is prepared in connection with this application. You are entitled to receive a copy of any investigative consumer report by submitting your request in writing. • Upon your written request, made within a reasonable time after you receive this notice, additional information as to the nature and scope of the investigation, if one is made, will be provided. You may send corrections and requests for additional information addressed to Nationwide Life and Annuity Insurance Company, [P.O. Box 182835, Columbus, Ohio 43218-2835]. In the event of an adverse decision, you will be notified in writing.
Medical Information Bureau Disclosure Notice	Information regarding your insurability will be treated as confidential. Nationwide Life and Annuity Insurance Company, or its reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is [50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734, telephone number 866-692-6901 (TTY 866-346-3642).] The e-mail address of the Bureau's information office is www.mib.com . Nationwide Life 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.



TEMPORARY INSURANCE AGREEMENT

NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY, COLUMBUS, OH

This Agreement provides a limited amount of Life Insurance coverage, for a limited period of time, subject to the terms of this Agreement.

HEALTH QUESTION

 Question must be answered by each Proposed Insured(s).	Proposed Primary Insured		Proposed Additional Insured		Any Child		Has anyone here proposed for insurance: To the best of your knowledge and belief, within the past 10 years, been treated for, consulted a licensed health care provider, or been diagnosed by a licensed health care provider as having: angina, or chest pain or discomfort; heart attack, heart murmur, or any other heart disorder; epilepsy, stroke or diabetes; AIDS (Acquired Immune Deficiency Syndrome), any AIDS-related disorder or positive HIV (Human Immunodeficiency Virus) test result; any brain, nervous, or mental disorder, any drug or alcohol addiction; any kidney disorder (other than kidney stones); or any cancer or other malignancy?
	Yes	No	Yes	No	Yes	No	
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

If the above question is answered YES or LEFT BLANK, NO COVERAGE will take effect under this Agreement and no representative of Nationwide Life and Annuity Insurance Company is authorized to accept money, and/or provide a temporary insurance receipt to the applicant.

TERMS AND CONDITIONS

Amount of Coverage <i>[\$1,000,000] overall maximum for all applications or agreements.</i>	Temporary Insurance under this Agreement will commence on the date of the application if the full first premium for the mode selected has been paid and accepted by Nationwide or authorized by Electronic Funds Transfer as advance payment for an application for Life Insurance. If any Proposed Insured dies while this temporary insurance is in effect, Nationwide will pay to the designated Beneficiary the lesser of: <ul style="list-style-type: none"> the amount of death benefits, if any, which would be payable under the policy and its riders if issued as applied for, excluding any accidental death benefits, or [\$1,000,000] This total benefit limit applies to all insurance applied for under this and any other current applications to Nationwide and any other Temporary Insurance Agreements for Life Insurance whether applied for on the life or lives of one or more Proposed Insureds.
Date Coverage Terminates <i>60 DAYS maximum coverage.</i>	Temporary Life Insurance under this Agreement will terminate automatically on the earliest of: <ul style="list-style-type: none"> 60 days from the date of this signed Agreement, or the date any policy is offered or issued to the Proposed Insured in connection with the above application, or the date Nationwide mails notice of termination of coverage and refund of the advance payment to the Proposed Insured, or the Owner, if different than the Proposed Insured.
Limitations	<ul style="list-style-type: none"> Fraud or material misrepresentation in the application or in the answers to the Health question of this Agreement invalidates this Agreement and Nationwide's only liability is for refund of any payment made. This Agreement does not provide coverage for Proposed Insured's who are under 15 days of age or over the age of 70 on the date of the Agreement. If any Proposed Insured dies by suicide, while sane or insane, Nationwide's liability under this Agreement is limited to a refund of the payment made. There is no coverage under this Agreement if the check submitted as payment is not honored by the bank on first presentation or if the Electronic Funds Transfer is not processed by the bank. No one is authorized to waive or modify any of the provisions of this Agreement.

SIGNATURES

Proposed Insured(s) and Owner Signatures	I HAVE RECEIVED A COPY OF AND HAVE READ THIS AGREEMENT AND DECLARE THAT THE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND AND AGREE TO ALL ITS TERMS. Dated (mm/dd/yyyy) <u>July 28, 2008</u> X <u>John D. Doe</u> Signature of Proposed Primary Insured (or parent if Proposed Primary Insured is under age 15) X _____ X _____ Signature of Applicant/Owner (if other than the Proposed Insured(s)) Signature of Proposed Additional Insured (if to be Insured)
Initial Premium Receipt and Producer's Signature  Be sure to include the amount of the initial premium payment.	An initial premium payment in the amount of \$ _____ has been submitted with this application. I have advised the Applicant/Owner that additional premium may need to be submitted at time of delivery. X <u>Sam A. Producer</u> _____ <u>Any Firm</u> _____ <u>02-A000000</u> Signature of Producer Firm Producer's Nationwide #



SERFF Tracking Number: NWPA-127334583 State: Arkansas
Filing Company: Nationwide Life and Annuity Insurance Company State Tracking Number: 49421
Company Tracking Number: LAA-0111M1; LAA-0112M1; LAA-0113M1, APPLICATIONS FOR INDIVIDUAL LIFE INSURANCE
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: LAA-0111M1, Application for Individual Life Insurance
Project Name/Number: LAA-0111M1, Application for Individual Life Insurance/LAA-0111M1, Application for Individual Life Insurance

Supporting Document Schedules

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

	Item Status:	Status Date:
Satisfied - Item: Application		
Comments: This is an application filing. All forms to be used with the applications are listed with approval dates in the general description.		

	Item Status:	Status Date:
Satisfied - Item: Statement of Variability		
Comments:		
Attachment: Statement of Variability-M1.pdf		



ARKANSAS

Certificate of Compliance

Insurer Nationwide Life and Annuity Insurance Company

Form Numbers: LAA-0111M1, Application for Life Insurance
LAA-0112M1, Application for Life Insurance
LAA-0113M1, 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.

These forms 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 "James J. Rabenstine".

James J. Rabenstine
Vice President
NF Compliance
Date: 07-22-2011

**NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY
(07/2011)**

STATEMENT OF VARIABILITY FOR FORMS:

**LAA-0111M1, Application for Life Insurance
LAA-0112M1, Application for Life Insurance
LAA-0113M1, Application for Life Insurance**

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

Page 3, Plan Information Section

Life Insurance Plan Names	The Plan Names are bracketed as they can change over time. We will remove or add Plan Names as appropriate.
Optional Benefits (Riders)	The Optional Benefits (Riders) are bracketed to allow us to add options as they are approved and to remove options that are discontinued. All the rider information for the previously approved riders will not change unless the rider is re-filed.

Page 8, Part C - Fraud Statements and Important Notices Section

Pre-Notice of Procedures as Required by The Fair Credit Reporting Act of 1970 and Medical Information Bureau Disclosure Notice	The address and/or telephone information is bracketed in case either change in the future.
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Page 10, Temporary Insurance Agreement, Terms and Conditions Section

Amount of Coverage	The current total benefit limit is bracketed in case it changes in the future.
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SERFF Tracking Number: NWPA-127334583 State: Arkansas
 Filing Company: Nationwide Life and Annuity Insurance Company State Tracking Number: 49421
 Company Tracking Number: LAA-0111M1; LAA-0112M1; LAA-0113M1, APPLICATIONS FOR INDIVIDUAL LIFE INSURANCE
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: LAA-0111M1, Application for Individual Life Insurance
 Project Name/Number: LAA-0111M1, Application for Individual Life Insurance/LAA-0111M1, Application for Individual Life Insurance

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
07/22/2011	Form	Application for Individual Life Insurance	08/02/2011	LAA-0111M1.pdf (Superseded)
07/22/2011	Form	Application for Individual Life Insurance	08/02/2011	LAA-0112M1.pdf (Superseded)
07/22/2011	Form	Application for Individual Life Insurance	08/02/2011	LAA-0113M1.pdf (Superseded)

NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY

Application for Individual Life Insurance

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

PART A – CLIENT INFORMATION

1. Proposed Primary Insured	Name (First, MI, Last) John D. Doe						SSN / Tax ID # 000 - 00 - 0000			
	Address One Any Street					City Any City				
	State Any State	Zip Code 00000	County Any County		Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	Former Name				
	Marital Status <input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other _____				Age 35	Date of Birth (mm/dd/yyyy) 02/07/1973	State of Birth OH			
	E-Mail Address JDDOE@YAHOO.COM					Phone # (000) 000-0000		<input type="checkbox"/> AM <input checked="" type="checkbox"/> PM		
	Driver's License # / State of Issue RL000000 OH			Annual Income		Net Worth				
	Occupation		Employer		Citizenship (If other, submit Foreign Supplement.) <input type="checkbox"/> U.S. <input type="checkbox"/> Canada <input type="checkbox"/> Other, how long have you lived in the U.S.? _____					
	2. Proposed Additional Insured <i>If applicable, complete for either:</i> a) Joint Insured for Survivorship Life Plan; or b) Term Rider on Another Covered Person (i.e., Spouse/Children) <i>If additional space is required, use Special Instructions Section.</i>	Name of Additional Insured(s)		Birth Date	Birth State	Sex	Height	Weight	SSN / Tax ID #	Relationship to Primary Insured
<i>Joint/Spouse Proposed Additional Insured Information Only</i>										
Former Name			Address <input type="checkbox"/> (Check box if same as Proposed Primary Insured)							
City		State	Zip Code		County					
E-Mail Address					Phone # ()		<input type="checkbox"/> AM <input type="checkbox"/> PM			
Driver's License # / State of Issue			Annual Income		Net Worth					
Occupation		Employer		Citizenship (If other, submit Foreign Supplement.) <input type="checkbox"/> U.S. <input type="checkbox"/> Canada <input type="checkbox"/> Other, how long have you lived in the U.S.? _____						
3. Owner <i>Complete ONLY if Owner is not the Proposed Primary Insured.</i> <i>Unless indicated the Proposed Primary Insured (Joint Insureds in the case of Survivorship) will own the policy.</i> <i>If more than two Owners are requested, use Special Instructions Section.</i> <i>TRUST - Submit a copy of first and signature pages of Trust document.</i>		Name (First, MI, Last)						SSN / Tax ID # - -		
		Address <input type="checkbox"/> (Check box if same as Proposed Primary Insured)					City			
		State	Zip Code	County		Date of Birth (mm/dd/yyyy)		Phone # ()		<input type="checkbox"/> AM <input type="checkbox"/> PM
	Type of Owner <input type="checkbox"/> Individual <input type="checkbox"/> Employer <input type="checkbox"/> Trust <input type="checkbox"/> Rabbi Trust <input type="checkbox"/> Other _____			Relationship to Insured		E-Mail Address				
	<i>If more than one Owner the following will be applicable: 1) Ownership will be vested jointly with right of survivorship, otherwise to the Executor or Administrator of the last owner's estate. 2) All notices will be mailed to the one address listed above unless otherwise instructed. 3) For tax reporting purposes, only one Social Security Number can be used. The SSN shown above will be used unless otherwise instructed.</i>									
	Joint Owner (First, MI, Last)						SSN / Tax ID # - -			
	Address <input type="checkbox"/> (Check box if same as Proposed Primary Insured)					City				
	State	Zip Code	County		Date of Birth (mm/dd/yyyy)		Phone # ()		<input type="checkbox"/> AM <input type="checkbox"/> PM	
	Type of Owner <input type="checkbox"/> Individual <input type="checkbox"/> Employer <input type="checkbox"/> Trust <input type="checkbox"/> Rabbi Trust <input type="checkbox"/> Other _____			Relationship to Insured		E-Mail Address				
	Exact Name of Trust			Trust Tax ID Number		Current Trustee(s)		Date of Trust		



4. Contingent Owner <i>Complete this section to name an alternative Owner in the event the Insured survives the Owner.</i>	Name (First, MI, Last)				SSN / Tax ID #	
	Address <input type="checkbox"/> (Check box if same as Proposed Primary Insured)				City	
	State	Zip Code	County	Relationship to Insured	Date of Birth (mm/dd/yyyy)	
5. Primary Beneficiary Designations <i>If Survivorship Life Plan, the Proposed Insureds may not be named as Beneficiary.</i> <i>If additional space is required, use Special Instructions Section.</i>	<i>When more than one Beneficiary is designated, payments will be made in equal shares to the Beneficiaries surviving the Insured, or in full to the last surviving Beneficiary, unless some other distribution of proceeds is provided.</i>					
	<input type="checkbox"/> <i>Check this box if Trust named in the Owner section is to be the Primary Beneficiary. If a different Trust is named as Primary Beneficiary or Trust is named as Contingent Beneficiary, provide the Trust information below.</i>					
	For Proposed Primary Insured					
	Primary Beneficiary(ies) Name(s) or Trust and Trustee(s)	Share %	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID #	Address
	Jane S. Doe	100	Wife	10/08/1975	000-00-0000	One Any Street Any City, Any State 00000
	For Proposed Additional Insured					
	Primary Beneficiary(ies) Name(s) or Trust and Trustee(s)	Share %	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID #	Address
6. Contingent Beneficiary Designations <i>If additional space is required, use Special Instructions Section.</i>	For Proposed Primary Insured					
	Contingent Beneficiary(ies) Name(s) or Trust and Trustee(s)	Share %	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID #	Address
	For Proposed Additional Insured					
	Contingent Beneficiary(ies) Name(s) or Trust and Trustee(s)	Share %	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID #	Address
7. Taxpayer ID Number  <i>Check box, if applicable</i>	I certify under penalties of perjury that: <ul style="list-style-type: none"> • The number shown on this form is my correct taxpayer identification number and, • I am not subject to backup withholding because <ul style="list-style-type: none"> ♦ I have not been notified that I am subject to backup withholding as a result of a failure to report all interest or dividends, or ♦ the Internal Revenue Service has notified me that I am no longer subject to backup withholding, or that I am exempt from backup withholding, and • I am a U.S. person (including a U.S. resident alien). <input type="checkbox"/> Check this box if you have been notified by the IRS that you are currently subject to backup withholding because of failure to report interest or dividends on your tax return.					
	The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.					



PLAN INFORMATION

8. Life Insurance Plan



*The Variable Life Fund Supplement MUST be completed if applying for a Variable Product.
The IUL Allocation Form MUST be completed if applying for an Index UL Product.*

- | | |
|---|--|
| <input type="checkbox"/> Nationwide YourLife® 10-year Term
<input type="checkbox"/> Nationwide YourLife® 15-year Term
<input type="checkbox"/> Nationwide YourLife® 20-year Term
<input type="checkbox"/> Nationwide YourLife® 30-year Term
<input type="checkbox"/> Nationwide YourLife® 20-Pay WL
<input type="checkbox"/> Nationwide YourLife® WL 100
<input type="checkbox"/> Nationwide YourLife® Current Assumption UL
<input type="checkbox"/> Nationwide YourLife® No-Lapse Guarantee UL | <input type="checkbox"/> Nationwide YourLife® Indexed UL
<input type="checkbox"/> Nationwide YourLife® SUL
<input type="checkbox"/> Nationwide YourLife® No-Lapse Guarantee SUL II
<input type="checkbox"/> Nationwide YourLife® Protection VUL
<input type="checkbox"/> Nationwide YourLife® Accumulation VUL
<input type="checkbox"/> Nationwide YourLife® Survivorship VUL
<input type="checkbox"/> Other _____ |
|---|--|

Base Specified Amount	+	Additional Term Rider/Supplemental Coverage Amount (check plan for availability)	=	Total Specified Amount (including Additional Term Rider/Supplemental Coverage)
\$ 250,000.00		\$ _____		\$ 250,000.00

9. Additional Options



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

- Death Benefit Option (If no option is selected here, Option 1 is elected.)**
- Option 1(The Specified Amount, or a multiple of the Cash/Accumulated Value, whichever is greater.)
- Option 2(The Specified Amount, plus the Cash/Accumulated Value, or a multiple of the Cash/Accumulated Value, whichever is greater.)
- Option 3(The Specified Amount, plus the Accumulated Premium Account at _____%* interest or a multiple of the Cash/Accumulated Value, whichever is greater.) *Enter a percentage up to 12% maximum, **ONLY** if the Owner is a business entity. If nothing is entered or the Owner is not a business entity, 0% will apply.
- Internal Revenue Code Life Insurance Qualification Test Option**
- Guideline Premium/Cash Value Corridor Test
- Cash Value Accumulation Test
- (If no selection is made here, the Guideline Premium/Cash Value Corridor Test is elected.)*

10. Optional Benefits

Check Plan for Availability.

- Variable or Universal Life Plans Only (Subject to Plan availability.)**
- | | |
|--|---|
| <input type="checkbox"/> Spouse Rider..... \$ _____
<input type="checkbox"/> Children's Term Insurance Rider..... \$ _____
<input type="checkbox"/> Long Term Care Rider* \$ _____
*Complete Supplement for Long Term Care Rider.
<input type="checkbox"/> Accidental Death Benefit Rider..... \$ _____
<input type="checkbox"/> Adjusted Sales Load Rider _____%
(in whole percentages only) waived for _____ years
<input type="checkbox"/> Extended Death Benefit Guarantee Rider
_____ Guarantee Percentage (Indicate percentage of specified amount)
_____ Guarantee Duration (Indicate number of years) | <input type="checkbox"/> Change of Insured Rider
<input type="checkbox"/> Other Rider(s) _____
<input type="checkbox"/> Other Rider(s) _____
Can select only one:
<input type="checkbox"/> Premium Waiver Rider \$ _____
<input type="checkbox"/> Waiver of Monthly Deductions Rider
Can select only one:
<input type="checkbox"/> Surrender Value Enhancement Benefit
<input type="checkbox"/> Conditional Return of Premium Rider (cannot be elected with Extended Death Benefit Guarantee Rider) |
|--|---|

- Survivorship Variable or Survivorship Universal Life Plans Only (Subject to Plan availability.)**
- Four Year Term Rider** \$ _____
- **If the No Charge Four Year Term Insurance has been illustrated you should NOT select this rider.*
- Policy Split Option Rider
 Other Rider(s) _____
 Other Rider(s) _____

- Whole or Term Life Plans Only (Subject to Plan availability.)**
- | | |
|--|---|
| <input type="checkbox"/> 20 Year Spouse Rider \$ _____
<input type="checkbox"/> Children's Term Insurance Rider..... \$ _____
<input type="checkbox"/> Accidental Death Benefit Rider..... \$ _____
<input type="checkbox"/> Guaranteed Insurability Benefit Rider \$ _____
<input type="checkbox"/> Waiver of Premium Disability Benefit Rider
<input type="checkbox"/> Owner's Waiver of Premium Death Benefit Rider
(Complete Part B for the Owner)
Occupation _____
Height _____
Weight _____
State of Birth _____ | <input type="checkbox"/> Owner's Waiver of Premium Death or Disability Benefit Rider (Complete Part B for the Owner)
Occupation _____
Height _____
Weight _____
State of Birth _____
<input type="checkbox"/> Other Rider(s) _____
<input type="checkbox"/> Other Rider(s) _____
<input type="checkbox"/> Other Rider(s) _____ |
|--|---|

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

No, do not issue with APL.



FUTURE BILLING AND PREMIUM INFORMATION

11. Amount Paid With Application
Check the applicable option and indicate the premium amount being submitted with the application.

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

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

(NOTE: Make all checks payable to NATIONWIDE.)

Web Remittance \$ _____

Draft initial payment only (indicate initial premium amount and complete Section 13b)..... \$ _____

Draft initial payment and future payments (indicate initial premium amount and complete Sections 12 & 13) \$ _____

12. Future Billing and Payment Options
Check the applicable billing or payment option(s) and indicate the premium amount.

<p>Billing Options:</p> <p><input type="checkbox"/> Monthly EFT* \$ _____</p> <p><i>*If selected, complete Section 13, Monthly Electronic Draft Authorization.</i></p> <p><input type="checkbox"/> Quarterly \$ _____</p> <p><input type="checkbox"/> Semi-Annual \$ _____</p> <p><input type="checkbox"/> Annual..... \$ _____</p>	<p>Payment Options:</p> <p><input type="checkbox"/> Single Premium \$ _____</p> <p><input type="checkbox"/> Billing Advantage \$ _____</p> <p>Account Number _____</p> <p><input type="checkbox"/> 1035 Exchange..... \$ _____</p> <p><input type="checkbox"/> Other..... \$ _____</p>
--	---

13. Electronic Draft Authorization

13a. Monthly Electronic Draft Options:

Monthly Draft Day (1st – 28th): _____

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

Draft Options:

*Checking - Use information on the initial premium check.

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

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

13b. If no check or deposit slip provided, indicate below the bank information to be used:

Financial Institution Name _____	Transit/ABA Number _____
Account Number _____	Type of Account: <input type="checkbox"/> *Checking <input type="checkbox"/> *Savings

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

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

Name (First, MI, Last) _____

Address _____	City _____	State _____	Zip Code _____
---------------	------------	-------------	----------------

INSURANCE INFORMATION

15. Replacement and Other Policy Information

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

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

Insured	Company	Policy Number	Amount Of Coverage	Year Issued	To Be Replaced	1035 Exch	Lapsed/ Surrendered/ Sold	Nationwide Term Conversion
			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>		<input type="checkbox"/>
			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>		<input type="checkbox"/>
			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>		<input type="checkbox"/>
			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>		<input type="checkbox"/>



FINANCIAL INFORMATION

<p>16. Financial Questions Explain all "yes" answers in Section 17 Details box below unless instructed otherwise.</p> <p style="text-align: center;">STOP</p> <p><i>This section needs to be completed by each Proposed Insured and Owner/Trustee, if other than Proposed Insured(s).</i></p>	<p>All questions must be answered by each Proposed Insured and Owner/Trustee, if other than Proposed Insured(s). For each yes answer, indicate the appropriate item(s) and provide details.</p>			<p>Proposed Primary Insured</p>		<p>Proposed Additional Insured</p>		<p>Owner/Trustee if other than Proposed Insured(s)</p>	
				Yes	No	Yes	No	Yes	No
	a. Is this policy being purchased for the purpose of selling or assigning this policy to a life settlement company, trust, limited liability corporation, viatical, or other secondary market purchaser?			<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b. Have you entered into any agreement, or made arrangements, for the sale or assignment of this policy to a life settlement company, trust, limited liability corporation, viatical, or other secondary market purchaser?			<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c. Have you been involved in any communication about the possible sale or assignment of this policy to a life settlement company, trust, limited liability corporation, viatical, or other secondary market purchaser?			<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d. Have you ever sold any life insurance policy to a life settlement company, trust, limited liability corporation, viatical, or other secondary market purchaser?			<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	e. Will any portion of the current or future premium for this policy be financed?			<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Will any Insured or Policy Owner receive any payment in connection with the insurance issued on the basis of this application?			<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

<p>17. Explanation of Financial Details If more space is needed, an additional blank sheet may be attached. Any Proposed Insured(s) or Owner(s) should sign and date additional pages.</p>	Question Letter	Person	Dates	Details

PART B - PERSONAL AND HEALTH INFORMATION

<p>18. Tobacco Use All questions are to be answered by each Proposed Insured.</p> <p style="text-align: center;">STOP</p> <p><i>Be sure to answer this section.</i></p>	<p>Have you used tobacco or nicotine in any form?</p>		<p>Proposed Primary Insured</p>		<p>Proposed Additional Insured</p>	
	1. In the last 12 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", date last used: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", date last used: _____	
	2. In the last 5 years?		<input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", date last used: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", date last used: _____	
	3. If "yes", check all forms of tobacco or nicotine products used.		<input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Other Tobacco <input type="checkbox"/> Nicotine Products (gum, patch, etc.)	<input type="checkbox"/> Cigars <input type="checkbox"/> Pipe <input type="checkbox"/> Snuff	<input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Other Tobacco <input type="checkbox"/> Nicotine Products (gum, patch, etc.)	<input type="checkbox"/> Cigars <input type="checkbox"/> Pipe <input type="checkbox"/> Snuff

<p>19. Physical Measurements Fill in information for the Proposed Primary Insured.</p>	Height	Current Weight	Weight 1 Year Ago	Reason for Weight Gain or Loss

<p>20. Personal Physicians If Child Rider coverage is requested, use Special Instructions Section to add Personal Physician information for each child.</p>	<p>Proposed Primary Insured</p>		<p>Proposed Additional Insured</p>		<p>Any Child</p>	
	Name of Personal Physician:					
	Address:					
	Telephone Number:					
	Date last consulted:					
	Reason last consulted:					
Treatment given or medication prescribed:						



HEALTH INFORMATION

23. Health Questions	To the best of your knowledge and belief, has anyone here proposed for insurance ever consulted a licensed health care provider for, been treated for, taken medication for, or been diagnosed as having:	Proposed Primary Insured		Proposed Additional Insured		Any Child	
		Yes	No	Yes	No	Yes	No
<i>All questions are to be answered by each Proposed Insured.</i> <i>Explain all "yes" answers in Section 24 Details box unless instructed otherwise.</i>	a. AIDS (Acquired Immune Deficiency Syndrome), or any other AIDS-related condition, or received a positive result of an HIV (Human Immunodeficiency Virus) test?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b. Heart disease including heart attack, angina, or other chest pain, cardiomyopathy, shortness of breath, congestive heart failure, heart murmur, or other disorder of the heart?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c. Irregular heart beat, palpitations, high blood pressure, high cholesterol, or high triglycerides?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d. Aneurysm, carotid artery disease, deep venous thrombosis, phlebitis, peripheral vascular disease, any other disorder of the blood vessels, or pulmonary embolism?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	e. Headaches, seizures, epilepsy, stroke, Alzheimer's disease, dementia, Parkinson's disease, multiple sclerosis, or any other brain or nervous disorder?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	f. Depression, neurosis, affective disorder, psychosis, or any other mental or emotional disorder?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	g. Asthma, emphysema, chronic bronchitis, tuberculosis, or any other disease of the lungs or respiratory system?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	h. Colitis, ulcer, persistent diarrhea, rectal bleeding, Crohn's disease, ulcerative colitis, or any other disease or disorder of the esophagus or digestive tract?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	i. Sugar, protein or blood in the urine, kidney stones, sexually transmitted disease, or any other disease or disorder of the kidneys, bladder, prostate, breast, urinary tract or reproductive system?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	j. Diabetes, hepatitis, cirrhosis or any other disease of the liver, pancreas, or thyroid?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	k. Disorder of the blood including anemia, sickle cell disorders, thalassemia, hemophilia, or any other disorder of the red blood cells, or white blood cells, platelets, or clotting factors?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	l. Cancer, or any malignant or benign tumor or cyst, or any chronic disease of the skin or lymph glands?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	m. Arthritis, rheumatoid arthritis, osteoporosis; or any paralysis or chronic back or muscle condition?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	n. Alcoholism, narcotic addiction, drug use, or hallucinations?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	o. Any disease or disorder of the eyes, ears, nose or throat?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
To the best of your knowledge and belief, in the past 5 years, has anyone here proposed for insurance:							
p. Consulted, or been examined or treated by any physician, chiropractor, psychologist or other health care practitioner or by any hospital, clinic, or other health care facility not already disclosed on this application? <i>(If it was for a "check up", annual physical, employment physical, etc., so state and give findings and results.)</i>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
q. Had any disease, disorder, injury, or operation not already disclosed on this application?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
r. Had any x-rays, electrocardiograms, or other medical tests for reasons not already disclosed on this application?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
s. Been medically advised to have any surgery, hospitalization, treatment or test that was not completed or results that you have not received?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
t. Currently taking any medication other than indicated above to include prescription, over-the-counter medications for more than 5 days, dietary supplements, "natural" or herbal medications? (Give details of dosage and frequency.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
u. Used alcoholic beverages? <i>(If yes, how much, what kind (beer, wine, liquor), and how often?)</i>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



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

25. Special Instructions Section	<i>If more space is needed, an additional blank sheet may be attached. Any Proposed Insured(s) or Owner(s) should sign and date additional pages.</i>			
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PART C – FRAUD STATEMENTS AND IMPORTANT NOTICES

RHODE ISLAND 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 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.
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: <ul style="list-style-type: none"> • An investigative consumer report may be made whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. This inquiry will include information as to character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation, with respect to you, members of your family, and others having an interest in or closely connected with the insurance transaction; and • You may elect to be interviewed if an investigative consumer report is prepared in connection with this application. You are entitled to receive a copy of any investigative consumer report by submitting your request in writing. • Upon your written request, made within a reasonable time after you receive this notice, additional information as to the nature and scope of the investigation, if one is made, will be provided. You may send corrections and requests for additional information addressed to Nationwide Life and Annuity Insurance Company, [P.O. Box 182835, Columbus, Ohio 43218-2835]. In the event of an adverse decision, you will be notified in writing.
Medical Information Bureau Disclosure Notice	Information regarding your insurability will be treated as confidential. Nationwide Life and Annuity Insurance Company, or its reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is [50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734, telephone number 866-692-6901 (TTY 866-346-3642).] The e-mail address of the Bureau's information office is www.mib.com. Nationwide Life and Annuity Insurance Company or its reinsurer(s) may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.



PART D – AGREEMENT, AUTHORIZATION AND SIGNATURE

<p>Agreement</p>	<p>I understand and agree that:</p> <ul style="list-style-type: none"> • This application, any amendments to it, and any related medical examination(s) will become a part of the Policy and are the basis of any insurance issued upon this application. • The Proposed Insured or Owner has a right to cancel this application at any time by contacting their producer or Nationwide in writing. No producer, medical examiner or other representative of Nationwide may accept risks or make or change any contract; or waive or change any of the Company's rights or requirements. • If the full first premium is made in exchange for a Temporary Insurance Agreement, Nationwide will only be liable to the extent set forth in that Agreement. • If the full first premium is not paid with this application, then insurance will only take effect when (1) a policy is issued by Nationwide and accepted by me; and (2) the full first premium is paid; and (3) all the answers and statements made on the application, medical examination(s) and amendments are true to the best of my knowledge and belief when (1) and (2) have occurred.
<p>Authorization</p>	<p>I authorize: any licensed physician or medical practitioner; any hospital, clinic, any pharmacy benefit managers, and other sources who maintain prescription drug records and related information, or other medical or medically related facility; any insurance company; the Medical Information Bureau; or any other organization, institution, or person to disclose my entire medical record and any other protected health information concerning me to the Medical Director of the 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. By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this form; and I instruct any physician; health care professional; hospital; clinic; medical facility; or other health care provider to release and disclose my entire medical record without restriction. I understand that any information that is disclosed pursuant to this form may be redisclosed and no longer be covered by federal rules governing privacy and confidentiality of health information. This form, or a copy of it, will be valid for a period of not more than two years (24 months) from the date it was signed. I understand that I have the right to revoke this form in writing, at anytime, by sending a written request for revocation to Nationwide Life and Annuity Insurance Company, [Attention: Underwriting, P.O. Box 182835, Columbus, Ohio 43218-2835]. I understand that a revocation is not effective to the extent that any of my providers have relied on this form; or to the extent that Nationwide Life and Annuity Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I further understand that if I refuse to sign this form to release my complete medical records, Nationwide Life 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.</p>
<p>Proposed Insured(s) and Owner/Trustee Signatures</p> <p style="text-align: center;"></p> <p><i>All Financial questions in Section 16 (a through f) are required to be answered for both the Proposed Insured(s) and Owner, if not Proposed Insured(s).</i></p>	<p>I HAVE READ THIS APPLICATION AND AGREEMENT AND DECLARE THAT THE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND AND AGREE TO ALL ITS TERMS.</p> <p>Signed at _____, on _____, _____, 2008 City/State Month/Day Year</p> <p>_____ X _____ John D. Doe John D. Doe Full Name of Proposed Primary Insured (print) Signature of Proposed Primary Insured (or parent if Proposed Primary Insured is under age 15)</p> <p>_____ X _____ Full Name of Proposed Additional Insured (print) Signature of Proposed Additional Insured (if to be Insured)</p> <p>X _____ X _____ Signature of Applicant/Owner Signature of Applicant/Owner (if other than the Proposed Insured(s)) (if other than the Proposed Insured(s))</p>

PART E - PRODUCER'S CERTIFICATION

<p>Producer's Certification</p> <p style="text-align: center;"></p> <p><i>Be sure to answer all three questions.</i></p>	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;"><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>a. I have truly and accurately recorded all Proposed Insureds' answers on this application.</td> </tr> <tr> <td><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>b. I have witnessed his/her/their signature(s) hereon. <i>(If "no", provide details in Special Instructions Section.)</i></td> </tr> <tr> <td><input type="checkbox"/> Will <input checked="" type="checkbox"/> Will Not</td> <td>c. To the best of my knowledge, the insurance applied for will or will not replace any Life Insurance, and/or Annuities.</td> </tr> </table> <p>_____ X _____ Sam A. Producer Sam A. Producer Producer's Name (print) Signature of Producer</p> <p>_____ _____ Any Firm 02-A000000 Firm Producer's Nationwide #</p>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	a. I have truly and accurately recorded all Proposed Insureds' answers on this application.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	b. I have witnessed his/her/their signature(s) hereon. <i>(If "no", provide details in Special Instructions Section.)</i>	<input type="checkbox"/> Will <input checked="" type="checkbox"/> Will Not	c. To the best of my knowledge, the insurance applied for will or will not replace any Life Insurance, and/or Annuities.
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	a. I have truly and accurately recorded all Proposed Insureds' answers on this application.						
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	b. I have witnessed his/her/their signature(s) hereon. <i>(If "no", provide details in Special Instructions Section.)</i>						
<input type="checkbox"/> Will <input checked="" type="checkbox"/> Will Not	c. To the best of my knowledge, the insurance applied for will or will not replace any Life Insurance, and/or Annuities.						



TEMPORARY INSURANCE AGREEMENT

NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY, COLUMBUS, OH

This Agreement provides a limited amount of Life Insurance coverage, for a limited period of time, subject to the terms of this Agreement.

HEALTH QUESTION

 Question must be answered by each Proposed Insured(s).	Proposed Primary Insured		Proposed Additional Insured		Any Child		Has anyone here proposed for insurance: To the best of your knowledge and belief, within the past 10 years, been treated for, consulted a licensed health care provider, or been diagnosed by a licensed health care provider as having: angina, or chest pain or discomfort; heart attack, heart murmur, or any other heart disorder; epilepsy, stroke or diabetes; AIDS (Acquired Immune Deficiency Syndrome), any AIDS-related disorder or positive HIV (Human Immunodeficiency Virus) test result; any brain, nervous, or mental disorder, any drug or alcohol addiction; any kidney disorder (other than kidney stones); or any cancer or other malignancy?
	Yes	No	Yes	No	Yes	No	
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

If the above question is answered YES or LEFT BLANK, NO COVERAGE will take effect under this Agreement and no representative of Nationwide Life and Annuity Insurance Company is authorized to accept money, and/or provide a temporary insurance receipt to the applicant.

TERMS AND CONDITIONS

Amount of Coverage <i>[\$1,000,000] overall maximum for all applications or agreements.</i>	Temporary Insurance under this Agreement will commence on the date of the application if the full first premium for the mode selected has been paid and accepted by Nationwide or authorized by Electronic Funds Transfer as advance payment for an application for Life Insurance. If any Proposed Insured dies while this temporary insurance is in effect, Nationwide will pay to the designated Beneficiary the lesser of: <ul style="list-style-type: none"> the amount of death benefits, if any, which would be payable under the policy and its riders if issued as applied for, excluding any accidental death benefits, or [\$1,000,000] This total benefit limit applies to all insurance applied for under this and any other current applications to Nationwide and any other Temporary Insurance Agreements for Life Insurance whether applied for on the life or lives of one or more Proposed Insureds.
Date Coverage Terminates <i>60 DAYS maximum coverage.</i>	Temporary Life Insurance under this Agreement will terminate automatically on the earliest of: <ul style="list-style-type: none"> 60 days from the date of this signed Agreement, or the date any policy is offered or issued to the Proposed Insured in connection with the above application, or the date Nationwide mails notice of termination of coverage and refund of the advance payment to the Proposed Insured, or the Owner, if different than the Proposed Insured.
Limitations	<ul style="list-style-type: none"> Fraud or material misrepresentation in the application or in the answers to the Health question of this Agreement invalidates this Agreement and Nationwide's only liability is for refund of any payment made. This Agreement does not provide coverage for Proposed Insured's who are under 15 days of age or over the age of 70 on the date of the Agreement. If any Proposed Insured dies by suicide, while sane or insane, Nationwide's liability under this Agreement is limited to a refund of the payment made. There is no coverage under this Agreement if the check submitted as payment is not honored by the bank on first presentation or if the Electronic Funds Transfer is not processed by the bank. No one is authorized to waive or modify any of the provisions of this Agreement.

SIGNATURES

Proposed Insured(s) and Owner Signatures	I HAVE RECEIVED A COPY OF AND HAVE READ THIS AGREEMENT AND DECLARE THAT THE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND AND AGREE TO ALL ITS TERMS. Dated (mm/dd/yyyy) <u>July 28, 2008</u> X <u>John D. Doe</u> Signature of Proposed Primary Insured (or parent if Proposed Primary Insured is under age 15) X _____ X _____ Signature of Applicant/Owner (if other than the Proposed Insured(s)) Signature of Proposed Additional Insured (if to be Insured)
Initial Premium Receipt and Producer's Signature  Be sure to include the amount of the initial premium payment.	An initial premium payment in the amount of \$ _____ has been submitted with this application. I have advised the Applicant/Owner that additional premium may need to be submitted at time of delivery. X <u>Sam A. Producer</u> _____ <u>Any Firm</u> _____ <u>02-A000000</u> Signature of Producer Firm Producer's Nationwide #



NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY

Application for Individual Life Insurance

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

PART A – CLIENT INFORMATION

1. Proposed Primary Insured	Name (First, MI, Last) John D. Doe						SSN / Tax ID # 000 - 00 - 0000			
	Address One Any Street					City Any City				
	State Any State	Zip Code 00000	County Any County		Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	Former Name				
	Marital Status <input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other _____				Age 35	Date of Birth (mm/dd/yyyy) 02/07/1973	State of Birth OH			
	E-Mail Address JDDOE@YAHOO.COM					Phone # (000) 000-0000		<input type="checkbox"/> AM <input checked="" type="checkbox"/> PM		
	Driver's License # / State of Issue RL000000 OH			Annual Income		Net Worth				
	Occupation		Employer		Citizenship (If other, submit Foreign Supplement.) <input type="checkbox"/> U.S. <input type="checkbox"/> Canada <input type="checkbox"/> Other, how long have you lived in the U.S.? _____					
	2. Proposed Additional Insured <i>If applicable, complete for either:</i> a) Joint Insured for Survivorship Life Plan; or b) Term Rider on Another Covered Person (i.e., Spouse/Children) <i>If additional space is required, use Special Instructions Section.</i>	Name of Additional Insured(s)		Birth Date	Birth State	Sex	Height	Weight	SSN / Tax ID #	Relationship to Primary Insured
<i>Joint/Spouse Proposed Additional Insured Information Only</i>										
Former Name			Address <input type="checkbox"/> (Check box if same as Proposed Primary Insured)							
City		State	Zip Code		County					
E-Mail Address					Phone # ()		<input type="checkbox"/> AM <input type="checkbox"/> PM			
Driver's License # / State of Issue			Annual Income		Net Worth					
Occupation		Employer		Citizenship (If other, submit Foreign Supplement.) <input type="checkbox"/> U.S. <input type="checkbox"/> Canada <input type="checkbox"/> Other, how long have you lived in the U.S.? _____						
3. Owner <i>Complete ONLY if Owner is not the Proposed Primary Insured.</i> <i>Unless indicated the Proposed Primary Insured (Joint Insureds in the case of Survivorship) will own the policy.</i> <i>If more than two Owners are requested, use Special Instructions Section.</i> TRUST - Submit a copy of first and signature pages of Trust document.		Name (First, MI, Last)						SSN / Tax ID #		
		Address <input type="checkbox"/> (Check box if same as Proposed Primary Insured)					City			
		State	Zip Code	County		Date of Birth (mm/dd/yyyy)		Phone # ()		<input type="checkbox"/> AM <input type="checkbox"/> PM
	Type of Owner <input type="checkbox"/> Individual <input type="checkbox"/> Employer <input type="checkbox"/> Trust <input type="checkbox"/> Rabbi Trust <input type="checkbox"/> Other _____			Relationship to Insured		E-Mail Address				
	<i>If more than one Owner the following will be applicable: 1) Ownership will be vested jointly with right of survivorship, otherwise to the Executor or Administrator of the last owner's estate. 2) All notices will be mailed to the one address listed above unless otherwise instructed. 3) For tax reporting purposes, only one Social Security Number can be used. The SSN shown above will be used unless otherwise instructed.</i>									
	Joint Owner (First, MI, Last)						SSN / Tax ID #			
	Address <input type="checkbox"/> (Check box if same as Proposed Primary Insured)					City				
	State	Zip Code	County		Date of Birth (mm/dd/yyyy)		Phone # ()		<input type="checkbox"/> AM <input type="checkbox"/> PM	
	Type of Owner <input type="checkbox"/> Individual <input type="checkbox"/> Employer <input type="checkbox"/> Trust <input type="checkbox"/> Rabbi Trust <input type="checkbox"/> Other _____			Relationship to Insured		E-Mail Address				
	Exact Name of Trust			Trust Tax ID Number		Current Trustee(s)		Date of Trust		



4. Contingent Owner <i>Complete this section to name an alternative Owner in the event the Insured survives the Owner.</i>	Name (First, MI, Last)				SSN / Tax ID #	
	Address <input type="checkbox"/> (Check box if same as Proposed Primary Insured)				City	
	State	Zip Code	County	Relationship to Insured	Date of Birth (mm/dd/yyyy)	
5. Primary Beneficiary Designations <i>If Survivorship Life Plan, the Proposed Insureds may not be named as Beneficiary.</i> <i>If additional space is required, use Special Instructions Section.</i>	<i>When more than one Beneficiary is designated, payments will be made in equal shares to the Beneficiaries surviving the Insured, or in full to the last surviving Beneficiary, unless some other distribution of proceeds is provided.</i>					
	<input type="checkbox"/> <i>Check this box if Trust named in the Owner section is to be the Primary Beneficiary. If a different Trust is named as Primary Beneficiary or Trust is named as Contingent Beneficiary, provide the Trust information below.</i>					
	For Proposed Primary Insured					
	Primary Beneficiary(ies) Name(s) or Trust and Trustee(s)	Share %	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID #	Address
	Jane S. Doe	100	Wife	10/08/1975	000-00-0000	One Any Street Any City, Any State 00000
	For Proposed Additional Insured					
	Primary Beneficiary(ies) Name(s) or Trust and Trustee(s)	Share %	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID #	Address
6. Contingent Beneficiary Designations <i>If additional space is required, use Special Instructions Section.</i>	For Proposed Primary Insured					
	Contingent Beneficiary(ies) Name(s) or Trust and Trustee(s)	Share %	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID #	Address
	For Proposed Additional Insured					
	Contingent Beneficiary(ies) Name(s) or Trust and Trustee(s)	Share %	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID #	Address
7. Taxpayer ID Number  <i>Check box, if applicable</i>	I certify under penalties of perjury that: <ul style="list-style-type: none"> • The number shown on this form is my correct taxpayer identification number and, • I am not subject to backup withholding because <ul style="list-style-type: none"> ♦ I have not been notified that I am subject to backup withholding as a result of a failure to report all interest or dividends, or ♦ the Internal Revenue Service has notified me that I am no longer subject to backup withholding, or that I am exempt from backup withholding, and • I am a U.S. person (including a U.S. resident alien). <input type="checkbox"/> Check this box if you have been notified by the IRS that you are currently subject to backup withholding because of failure to report interest or dividends on your tax return.					
	The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.					



PLAN INFORMATION

8. Life Insurance Plan



*The Variable Life Fund Supplement MUST be completed if applying for a Variable Product.
The IUL Allocation Form MUST be completed if applying for an Index UL Product.*

- Waddell & Reed Protection VUL
- Waddell & Reed Accumulation VUL
- Waddell & Reed Survivorship Universal Life
- Nationwide YourLife® 10-year Term
- Nationwide YourLife® 15-year Term
- Nationwide YourLife® 20-year Term
- Nationwide YourLife® 30-year Term
- Nationwide YourLife® 20-Pay WL
- Nationwide YourLife® WL 100

- Nationwide YourLife® Indexed UL
- Nationwide YourLife® Current Assumption UL
- Nationwide YourLife® No-Lapse Guarantee UL
- Nationwide YourLife® SUL
- Nationwide YourLife® No-Lapse Guarantee SUL II
- Nationwide YourLife® Protection VUL
- Nationwide YourLife® Accumulation VUL
- Nationwide YourLife® Survivorship VUL
- Other _____

Base Specified Amount	+	Additional Term Rider/Supplemental Coverage Amount (check plan for availability)	=	Total Specified Amount (including Additional Term Rider/Supplemental Coverage)
\$ 250,000.00		\$ _____		\$ 250,000.00

9. Additional Options



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

- Death Benefit Option (If no option is selected here, Option 1 is elected.)**
- Option 1(The Specified Amount, or a multiple of the Cash/Accumulated Value, whichever is greater.)
 - Option 2(The Specified Amount, plus the Cash/Accumulated Value, or a multiple of the Cash/Accumulated Value, whichever is greater.)
 - Option 3(The Specified Amount, plus the Accumulated Premium Account at _____%* interest or a multiple of the Cash/Accumulated Value, whichever is greater.) *Enter a percentage up to 12% maximum, ONLY if the Owner is a business entity. If nothing is entered or the Owner is not a business entity, 0% will apply.
- Internal Revenue Code Life Insurance Qualification Test Option**
- Guideline Premium/Cash Value Corridor Test
 - Cash Value Accumulation Test
- (If no selection is made here, the Guideline Premium/Cash Value Corridor Test is elected.)*

10. Optional Benefits

Check Plan for Availability.

- Variable or Universal Life Plans Only (Subject to Plan availability.)**
- | | |
|--|---|
| <input type="checkbox"/> Spouse Rider \$ _____ | <input type="checkbox"/> Change of Insured Rider |
| <input type="checkbox"/> Children's Term Insurance Rider \$ _____ | <input type="checkbox"/> Other Rider(s) _____ |
| <input type="checkbox"/> Long Term Care Rider* \$ _____ | <input type="checkbox"/> Other Rider(s) _____ |
| <i>*Complete Supplement for Long Term Care Rider.</i> | |
| <input type="checkbox"/> Accidental Death Benefit Rider \$ _____ | Can select only one:
<input type="checkbox"/> Premium Waiver Rider \$ _____
<input type="checkbox"/> Waiver of Monthly Deductions Rider |
| <input type="checkbox"/> Adjusted Sales Load Rider _____ %
<i>(in whole percentages only) waived for _____ years</i> | |
| <input type="checkbox"/> Extended Death Benefit Guarantee Rider
_____ Guarantee Percentage <i>(Indicate percentage of specified amount)</i>
_____ Guarantee Duration <i>(Indicate number of years)</i> | Can select only one:
<input type="checkbox"/> Surrender Value Enhancement Benefit
<input type="checkbox"/> Conditional Return of Premium Rider (cannot be elected with Extended Death Benefit Guarantee Rider) |

- Survivorship Variable or Survivorship Universal Life Plans Only (Subject to Plan availability.)**
- | | |
|---|--|
| <input type="checkbox"/> Four Year Term Rider** \$ _____ | <input type="checkbox"/> Policy Split Option Rider |
| <i>**If the No Charge Four Year Term Insurance has been illustrated you should NOT select this rider.</i> | <input type="checkbox"/> Other Rider(s) _____ |
| | <input type="checkbox"/> Other Rider(s) _____ |

- Whole or Term Life Plans Only (Subject to Plan availability.)**
- | | |
|--|--|
| <input type="checkbox"/> 20 Year Spouse Rider \$ _____ | <input type="checkbox"/> Owner's Waiver of Premium Death or Disability Benefit Rider (Complete Part B for the Owner)
Occupation _____
Height _____
Weight _____
State of Birth _____ |
| <input type="checkbox"/> Children's Term Insurance Rider \$ _____ | |
| <input type="checkbox"/> Accidental Death Benefit Rider \$ _____ | <input type="checkbox"/> Other Rider(s) _____
<input type="checkbox"/> Other Rider(s) _____
<input type="checkbox"/> Other Rider(s) _____ |
| <input type="checkbox"/> Guaranteed Insurability Benefit Rider \$ _____ | |
| <input type="checkbox"/> Waiver of Premium Disability Benefit Rider | |
| <input type="checkbox"/> Owner's Waiver of Premium Death Benefit Rider (Complete Part B for the Owner)
Occupation _____
Height _____
Weight _____
State of Birth _____ | |

Policy will be issued with Automatic Premium Loan Option (APL) for Whole Life Plans only, if available, unless the box below is checked.
 No, do not issue with APL.



FUTURE BILLING AND PREMIUM INFORMATION

11. Amount Paid With Application
Check the applicable option and indicate the premium amount being submitted with the application.

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

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

(NOTE: Make all checks payable to NATIONWIDE.)

Web Remittance \$ _____

Draft initial payment only (indicate initial premium amount and complete Section 13b)..... \$ _____

Draft initial payment and future payments (indicate initial premium amount and complete Sections 12 & 13) \$ _____

12. Future Billing and Payment Options
Check the applicable billing or payment option(s) and indicate the premium amount.

Billing Options:	Payment Options:
<input type="checkbox"/> Monthly EFT* \$ _____ <i>*If selected, complete Section 13, Monthly Electronic Draft Authorization.</i>	<input type="checkbox"/> Single Premium \$ _____
<input type="checkbox"/> Quarterly \$ _____	<input type="checkbox"/> Billing Advantage \$ _____ Account Number _____
<input type="checkbox"/> Semi-Annual \$ _____	<input type="checkbox"/> 1035 Exchange \$ _____
<input type="checkbox"/> Annual \$ _____	<input type="checkbox"/> Other \$ _____

13. Electronic Draft Authorization

13a. Monthly Electronic Draft Options:

Monthly Draft Day (1st – 28th): _____

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

Draft Options:

*Checking - Use information on the initial premium check.

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

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

13b. If no check or deposit slip provided, indicate below the bank information to be used:

Financial Institution Name _____	Transit/ABA Number _____
Account Number _____	Type of Account: <input type="checkbox"/> *Checking <input type="checkbox"/> *Savings

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

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

Name (First, MI, Last) _____

Address _____	City _____	State _____	Zip Code _____
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INSURANCE INFORMATION

15. Replacement and Other Policy Information

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

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

Insured	Company	Policy Number	Amount Of Coverage	Year Issued	To Be Replaced	1035 Exch	Lapsed/ Surrendered/ Sold	Nationwide Term Conversion
			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>		<input type="checkbox"/>
			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>		<input type="checkbox"/>
			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>		<input type="checkbox"/>
			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>		<input type="checkbox"/>



FINANCIAL INFORMATION

<p>16. Financial Questions Explain all "yes" answers in Section 17 Details box below unless instructed otherwise.</p> <p style="text-align: center;">STOP</p> <p><i>This section needs to be completed by each Proposed Insured and Owner/Trustee, if other than Proposed Insured(s).</i></p>	<p>All questions must be answered by each Proposed Insured and Owner/Trustee, if other than Proposed Insured(s). For each yes answer, indicate the appropriate item(s) and provide details.</p>				<p>Proposed Primary Insured</p>		<p>Proposed Additional Insured</p>		<p>Owner/Trustee if other than Proposed Insured(s)</p>	
					Yes	No	Yes	No	Yes	No
	a. Is this policy being purchased for the purpose of selling or assigning this policy to a life settlement company, trust, limited liability corporation, viatical, or other secondary market purchaser?				<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b. Have you entered into any agreement, or made arrangements, for the sale or assignment of this policy to a life settlement company, trust, limited liability corporation, viatical, or other secondary market purchaser?				<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c. Have you been involved in any communication about the possible sale or assignment of this policy to a life settlement company, trust, limited liability corporation, viatical, or other secondary market purchaser?				<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d. Have you ever sold any life insurance policy to a life settlement company, trust, limited liability corporation, viatical, or other secondary market purchaser?				<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	e. Will any portion of the current or future premium for this policy be financed?				<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Will any Insured or Policy Owner receive any payment in connection with the insurance issued on the basis of this application?				<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

<p>17. Explanation of Financial Details If more space is needed, an additional blank sheet may be attached. Any Proposed Insured(s) or Owner(s) should sign and date additional pages.</p>	Question Letter	Person	Dates	Details

PART B - PERSONAL AND HEALTH INFORMATION

<p>18. Tobacco Use All questions are to be answered by each Proposed Insured.</p> <p style="text-align: center;">STOP</p> <p><i>Be sure to answer this section.</i></p>	<p>Have you used tobacco or nicotine in any form?</p>		<p>Proposed Primary Insured</p>		<p>Proposed Additional Insured</p>	
	1. In the last 12 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", date last used: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", date last used: _____	
	2. In the last 5 years?		<input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", date last used: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", date last used: _____	
	3. If "yes", check all forms of tobacco or nicotine products used.		<input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Other Tobacco <input type="checkbox"/> Nicotine Products (gum, patch, etc.)	<input type="checkbox"/> Cigars <input type="checkbox"/> Pipe <input type="checkbox"/> Snuff	<input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Other Tobacco <input type="checkbox"/> Nicotine Products (gum, patch, etc.)	<input type="checkbox"/> Cigars <input type="checkbox"/> Pipe <input type="checkbox"/> Snuff

<p>19. Physical Measurements Fill in information for the Proposed Primary Insured.</p>	Height	Current Weight	Weight 1 Year Ago	Reason for Weight Gain or Loss

<p>20. Personal Physicians If Child Rider coverage is requested, use Special Instructions Section to add Personal Physician information for each child.</p>	<p>Proposed Primary Insured</p>		<p>Proposed Additional Insured</p>		<p>Any Child</p>	
	Name of Personal Physician:					
	Address:					
	Telephone Number:					
	Date last consulted:					
	Reason last consulted:					
Treatment given or medication prescribed:						



HEALTH INFORMATION

23. Health Questions	To the best of your knowledge and belief, has anyone here proposed for insurance ever consulted a licensed health care provider for, been treated for, taken medication for, or been diagnosed as having:	Proposed Primary Insured		Proposed Additional Insured		Any Child	
		Yes	No	Yes	No	Yes	No
<p><i>All questions are to be answered by each Proposed Insured.</i></p> <p><i>Explain all "yes" answers in Section 24 Details box unless instructed otherwise.</i></p>	a. AIDS (Acquired Immune Deficiency Syndrome), or any other AIDS-related condition, or received a positive result of an HIV (Human Immunodeficiency Virus) test?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b. Heart disease including heart attack, angina, or other chest pain, cardiomyopathy, shortness of breath, congestive heart failure, heart murmur, or other disorder of the heart?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c. Irregular heart beat, palpitations, high blood pressure, high cholesterol, or high triglycerides?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d. Aneurysm, carotid artery disease, deep venous thrombosis, phlebitis, peripheral vascular disease, any other disorder of the blood vessels, or pulmonary embolism?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	e. Headaches, seizures, epilepsy, stroke, Alzheimer's disease, dementia, Parkinson's disease, multiple sclerosis, or any other brain or nervous disorder?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	f. Depression, neurosis, affective disorder, psychosis, or any other mental or emotional disorder?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	g. Asthma, emphysema, chronic bronchitis, tuberculosis, or any other disease of the lungs or respiratory system?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	h. Colitis, ulcer, persistent diarrhea, rectal bleeding, Crohn's disease, ulcerative colitis, or any other disease or disorder of the esophagus or digestive tract?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	i. Sugar, protein or blood in the urine, kidney stones, sexually transmitted disease, or any other disease or disorder of the kidneys, bladder, prostate, breast, urinary tract or reproductive system?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	j. Diabetes, hepatitis, cirrhosis or any other disease of the liver, pancreas, or thyroid?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	k. Disorder of the blood including anemia, sickle cell disorders, thalassemia, hemophilia, or any other disorder of the red blood cells, or white blood cells, platelets, or clotting factors?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	l. Cancer, or any malignant or benign tumor or cyst, or any chronic disease of the skin or lymph glands?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	m. Arthritis, rheumatoid arthritis, osteoporosis; or any paralysis or chronic back or muscle condition?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	n. Alcoholism, narcotic addiction, drug use, or hallucinations?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	o. Any disease or disorder of the eyes, ears, nose or throat?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
To the best of your knowledge and belief, in the past 5 years, has anyone here proposed for insurance:							
p. Consulted, or been examined or treated by any physician, chiropractor, psychologist or other health care practitioner or by any hospital, clinic, or other health care facility not already disclosed on this application? <i>(If it was for a "check up", annual physical, employment physical, etc., so state and give findings and results.)</i>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
q. Had any disease, disorder, injury, or operation not already disclosed on this application?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
r. Had any x-rays, electrocardiograms, or other medical tests for reasons not already disclosed on this application?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
s. Been medically advised to have any surgery, hospitalization, treatment or test that was not completed or results that you have not received?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
t. Currently taking any medication other than indicated above to include prescription, over-the-counter medications for more than 5 days, dietary supplements, "natural" or herbal medications? (Give details of dosage and frequency.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
u. Used alcoholic beverages? <i>(If yes, how much, what kind (beer, wine, liquor), and how often?)</i>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



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

25. Special Instructions Section	<i>If more space is needed, an additional blank sheet may be attached. Any Proposed Insured(s) or Owner(s) should sign and date additional pages.</i>			
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PART C – FRAUD STATEMENTS AND IMPORTANT NOTICES

RHODE ISLAND 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 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.
Pre-Notice of Procedures as Required by The Fair Credit Reporting Act of 1970	<p>This notice is to inform you that as part of our normal underwriting procedures in connection with an application for insurance:</p> <ul style="list-style-type: none"> • An investigative consumer report may be made whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. This inquiry will include information as to character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation, with respect to you, members of your family, and others having an interest in or closely connected with the insurance transaction; and • You may elect to be interviewed if an investigative consumer report is prepared in connection with this application. You are entitled to receive a copy of any investigative consumer report by submitting your request in writing. • Upon your written request, made within a reasonable time after you receive this notice, additional information as to the nature and scope of the investigation, if one is made, will be provided. You may send corrections and requests for additional information addressed to Nationwide Life and Annuity Insurance Company, [P.O. Box 182835, Columbus, Ohio 43218-2835]. In the event of an adverse decision, you will be notified in writing.
Medical Information Bureau Disclosure Notice	Information regarding your insurability will be treated as confidential. Nationwide Life and Annuity Insurance Company, or its reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is [50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734, telephone number 866-692-6901 (TTY 866-346-3642).] The e-mail address of the Bureau's information office is www.mib.com. Nationwide Life 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.



TEMPORARY INSURANCE AGREEMENT

NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY, COLUMBUS, OH

This Agreement provides a limited amount of Life Insurance coverage, for a limited period of time, subject to the terms of this Agreement.

HEALTH QUESTION

 Question must be answered by each Proposed Insured(s).	Proposed Primary Insured		Proposed Additional Insured		Any Child		Has anyone here proposed for insurance: To the best of your knowledge and belief, within the past 10 years, been treated for, consulted a licensed health care provider, or been diagnosed by a licensed health care provider as having: angina, or chest pain or discomfort; heart attack, heart murmur, or any other heart disorder; epilepsy, stroke or diabetes; AIDS (Acquired Immune Deficiency Syndrome), any AIDS-related disorder or positive HIV (Human Immunodeficiency Virus) test result; any brain, nervous, or mental disorder, any drug or alcohol addiction; any kidney disorder (other than kidney stones); or any cancer or other malignancy?
	Yes	No	Yes	No	Yes	No	
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

If the above question is answered YES or LEFT BLANK, NO COVERAGE will take effect under this Agreement and no representative of Nationwide Life and Annuity Insurance Company is authorized to accept money, and/or provide a temporary insurance receipt to the applicant.

TERMS AND CONDITIONS

Amount of Coverage [\$1,000,000] overall maximum for all applications or agreements.	Temporary Insurance under this Agreement will commence on the date of the application if the full first premium for the mode selected has been paid and accepted by Nationwide or authorized by Electronic Funds Transfer as advance payment for an application for Life Insurance. If any Proposed Insured dies while this temporary insurance is in effect, Nationwide will pay to the designated Beneficiary the lesser of: <ul style="list-style-type: none"> the amount of death benefits, if any, which would be payable under the policy and its riders if issued as applied for, excluding any accidental death benefits, or [\$1,000,000] This total benefit limit applies to all insurance applied for under this and any other current applications to Nationwide and any other Temporary Insurance Agreements for Life Insurance whether applied for on the life or lives of one or more Proposed Insureds.
Date Coverage Terminates 60 DAYS maximum coverage.	Temporary Life Insurance under this Agreement will terminate automatically on the earliest of: <ul style="list-style-type: none"> 60 days from the date of this signed Agreement, or the date any policy is offered or issued to the Proposed Insured in connection with the above application, or the date Nationwide mails notice of termination of coverage and refund of the advance payment to the Proposed Insured, or the Owner, if different than the Proposed Insured.
Limitations	<ul style="list-style-type: none"> Fraud or material misrepresentation in the application or in the answers to the Health question of this Agreement invalidates this Agreement and Nationwide's only liability is for refund of any payment made. This Agreement does not provide coverage for Proposed Insured's who are under 15 days of age or over the age of 70 on the date of the Agreement. If any Proposed Insured dies by suicide, while sane or insane, Nationwide's liability under this Agreement is limited to a refund of the payment made. There is no coverage under this Agreement if the check submitted as payment is not honored by the bank on first presentation or if the Electronic Funds Transfer is not processed by the bank. No one is authorized to waive or modify any of the provisions of this Agreement.

SIGNATURES

Proposed Insured(s) and Owner Signatures	I HAVE RECEIVED A COPY OF AND HAVE READ THIS AGREEMENT AND DECLARE THAT THE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND AND AGREE TO ALL ITS TERMS. Dated (mm/dd/yyyy) <u>July 28, 2008</u> X <u>John D. Doe</u> Signature of Proposed Primary Insured (or parent if Proposed Primary Insured is under age 15) X _____ X _____ Signature of Applicant/Owner (if other than the Proposed Insured(s)) Signature of Proposed Additional Insured (if to be Insured)
Initial Premium Receipt and Producer's Signature  Be sure to include the amount of the initial premium payment.	An initial premium payment in the amount of \$ _____ has been submitted with this application. I have advised the Applicant/Owner that additional premium may need to be submitted at time of delivery. X <u>Sam A. Producer</u> _____ <u>Any Firm</u> _____ <u>02-A000000</u> Signature of Producer Firm Producer's Nationwide #



NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY

Application for Individual Life Insurance

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

PART A – CLIENT INFORMATION

1. Proposed Primary Insured	Name (First, MI, Last) John D. Doe						SSN / Tax ID # 000 - 00 - 0000			
	Address One Any Street					City Any City				
	State Any State	Zip Code 00000	County Any County		Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	Former Name				
	Marital Status <input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other _____				Age 35	Date of Birth (mm/dd/yyyy) 02/07/1973	State of Birth OH			
	E-Mail Address JDDOE@YAHOO.COM					Phone # (000) 000-0000		<input type="checkbox"/> AM <input checked="" type="checkbox"/> PM		
	Driver's License # / State of Issue RL000000 OH			Annual Income		Net Worth				
	Occupation		Employer		Citizenship (If other, submit Foreign Supplement.) <input type="checkbox"/> U.S. <input type="checkbox"/> Canada <input type="checkbox"/> Other, how long have you lived in the U.S.? _____					
	2. Proposed Additional Insured <i>If applicable, complete for either:</i> a) Joint Insured for Survivorship Life Plan; or b) Term Rider on Another Covered Person (i.e., Spouse/Children) <i>If additional space is required, use Special Instructions Section.</i>	Name of Additional Insured(s)		Birth Date	Birth State	Sex	Height	Weight	SSN / Tax ID #	Relationship to Primary Insured
<i>Joint/Spouse Proposed Additional Insured Information Only</i>										
Former Name			Address <input type="checkbox"/> (Check box if same as Proposed Primary Insured)							
City		State	Zip Code		County					
E-Mail Address					Phone # ()		<input type="checkbox"/> AM <input type="checkbox"/> PM			
Driver's License # / State of Issue			Annual Income		Net Worth					
Occupation		Employer		Citizenship (If other, submit Foreign Supplement.) <input type="checkbox"/> U.S. <input type="checkbox"/> Canada <input type="checkbox"/> Other, how long have you lived in the U.S.? _____						
3. Owner <i>Complete ONLY if Owner is not the Proposed Primary Insured.</i> <i>Unless indicated the Proposed Primary Insured (Joint Insureds in the case of Survivorship) will own the policy.</i> <i>If more than two Owners are requested, use Special Instructions Section.</i> <i>TRUST - Submit a copy of first and signature pages of Trust document.</i>		Name (First, MI, Last)						SSN / Tax ID #		
		Address <input type="checkbox"/> (Check box if same as Proposed Primary Insured)					City			
		State	Zip Code	County		Date of Birth (mm/dd/yyyy)		Phone # ()		<input type="checkbox"/> AM <input type="checkbox"/> PM
	Type of Owner <input type="checkbox"/> Individual <input type="checkbox"/> Employer <input type="checkbox"/> Trust <input type="checkbox"/> Rabbi Trust <input type="checkbox"/> Other _____			Relationship to Insured		E-Mail Address				
	<i>If more than one Owner the following will be applicable: 1) Ownership will be vested jointly with right of survivorship, otherwise to the Executor or Administrator of the last owner's estate. 2) All notices will be mailed to the one address listed above unless otherwise instructed. 3) For tax reporting purposes, only one Social Security Number can be used. The SSN shown above will be used unless otherwise instructed.</i>									
	Joint Owner (First, MI, Last)						SSN / Tax ID #			
	Address <input type="checkbox"/> (Check box if same as Proposed Primary Insured)					City				
	State	Zip Code	County		Date of Birth (mm/dd/yyyy)		Phone # ()		<input type="checkbox"/> AM <input type="checkbox"/> PM	
	Type of Owner <input type="checkbox"/> Individual <input type="checkbox"/> Employer <input type="checkbox"/> Trust <input type="checkbox"/> Rabbi Trust <input type="checkbox"/> Other _____			Relationship to Insured		E-Mail Address				
	Exact Name of Trust			Trust Tax ID Number		Current Trustee(s)		Date of Trust		



4. Contingent Owner <i>Complete this section to name an alternative Owner in the event the Insured survives the Owner.</i>	Name (First, MI, Last)				SSN / Tax ID #		
	Address <input type="checkbox"/> (Check box if same as Proposed Primary Insured)				City		
	State	Zip Code	County	Relationship to Insured	Date of Birth (mm/dd/yyyy)		
5. Primary Beneficiary Designations <i>If Survivorship Life Plan, the Proposed Insureds may not be named as Beneficiary.</i> <i>If additional space is required, use Special Instructions Section.</i>	<i>When more than one Beneficiary is designated, payments will be made in equal shares to the Beneficiaries surviving the Insured, or in full to the last surviving Beneficiary, unless some other distribution of proceeds is provided.</i>						
	<input type="checkbox"/> <i>Check this box if Trust named in the Owner section is to be the Primary Beneficiary. If a different Trust is named as Primary Beneficiary or Trust is named as Contingent Beneficiary, provide the Trust information below.</i>						
	For Proposed Primary Insured						
	Primary Beneficiary(ies) Name(s) or Trust and Trustee(s)		Share %	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID #	Address
	Jane S. Doe		100	Wife	10/08/1975	000-00-0000	One Any Street Any City, Any State 00000
	For Proposed Additional Insured						
	Primary Beneficiary(ies) Name(s) or Trust and Trustee(s)		Share %	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID #	Address
6. Contingent Beneficiary Designations <i>If additional space is required, use Special Instructions Section.</i>	For Proposed Primary Insured						
	Contingent Beneficiary(ies) Name(s) or Trust and Trustee(s)		Share %	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID #	Address
	For Proposed Additional Insured						
	Contingent Beneficiary(ies) Name(s) or Trust and Trustee(s)		Share %	Relationship to Insured(s)	Birth Date or Trust Date	SSN/Tax ID #	Address
7. Taxpayer ID Number  <i>Check box, if applicable</i>	I certify under penalties of perjury that: <ul style="list-style-type: none"> • The number shown on this form is my correct taxpayer identification number and, • I am not subject to backup withholding because <ul style="list-style-type: none"> ♦ I have not been notified that I am subject to backup withholding as a result of a failure to report all interest or dividends, or ♦ the Internal Revenue Service has notified me that I am no longer subject to backup withholding, or that I am exempt from backup withholding, and • I am a U.S. person (including a U.S. resident alien). <input type="checkbox"/> Check this box if you have been notified by the IRS that you are currently subject to backup withholding because of failure to report interest or dividends on your tax return.						
	The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.						



PLAN INFORMATION

8. Life Insurance Plan



The Variable Life Fund Supplement MUST be completed if applying for a Variable Product.
The IUL Allocation Form MUST be completed if applying for an Index UL Product.

- | | |
|---|---|
| <input type="checkbox"/> Nationwide Marathon SM Performance VUL - Protection
<input type="checkbox"/> Nationwide Marathon SM Performance VUL - Accumulation
<input type="checkbox"/> Nationwide Marathon SM No Lapse Guarantee UL
<input type="checkbox"/> Nationwide Marathon SM Indexed UL
<input type="checkbox"/> Nationwide YourLife [®] Protection VUL
<input type="checkbox"/> Nationwide YourLife [®] Accumulation VUL
<input type="checkbox"/> Nationwide YourLife [®] Survivorship VUL
<input type="checkbox"/> Nationwide YourLife [®] Current Assumption UL
<input type="checkbox"/> Nationwide YourLife [®] No-Lapse Guarantee UL
<input type="checkbox"/> Nationwide YourLife [®] Indexed UL | <input type="checkbox"/> Nationwide YourLife [®] SUL
<input type="checkbox"/> Nationwide YourLife [®] No-Lapse Guarantee SUL II
<input type="checkbox"/> Nationwide YourLife [®] 20-Pay WL
<input type="checkbox"/> Nationwide YourLife [®] WL 100
<input type="checkbox"/> Nationwide YourLife [®] 10-year Term
<input type="checkbox"/> Nationwide YourLife [®] 15-year Term
<input type="checkbox"/> Nationwide YourLife [®] 20-year Term
<input type="checkbox"/> Nationwide YourLife [®] 30-year Term
<input type="checkbox"/> Other _____ |
|---|---|

Base Specified Amount	+	Additional Term Rider/Supplemental Coverage Amount <i>(check plan for availability)</i>	=	Total Specified Amount <i>(including Additional Term Rider/Supplemental Coverage)</i>
\$ 250,000.00		\$ _____		\$ 250,000.00

9. Additional Options



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

- Death Benefit Option *(If no option is selected here, Option 1 is elected.)***
- Option 1(The Specified Amount, or a multiple of the Cash/Accumulated Value, whichever is greater.)
- Option 2(The Specified Amount, plus the Cash/Accumulated Value, or a multiple of the Cash/Accumulated Value, whichever is greater.)
- Option 3(The Specified Amount, plus the Accumulated Premium Account at _____%* interest or a multiple of the Cash/Accumulated Value, whichever is greater.) **Enter a percentage up to 12% maximum, ONLY if the Owner is a business entity. If nothing is entered or the Owner is not a business entity, 0% will apply.*
- Internal Revenue Code Life Insurance Qualification Test Option**
- Guideline Premium/Cash Value Corridor Test
- Cash Value Accumulation Test
- (If no selection is made here, the Guideline Premium/Cash Value Corridor Test is elected.)*

10. Optional Benefits

Check Plan for Availability.

- Variable or Universal Life Plans Only *(Subject to Plan availability.)***
- | | |
|---|---|
| <input type="checkbox"/> Spouse Rider \$ _____
<input type="checkbox"/> Children's Term Insurance Rider \$ _____
<input type="checkbox"/> Long Term Care Rider* \$ _____
*Complete Supplement for Long Term Care Rider.
<input type="checkbox"/> Accidental Death Benefit Rider \$ _____
<input type="checkbox"/> Adjusted Sales Load Rider _____%
(in whole percentages only) waived for _____ years
<input type="checkbox"/> Extended Death Benefit Guarantee Rider
_____ Guarantee Percentage <i>(Indicate percentage of specified amount)</i>
_____ Guarantee Duration <i>(Indicate number of years)</i> | <input type="checkbox"/> Change of Insured Rider
<input type="checkbox"/> Other Rider(s) _____
<input type="checkbox"/> Other Rider(s) _____
Can select only one:
<input type="checkbox"/> Premium Waiver Rider \$ _____
<input type="checkbox"/> Waiver of Monthly Deductions Rider
Can select only one:
<input type="checkbox"/> Surrender Value Enhancement Benefit
<input type="checkbox"/> Conditional Return of Premium Rider (cannot be elected with Extended Death Benefit Guarantee Rider) |
|---|---|

- Survivorship Variable or Survivorship Universal Life Plans Only *(Subject to Plan availability.)***
- | | |
|--|--|
| <input type="checkbox"/> Four Year Term Rider** \$ _____
**If the No Charge Four Year Term Insurance has been illustrated you should NOT select this rider. | <input type="checkbox"/> Policy Split Option Rider
<input type="checkbox"/> Other Rider(s) _____
<input type="checkbox"/> Other Rider(s) _____ |
|--|--|

- Whole or Term Life Plans Only *(Subject to Plan availability.)***
- | | |
|--|---|
| <input type="checkbox"/> 20 Year Spouse Rider \$ _____
<input type="checkbox"/> Children's Term Insurance Rider \$ _____
<input type="checkbox"/> Accidental Death Benefit Rider \$ _____
<input type="checkbox"/> Guaranteed Insurability Benefit Rider \$ _____
<input type="checkbox"/> Waiver of Premium Disability Benefit Rider
<input type="checkbox"/> Owner's Waiver of Premium Death Benefit Rider
(Complete Part B for the Owner)
Occupation _____
Height _____
Weight _____
State of Birth _____ | <input type="checkbox"/> Owner's Waiver of Premium Death or Disability Benefit Rider (Complete Part B for the Owner)
Occupation _____
Height _____
Weight _____
State of Birth _____
<input type="checkbox"/> Other Rider(s) _____
<input type="checkbox"/> Other Rider(s) _____
<input type="checkbox"/> Other Rider(s) _____ |
|--|---|

Policy will be issued with Automatic Premium Loan Option (APL) for Whole Life Plans only, if available, unless the box below is checked.
 No, do not issue with APL.



FUTURE BILLING AND PREMIUM INFORMATION

11. Amount Paid With Application
Check the applicable option and indicate the premium amount being submitted with the application.

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

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

(NOTE: Make all checks payable to NATIONWIDE.)

Web Remittance \$ _____

Draft initial payment only (indicate initial premium amount and complete Section 13b)..... \$ _____

Draft initial payment and future payments (indicate initial premium amount and complete Sections 12 & 13) \$ _____

12. Future Billing and Payment Options
Check the applicable billing or payment option(s) and indicate the premium amount.

Billing Options:	Payment Options:
<input type="checkbox"/> Monthly EFT* \$ _____	<input type="checkbox"/> Single Premium \$ _____
<i>*If selected, complete Section 13, Monthly Electronic Draft Authorization.</i>	<input type="checkbox"/> Billing Advantage \$ _____
?? Quarterly \$ _____	Account Number _____
<input type="checkbox"/> Semi-Annual \$ _____	<input type="checkbox"/> 1035 Exchange \$ _____
<input type="checkbox"/> Annual \$ _____	<input type="checkbox"/> Other \$ _____

13. Electronic Draft Authorization

13a. Monthly Electronic Draft Options:

Monthly Draft Day (1st – 28th): _____

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

Draft Options:

*Checking - Use information on the initial premium check.

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

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

13b. If no check or deposit slip provided, indicate below the bank information to be used:

Financial Institution Name _____	Transit/ABA Number _____
Account Number _____	Type of Account: <input type="checkbox"/> *Checking <input type="checkbox"/> *Savings

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

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

Name (First, MI, Last) _____

Address _____	City _____	State _____	Zip Code _____
---------------	------------	-------------	----------------

INSURANCE INFORMATION

15. Replacement and Other Policy Information

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

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

Insured	Company	Policy Number	Amount Of Coverage	Year Issued	To Be Replaced	1035 Exch	Lapsed/ Surrendered/ Sold	Nationwide Term Conversion
			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>		<input type="checkbox"/>
			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>		<input type="checkbox"/>
			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>		<input type="checkbox"/>
			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>		<input type="checkbox"/>



FINANCIAL INFORMATION

<p>16. Financial Questions Explain all "yes" answers in Section 17 Details box below unless instructed otherwise.</p> <p style="text-align: center;">STOP</p> <p><i>This section needs to be completed by each Proposed Insured and Owner/Trustee, if other than Proposed Insured(s).</i></p>	All questions must be answered by each Proposed Insured and Owner/Trustee, if other than Proposed Insured(s). For each yes answer, indicate the appropriate item(s) and provide details.				Proposed Primary Insured		Proposed Additional Insured		Owner/Trustee if other than Proposed Insured(s)	
					Yes	No	Yes	No	Yes	No
	a. Is this policy being purchased for the purpose of selling or assigning this policy to a life settlement company, trust, limited liability corporation, viatical, or other secondary market purchaser?				<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b. Have you entered into any agreement, or made arrangements, for the sale or assignment of this policy to a life settlement company, trust, limited liability corporation, viatical, or other secondary market purchaser?				<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c. Have you been involved in any communication about the possible sale or assignment of this policy to a life settlement company, trust, limited liability corporation, viatical, or other secondary market purchaser?				<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d. Have you ever sold any life insurance policy to a life settlement company, trust, limited liability corporation, viatical, or other secondary market purchaser?				<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	e. Will any portion of the current or future premium for this policy be financed?				<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Will any Insured or Policy Owner receive any payment in connection with the insurance issued on the basis of this application?				<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

<p>17. Explanation of Financial Details If more space is needed, an additional blank sheet may be attached. Any Proposed Insured(s) or Owner(s) should sign and date additional pages.</p>	Question Letter	Person	Dates	Details

PART B - PERSONAL AND HEALTH INFORMATION

<p>18. Tobacco Use All questions are to be answered by each Proposed Insured.</p> <p style="text-align: center;">STOP</p> <p><i>Be sure to answer this section.</i></p>	Have you used tobacco or nicotine in any form?		Proposed Primary Insured		Proposed Additional Insured	
	1. In the last 12 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", date last used: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", date last used: _____	
	2. In the last 5 years?		<input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", date last used: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", date last used: _____	
	3. If "yes", check all forms of tobacco or nicotine products used.		<input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Other Tobacco <input type="checkbox"/> Nicotine Products (gum, patch, etc.)	<input type="checkbox"/> Cigars <input type="checkbox"/> Pipe <input type="checkbox"/> Snuff	<input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Other Tobacco <input type="checkbox"/> Nicotine Products (gum, patch, etc.)	<input type="checkbox"/> Cigars <input type="checkbox"/> Pipe <input type="checkbox"/> Snuff

<p>19. Physical Measurements Fill in information for the Proposed Primary Insured.</p>	Height	Current Weight	Weight 1 Year Ago	Reason for Weight Gain or Loss

<p>20. Personal Physicians If Child Rider coverage is requested, use Special Instructions Section to add Personal Physician information for each child.</p>	Proposed Primary Insured		Proposed Additional Insured		Any Child
	Name of Personal Physician:				
	Address:				
	Telephone Number:				
	Date last consulted:				
	Reason last consulted:				
Treatment given or medication prescribed:					



HEALTH INFORMATION

23. Health Questions	To the best of your knowledge and belief, has anyone here proposed for insurance ever consulted a licensed health care provider for, been treated for, taken medication for, or been diagnosed as having:	Proposed Primary Insured		Proposed Additional Insured		Any Child	
		Yes	No	Yes	No	Yes	No
<i>All questions are to be answered by each Proposed Insured.</i> <i>Explain all "yes" answers in Section 24 Details box unless instructed otherwise.</i>	a. AIDS (Acquired Immune Deficiency Syndrome), or any other AIDS-related condition, or received a positive result of an HIV (Human Immunodeficiency Virus) test?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b. Heart disease including heart attack, angina, or other chest pain, cardiomyopathy, shortness of breath, congestive heart failure, heart murmur, or other disorder of the heart?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c. Irregular heart beat, palpitations, high blood pressure, high cholesterol, or high triglycerides?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d. Aneurysm, carotid artery disease, deep venous thrombosis, phlebitis, peripheral vascular disease, any other disorder of the blood vessels, or pulmonary embolism?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	e. Headaches, seizures, epilepsy, stroke, Alzheimer's disease, dementia, Parkinson's disease, multiple sclerosis, or any other brain or nervous disorder?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	f. Depression, neurosis, affective disorder, psychosis, or any other mental or emotional disorder?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	g. Asthma, emphysema, chronic bronchitis, tuberculosis, or any other disease of the lungs or respiratory system?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	h. Colitis, ulcer, persistent diarrhea, rectal bleeding, Crohn's disease, ulcerative colitis, or any other disease or disorder of the esophagus or digestive tract?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	i. Sugar, protein or blood in the urine, kidney stones, sexually transmitted disease, or any other disease or disorder of the kidneys, bladder, prostate, breast, urinary tract or reproductive system?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	j. Diabetes, hepatitis, cirrhosis or any other disease of the liver, pancreas, or thyroid?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	k. Disorder of the blood including anemia, sickle cell disorders, thalassemia, hemophilia, or any other disorder of the red blood cells, or white blood cells, platelets, or clotting factors?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	l. Cancer, or any malignant or benign tumor or cyst, or any chronic disease of the skin or lymph glands?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	m. Arthritis, rheumatoid arthritis, osteoporosis; or any paralysis or chronic back or muscle condition?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	n. Alcoholism, narcotic addiction, drug use, or hallucinations?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	o. Any disease or disorder of the eyes, ears, nose or throat?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
To the best of your knowledge and belief, in the past 5 years, has anyone here proposed for insurance:							
p. Consulted, or been examined or treated by any physician, chiropractor, psychologist or other health care practitioner or by any hospital, clinic, or other health care facility not already disclosed on this application? <i>(If it was for a "check up", annual physical, employment physical, etc., so state and give findings and results.)</i>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
q. Had any disease, disorder, injury, or operation not already disclosed on this application?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
r. Had any x-rays, electrocardiograms, or other medical tests for reasons not already disclosed on this application?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
s. Been medically advised to have any surgery, hospitalization, treatment or test that was not completed or results that you have not received?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
t. Currently taking any medication other than indicated above to include prescription, over-the-counter medications for more than 5 days, dietary supplements, "natural" or herbal medications? (Give details of dosage and frequency.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
u. Used alcoholic beverages? <i>(If yes, how much, what kind (beer, wine, liquor), and how often?)</i>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



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

25. Special Instructions Section	<i>If more space is needed, an additional blank sheet may be attached. Any Proposed Insured(s) or Owner(s) should sign and date additional pages.</i>			
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PART C – FRAUD STATEMENTS AND IMPORTANT NOTICES

RHODE ISLAND 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 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.
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: <ul style="list-style-type: none"> • An investigative consumer report may be made whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. This inquiry will include information as to character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation, with respect to you, members of your family, and others having an interest in or closely connected with the insurance transaction; and • You may elect to be interviewed if an investigative consumer report is prepared in connection with this application. You are entitled to receive a copy of any investigative consumer report by submitting your request in writing. • Upon your written request, made within a reasonable time after you receive this notice, additional information as to the nature and scope of the investigation, if one is made, will be provided. You may send corrections and requests for additional information addressed to Nationwide Life and Annuity Insurance Company, [P.O. Box 182835, Columbus, Ohio 43218-2835]. In the event of an adverse decision, you will be notified in writing.
Medical Information Bureau Disclosure Notice	Information regarding your insurability will be treated as confidential. Nationwide Life and Annuity Insurance Company, or its reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is [50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734, telephone number 866-692-6901 (TTY 866-346-3642).] The e-mail address of the Bureau's information office is www.mib.com. Nationwide Life and Annuity Insurance Company or its reinsurer(s) may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.



PART D – AGREEMENT, AUTHORIZATION AND SIGNATURE

<p>Agreement</p>	<p>I understand and agree that:</p> <ul style="list-style-type: none"> • This application, any amendments to it, and any related medical examination(s) will become a part of the Policy and are the basis of any insurance issued upon this application. • The Proposed Insured or Owner has a right to cancel this application at any time by contacting their producer or Nationwide in writing. No producer, medical examiner or other representative of Nationwide may accept risks or make or change any contract; or waive or change any of the Company's rights or requirements. • If the full first premium is made in exchange for a Temporary Insurance Agreement, Nationwide will only be liable to the extent set forth in that Agreement. • If the full first premium is not paid with this application, then insurance will only take effect when (1) a policy is issued by Nationwide and accepted by me; and (2) the full first premium is paid; and (3) all the answers and statements made on the application, medical examination(s) and amendments are true to the best of my knowledge and belief when (1) and (2) have occurred.
<p>Authorization</p>	<p>I authorize: any licensed physician or medical practitioner; any hospital, clinic, any pharmacy benefit managers, and other sources who maintain prescription drug records and related information, or other medical or medically related facility; any insurance company; the Medical Information Bureau; or any other organization, institution, or person to disclose my entire medical record and any other protected health information concerning me to the Medical Director of the 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. By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this form; and I instruct any physician; health care professional; hospital; clinic; medical facility; or other health care provider to release and disclose my entire medical record without restriction. I understand that any information that is disclosed pursuant to this form may be redisclosed and no longer be covered by federal rules governing privacy and confidentiality of health information. This form, or a copy of it, will be valid for a period of not more than two years (24 months) from the date it was signed. I understand that I have the right to revoke this form in writing, at anytime, by sending a written request for revocation to Nationwide Life and Annuity Insurance Company, [Attention: Underwriting, P.O. Box 182835, Columbus, Ohio 43218-2835]. I understand that a revocation is not effective to the extent that any of my providers have relied on this form; or to the extent that Nationwide Life and Annuity Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I further understand that if I refuse to sign this form to release my complete medical records, Nationwide Life 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.</p>
<p>Proposed Insured(s) and Owner/Trustee Signatures</p> <p style="text-align: center;"></p> <p><i>All Financial questions in Section 16 (a through f) are required to be answered for both the Proposed Insured(s) and Owner, if not Proposed Insured(s).</i></p>	<p>I HAVE READ THIS APPLICATION AND AGREEMENT AND DECLARE THAT THE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND AND AGREE TO ALL ITS TERMS.</p> <p>Signed at _____, on _____, _____, 2008 City/State Month/Day Year</p> <p>_____ X _____ John D. Doe John D. Doe Full Name of Proposed Primary Insured (print) Signature of Proposed Primary Insured (or parent if Proposed Primary Insured is under age 15)</p> <p>_____ X _____ Full Name of Proposed Additional Insured (print) Signature of Proposed Additional Insured (if to be Insured)</p> <p>X _____ X _____ Signature of Applicant/Owner (if other than the Proposed Insured(s)) Signature of Applicant/Owner (if other than the Proposed Insured(s))</p>

PART E - PRODUCER'S CERTIFICATION

<p>Producer's Certification</p> <p style="text-align: center;"></p> <p><i>Be sure to answer all three questions.</i></p>	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Will <input checked="" type="checkbox"/> Will Not</p>	<p>a. I have truly and accurately recorded all Proposed Insureds' answers on this application.</p> <p>b. I have witnessed his/her/their signature(s) hereon. <i>(If "no", provide details in Special Instructions Section.)</i></p> <p>c. To the best of my knowledge, the insurance applied for will or will not replace any Life Insurance, and/or Annuities.</p>
	<p>_____ X _____ Sam A. Producer Sam A. Producer Producer's Name (print) Signature of Producer</p> <p>_____ _____ Any Firm 02-A000000 Firm Producer's Nationwide #</p>	



TEMPORARY INSURANCE AGREEMENT

NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY, COLUMBUS, OH

This Agreement provides a limited amount of Life Insurance coverage, for a limited period of time, subject to the terms of this Agreement.

HEALTH QUESTION

 Question must be answered by each Proposed Insured(s).	Proposed Primary Insured		Proposed Additional Insured		Any Child		Has anyone here proposed for insurance: To the best of your knowledge and belief, within the past 10 years, been treated for, consulted a licensed health care provider, or been diagnosed by a licensed health care provider as having: angina, or chest pain or discomfort; heart attack, heart murmur, or any other heart disorder; epilepsy, stroke or diabetes; AIDS (Acquired Immune Deficiency Syndrome), any AIDS-related disorder or positive HIV (Human Immunodeficiency Virus) test result; any brain, nervous, or mental disorder, any drug or alcohol addiction; any kidney disorder (other than kidney stones); or any cancer or other malignancy?
	Yes	No	Yes	No	Yes	No	
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

If the above question is answered YES or LEFT BLANK, NO COVERAGE will take effect under this Agreement and no representative of Nationwide Life and Annuity Insurance Company is authorized to accept money, and/or provide a temporary insurance receipt to the applicant.

TERMS AND CONDITIONS

Amount of Coverage [\$1,000,000] overall maximum for all applications or agreements.	Temporary Insurance under this Agreement will commence on the date of the application if the full first premium for the mode selected has been paid and accepted by Nationwide or authorized by Electronic Funds Transfer as advance payment for an application for Life Insurance. If any Proposed Insured dies while this temporary insurance is in effect, Nationwide will pay to the designated Beneficiary the lesser of: <ul style="list-style-type: none"> the amount of death benefits, if any, which would be payable under the policy and its riders if issued as applied for, excluding any accidental death benefits, or [\$1,000,000] This total benefit limit applies to all insurance applied for under this and any other current applications to Nationwide and any other Temporary Insurance Agreements for Life Insurance whether applied for on the life or lives of one or more Proposed Insureds.
Date Coverage Terminates 60 DAYS maximum coverage.	Temporary Life Insurance under this Agreement will terminate automatically on the earliest of: <ul style="list-style-type: none"> 60 days from the date of this signed Agreement, or the date any policy is offered or issued to the Proposed Insured in connection with the above application, or the date Nationwide mails notice of termination of coverage and refund of the advance payment to the Proposed Insured, or the Owner, if different than the Proposed Insured.
Limitations	<ul style="list-style-type: none"> Fraud or material misrepresentation in the application or in the answers to the Health question of this Agreement invalidates this Agreement and Nationwide's only liability is for refund of any payment made. This Agreement does not provide coverage for Proposed Insured's who are under 15 days of age or over the age of 70 on the date of the Agreement. If any Proposed Insured dies by suicide, while sane or insane, Nationwide's liability under this Agreement is limited to a refund of the payment made. There is no coverage under this Agreement if the check submitted as payment is not honored by the bank on first presentation or if the Electronic Funds Transfer is not processed by the bank. No one is authorized to waive or modify any of the provisions of this Agreement.

SIGNATURES

Proposed Insured(s) and Owner Signatures	I HAVE RECEIVED A COPY OF AND HAVE READ THIS AGREEMENT AND DECLARE THAT THE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND AND AGREE TO ALL ITS TERMS. Dated (mm/dd/yyyy) <u>July 28, 2008</u> X <u>John D. Doe</u> Signature of Proposed Primary Insured (or parent if Proposed Primary Insured is under age 15) X _____ X _____ Signature of Applicant/Owner (if other than the Proposed Insured(s)) Signature of Proposed Additional Insured (if to be Insured)
Initial Premium Receipt and Producer's Signature  Be sure to include the amount of the initial premium payment.	An initial premium payment in the amount of \$ _____ has been submitted with this application. I have advised the Applicant/Owner that additional premium may need to be submitted at time of delivery. X <u>Sam A. Producer</u> _____ <u>Any Firm</u> _____ <u>02-A000000</u> Signature of Producer Firm Producer's Nationwide #

