

State: Arkansas **Filing Company:** Nationwide Life and Annuity Insurance Company
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: LAA-0111M1.1; LAA-0112M1.1; LAA-0113M1.1 Applications for Life Insurance
Project Name/Number: LAA-0111M1.1; LAA-0112M1.1; LAA-0113M1.1 Applications for Life Insurance/LAA-0111M1.1; LAA-0112M1.1; LAA-0113M1.1 Applications for Life Insurance

Filing at a Glance

Company: Nationwide Life and Annuity Insurance Company
 Product Name: LAA-0111M1.1; LAA-0112M1.1; LAA-0113M1.1 Applications for Life Insurance
 State: Arkansas
 TOI: L08 Life - Other
 Sub-TOI: L08.000 Life - Other
 Filing Type: Form
 Date Submitted: 10/12/2012
 SERFF Tr Num: NWPA-128719513
 SERFF Status: Closed-Approved-Closed
 State Tr Num:
 State Status: Approved-Closed
 Co Tr Num: LAA-0111M1.1; LAA-0112M1.1; LAA-0113M1.1 APPLICATIONS FOR LIFE INSURANCE
 Implementation: 01/04/2013
 Date Requested:
 Author(s): Amy Burchette, Sandra Davies, Dan Gallion, Cindy Malloy, Clara Pollard, Carrie Ruhlen, Georgia Sollars, Darcy L. Spangler, Drema Wallace, Leslie Hernandez, Darcy Spangler
 Reviewer(s): Linda Bird (primary)
 Disposition Date: 10/15/2012
 Disposition Status: Approved-Closed
 Implementation Date:
 State Filing Description:

State: Arkansas **Filing Company:** Nationwide Life and Annuity Insurance Company
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: LAA-0111M1.1; LAA-0112M1.1; LAA-0113M1.1 Applications for Life Insurance
Project Name/Number: LAA-0111M1.1; LAA-0112M1.1; LAA-0113M1.1 Applications for Life Insurance/LAA-0111M1.1; LAA-0112M1.1; LAA-0113M1.1 Applications for Life Insurance

General Information

Project Name: LAA-0111M1.1; LAA-0112M1.1; LAA-0113M1.1 Status of Filing in Domicile: Pending Applications for Life Insurance

Project Number: LAA-0111M1.1; LAA-0112M1.1; LAA-0113M1.1 Applications for Life Insurance

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Deemer Date:

Submitted By: Carrie Ruhlen

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 10/15/2012

State Status Changed: 10/15/2012

Created By: Carrie Ruhlen

Corresponding Filing Tracking Number: LAA-0111M1.1; LAA-0112M1.1; LAA-0113M1.1 Applications for Life Insurance

Filing Description:

Re: LAA-0111M1.1, Application for Individual Life Insurance
 LAA-0112M1.1, Application for Individual Life Insurance
 LAA-0113M1.1, Application for Individual Life Insurance
 NAIC #92657

Enclosed for filing, subject to your approval, are forms LAA-0111M1.1, LAA-0112M1.1, and LAA-0113M1.1, Applications for Individual Life Insurance. These are revised forms and will replace forms LAA-0111M1, LAA-0112M1, and LAA-0113M1, Applications for Life Insurance, approved 08-31-2011, SERFF #NWPA-127385672, State Tracking #49632

The following revisions have been made to each of the attached forms:

LAA-0111M1.1, LAA-0112M1.1 and LAA-0113M1.1:

- 1) In #5, Primary Beneficiary Designations section, and #6, Contingent Beneficiary Designations section, changed from "Address" to "Address & Phone #".
- 2) In #8, Life Insurance Plan section, in left hand column, changed name from "Index UL Product" to "Indexed UL Product".
- 3) In #10, Optional Benefits section, the right hand column of the Variable or Universal Life Plans Only section, added new part that reads:
 "Can select only one:
 fß Surrender Value Enhancement Benefit (moved from the top of this column)
 fß Conditional Return of Premium Rider (cannot be elected with Extended Death Benefit Guarantee Rider)"
- 4) In #11, Amount Paid With Application section, after Web Remittance, added wording that reads ;v "(this option is not available for VUL products)".
- 5) In Part C, the Medical Information Bureau (MIB, Inc.) section, changed all references from "Medical Information Bureau" to "MIB, Inc."
- 6) In Part D, the Authorization section, changed all references from "Medical Information Bureau" to "MIB, Inc."
- 7) In Part D, the Authorization section, in the left hand column added "HIPAA Compliant" to the title. The title now reads "HIPAA Compliant Authorization".
- 8) In Part D, the Authorization section, added sentence after "to investigate claims." that reads "I also authorize Nationwide to report information to MIB, Inc."

LAA-0112M1.1 Only:

State: Arkansas **Filing Company:** Nationwide Life and Annuity Insurance Company
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: LAA-0111M1.1; LAA-0112M1.1; LAA-0113M1.1 Applications for Life Insurance
Project Name/Number: LAA-0111M1.1; LAA-0112M1.1; LAA-0113M1.1 Applications for Life Insurance/LAA-0111M1.1; LAA-0112M1.1; LAA-0113M1.1 Applications for Life Insurance

- 1) In #8, the Life Insurance Plan section, changed product from "Waddell & Reed Protection VUL" to "Waddell & Reed Protection VUL II".
- 2) In #8, the Life Insurance Plan section, changed product from "Waddell & Reed Accumulation VUL" to "Waddell & Reed Accumulation VUL II".
- 3) In #8, the Life Insurance Plan section, removed the product "Waddell & Reed Survivorship UL."

LAA-0113M1.1 Only:

1) In #10, Optional Benefits section, the right hand column of the Variable or Universal Life Plans Only section, added rider that reads:

Surrender Charge Waiver Options: fβFull fβPartial
 (If the Full or Partial option is not selected, standard surrender charges will be applied.)

These forms are being filed concurrently in our state of domicile. Forms LAA-0111M1.1, LAA-0112M1.1, and LAA-0113M1.1 have been written in a readable fashion and attain a Flesch score of 48.4.

We will begin using the approved forms on January 4, 2013 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) Readability Certification
- 2) Form LAA-0111M1.1, Application for Life Insurance
- 3) Form LAA-0112M1.1, Application for Life Insurance
- 4) Form LAA-0113M1.1, Application for Life Insurance
- 5) Statement of Variability

Company and Contact

Filing Contact Information

Carrie Ruhlen, Compliance Specialist ruhlerc@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 Company | CoCode: 92657 | State of Domicile: Ohio |
| One Nationwide Plaza | Group Code: 140 | Company Type: |
| 1-10-03 | Group Name: | State ID Number: |
| Columbus, OH 43215 | FEIN Number: 31-1000740 | |
| (800) 882-2822 ext. [Phone] | | |

Filing Fees

State: Arkansas **Filing Company:** Nationwide Life and Annuity Insurance Company
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: LAA-0111M1.1; LAA-0112M1.1; LAA-0113M1.1 Applications for Life Insurance
Project Name/Number: LAA-0111M1.1; LAA-0112M1.1; LAA-0113M1.1 Applications for Life Insurance/LAA-0111M1.1; LAA-0112M1.1; LAA-0113M1.1 Applications for Life Insurance

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

| Company | Amount | Date Processed | Transaction # |
|---|----------|----------------|---------------|
| Nationwide Life and Annuity Insurance Company | \$150.00 | 10/12/2012 | 63752067 |

SERFF Tracking #: NWPA-128719513 **State Tracking #:** **Company Tracking #:** LAA-0111M1.1; LAA-0112M1.1; LAA-0113M1.1...

State: Arkansas **Filing Company:** Nationwide Life and Annuity Insurance Company
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: LAA-0111M1.1; LAA-0112M1.1; LAA-0113M1.1 Applications for Life Insurance
Project Name/Number: LAA-0111M1.1; LAA-0112M1.1; LAA-0113M1.1 Applications for Life Insurance/LAA-0111M1.1; LAA-0112M1.1; LAA-0113M1.1 Applications for Life Insurance

Correspondence Summary

Dispositions

| Status | Created By | Created On | Date Submitted |
|-----------------|------------|------------|----------------|
| Approved-Closed | Linda Bird | 10/15/2012 | 10/15/2012 |

SERFF Tracking #:

NWPA-128719513

State Tracking #:**Company Tracking #:**

LAA-0111M1.1; LAA-0112M1.1; LAA-0113M1.1...

State:

Arkansas

Filing Company:

Nationwide Life and Annuity Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

LAA-0111M1.1; LAA-0112M1.1; LAA-0113M1.1 Applications for Life Insurance

Project Name/Number:

LAA-0111M1.1; LAA-0112M1.1; LAA-0113M1.1 Applications for Life Insurance/LAA-0111M1.1; LAA-0112M1.1; LAA-0113M1.1 Applications for Life Insurance

Disposition

Disposition Date: 10/15/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

| Schedule | Schedule Item | Schedule Item Status | Public Access |
|---------------------|---|----------------------|---------------|
| Supporting Document | Flesch Certification | | Yes |
| Supporting Document | Application | | Yes |
| Supporting Document | Statement of Variability | | Yes |
| Supporting Document | Red-Lined versions of applications | | Yes |
| Form | Application for Individual Life Insurance | | Yes |
| Form | Application for Individual Life Insurance | | Yes |
| Form | Application for Individual Life Insurance | | Yes |

SERFF Tracking #:

NWPA-128719513

State Tracking #:

Company Tracking #:

LAA-0111M1.1; LAA-0112M1.1; LAA-0113M1.1...

State: Arkansas

Filing Company:

Nationwide Life and Annuity Insurance Company

TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other

Product Name: LAA-0111M1.1; LAA-0112M1.1; LAA-0113M1.1 Applications for Life Insurance

Project Name/Number: LAA-0111M1.1; LAA-0112M1.1; LAA-0113M1.1 Applications for Life Insurance/LAA-0111M1.1; LAA-0112M1.1; LAA-0113M1.1 Applications for Life Insurance

Form Schedule

Lead Form Number: LAA-0111M1.1

| Item No. | Schedule Item Status | Form Number | Form Type | Form Name | Action/ Action Specific Data | Readability Score | Attachments |
|----------|----------------------|--------------|-----------|---|---|-------------------|---------------------------|
| 1 | | LAA-0111M1.1 | AEF | Application for Individual Life Insurance | Revised: Replaced Form #: LAA-0111M1 Previous Filing #: 49632 | 48.400 | LAA-0111M1 John Doe.pdf |
| 2 | | LAA-0112M1.1 | AEF | Application for Individual Life Insurance | Revised: Replaced Form #: LAA-0112M1 Previous Filing #: 49632 | 48.400 | LAA-0112M1.1 John Doe.pdf |
| 3 | | LAA-0113M1.1 | AEF | Application for Individual Life Insurance | Revised: Replaced Form #: LAA-0113M1 Previous Filing #: 49632 | 48.400 | LAA-0113M1.1 John Doe.pdf |

Form Type Legend:

| | | | |
|-------------|---|-------------|--|
| ADV | Advertising | AEF | Application/Enrollment Form |
| CER | Certificate | CERA | Certificate Amendment, Insert Page, Endorsement or Rider |
| DDP | Data/Declaration Pages | FND | Funding Agreement (Annuity, Individual and Group) |
| MTX | Matrix | NOC | Notice of Coverage |
| OTH | Other | OUT | Outline of Coverage |
| PJK | Policy Jacket | POL | Policy/Contract/Fraternal Certificate |
| POLA | Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider | SCH | Schedule Pages |

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: 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.</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"/> (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 | | | | | | | | |
| | 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"/> Check this box if Trust named in the Owner section is to be the Primary Beneficiary. If a different Trust is named as Primary Beneficiary or Trust is named as Contingent Beneficiary, provide the Trust information below. | | | | | |
| | For Proposed Primary Insured | | | | | |
| | Primary Beneficiary(ies) Name(s) or Trust and Trustee(s) | Share % | Relationship to Insured(s) | Birth Date or Trust Date | SSN/Tax ID # | Address & Phone # |
| | Jane S. Doe | 100 | Wife | 10/08/1975 | 000-00-0000 | One Any Street Any City, Any State 00000 (000) 000-0000 |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | For Proposed Additional Insured | | | | | |
| | Primary Beneficiary(ies) Name(s) or Trust and Trustee(s) | Share % | Relationship to Insured(s) | Birth Date or Trust Date | SSN/Tax ID # | Address & Phone # |
| | | | | | | |
| | | | | | | |
| 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 & Phone # |
| | | | | | | |
| | | | | | | |
| | For Proposed Additional Insured | | | | | |
| | Contingent Beneficiary(ies) Name(s) or Trust and Trustee(s) | Share % | Relationship to Insured(s) | Birth Date or Trust Date | SSN/Tax ID # | Address & Phone # |
| | | | | | | |
| | | | | | | |
| 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 Indexed UL Product.

- 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® Current Assumption UL
- Nationwide YourLife® No-Lapse Guarantee UL

- Nationwide YourLife® Indexed UL
- 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) |
| \$ <u>250,000.00</u> | | \$ _____ | | \$ <u>250,000.00</u> |

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.)

- Spouse Rider \$ _____
- Children's Term Insurance Rider \$ _____
- Long Term Care Rider* \$ _____
*Complete Supplement for Long Term Care Rider.
- Accidental Death Benefit Rider \$ _____
- Adjusted Sales Load Rider _____ %
(in whole percentages only) waived for _____ years
- Extended Death Benefit Guarantee Rider
_____ Guarantee Percentage (Indicate percentage of specified amount)
_____ Guarantee Duration (Indicate number of years)

- Change of Insured Rider
- Other Rider(s) _____
- Other Rider(s) _____

- Can select only one:**
- Premium Waiver Rider \$ _____
 - Waiver of Monthly Deductions Rider

- Can select only one:**
- Surrender Value Enhancement Benefit
 - Conditional Return of Premium Rider (cannot be elected with Extended Death Benefit 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.)

- 20 Year Spouse Rider \$ _____
- Children's Term Insurance Rider \$ _____
- Accidental Death Benefit Rider \$ _____
- Guaranteed Insurability Benefit Rider \$ _____
- Waiver of Premium Disability Benefit Rider
- Owner's Waiver of Premium Death Benefit Rider (Complete Part B for the Owner)
Occupation _____
Height _____
Weight _____
State of Birth _____

- Owner's Waiver of Premium Death or Disability Benefit Rider (Complete Part B for the Owner)
Occupation _____
Height _____
Weight _____
State of Birth _____
- Other Rider(s) _____
- Other Rider(s) _____
- 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 (this option is not available for VUL products)..... \$ _____

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* \$ _____ *If selected, complete Section 13, Monthly Electronic Draft Authorization. | <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? (If "yes", list below.) |
| <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? (If "yes", provide name of Company, amount applied for and purpose of coverage.) |
| <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? (If "yes", list below and complete appropriate replacement forms. If this is an IRC Sect 1035 Exchange, attach 1035 forms.) |
| <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? (If "yes", provide name of Company, face amount and reason coverage is no longer in force.) |

| Insured | Company | Policy Number | Amount Of Coverage | Year Issued | To Be Replaced | 1035 Exch | Lapsed/ Surrendered/ Sold | Nationwide Term Conversion |
|---------|---------|---------------|--------------------|-------------|--|--------------------------|---------------------------|----------------------------|
| | | | \$ | | <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> | 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

All questions are to be answered by each Proposed Insured.

Explain all "yes" answers in Section 24 Details box unless instructed otherwise.

| | To the best of your knowledge and belief, has anyone here proposed for insurance ever consulted a licensed health care provider for, been treated for, taken medication for, or been diagnosed as having: | Proposed Primary Insured | | Proposed Additional Insured | | Any Child | |
|---|---|---------------------------------|-------------------------------------|------------------------------------|--------------------------|--------------------------|--------------------------|
| | | Yes | No | Yes | No | Yes | No |
| a. | AIDS (Acquired Immune Deficiency Syndrome), or 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> |
|---|---|

PART C – FRAUD STATEMENTS AND IMPORTANT NOTICES

WYOMING only: Any person who submits an application or a claim containing a false or deceptive statement, and does so with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, may be guilty of insurance fraud.

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

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

Pre-Notice of Procedures as Required by The Fair Credit Reporting Act of 1970
This notice is to inform you that as part of our normal underwriting procedures in connection with an application for insurance:

- An investigative consumer report may be made whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. This inquiry will include information as to character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation, with respect to you, members of your family, and others having an interest in or closely connected with the insurance transaction; and
- You may elect to be interviewed if an investigative consumer report is prepared in connection with this application. You are entitled to receive a copy of any investigative consumer report by submitting your request in writing.
- Upon your written request, made within a reasonable time after you receive this notice, additional information as to the nature and scope of the investigation, if one is made, will be provided. You may send corrections and requests for additional information addressed to Nationwide Life and Annuity Insurance Company, [P.O. Box 182835, Columbus, Ohio 43218-2835]. In the event of an adverse decision, you will be notified in writing.

MIB, Inc. Disclosure Notice
Information regarding your insurability will be treated as confidential. Nationwide Life and Annuity Insurance Company, or its reinsurer(s) may, however, make a brief report thereon to MIB, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB, Inc. member company for life or health insurance coverage or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB, Inc. file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB, Inc. information office is [50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734, telephone number 866-692-6901 (TTY 866-346-3642).] The e-mail address of the MIB, Inc. information office is www.mib.com. Nationwide Life and Annuity Insurance Company or its reinsurer(s) may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.



PART D – AGREEMENT, AUTHORIZATION AND SIGNATURE

Agreement

I understand and agree that:

- 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.

HIPAA Compliant Authorization

I authorize: any licensed physician or medical practitioner, any hospital, clinic, any pharmacy or pharmacy benefit managers, and other sources who maintain prescription drug records and related information, or other medical or medically related facility; any insurance company; MIB, Inc.; or any other organization, institution, or person, to disclose any information concerning me, including, but not limited to, my entire medical/health record to the Medical Director of Nationwide Life and Annuity Insurance Company or its affiliates, including, but not limited to, RSA Medical, for the purpose of underwriting my application in order to determine eligibility for Life Insurance and to investigate claims. I also authorize Nationwide to report information to MIB, Inc. By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this form; and I instruct any physician; health care professional; hospital; clinic; pharmacy or pharmacy benefit managers; medical facility, or other health care provider to release and disclose my entire medical/health record without restriction. I understand that any information that is disclosed pursuant to this form may be redisclosed and no longer be covered by federal rules governing privacy and confidentiality of health information. This form, or a copy of it, will be valid for a period of not more than two years (24 months) from the date it was signed. I understand that I have the right to revoke this form in writing, at any time, by sending a written request for revocation to Nationwide Life 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 records, or, if I revoke this authorization before a policy is issued, 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.

Proposed Insured(s) and Owner/Trustee Signatures

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.

Signed at Any City, Any State, on July 28, 2008
 City/State Month/Day Year

STOP

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).

_____ X 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)

_____ X _____
 Full Name of Proposed Additional Insured (print) Signature of Proposed Additional Insured
 (if to be Insured)

X _____ X _____
 Signature of Applicant/Owner Signature of Applicant/Owner
 (if other than the Proposed Insured(s)) (if other than the Proposed Insured(s))

PART E - PRODUCER'S CERTIFICATION

Producer's Certification

STOP

Be sure to answer all three questions.

| | |
|--|--|
| <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. (If "no", provide details in Special Instructions Section.) |
| <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. |

_____ X _____
Sam A. Producer Producer's Name (print) Signature of Producer

_____ _____
Any Firm Firm 02-A000000 Producer's Nationwide #



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

| | | | | | | | |
|---|---------------------------------|-------------------------------------|------------------------------------|--------------------------|--------------------------|--------------------------|--|
|  <p>Question must be answered by each Proposed Insured(s).</p> | Proposed Primary Insured | | Proposed Additional Insured | | Any Child | | Has anyone here proposed for insurance: |
| | 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"/> | 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? |
| 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  <p>Be sure to include the amount of the initial premium payment.</p> | 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-A00000</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: 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.</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"/> (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. 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.</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 # () | |
| | 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 # () | |
| | 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 Complete this section to name an alternative Owner in the event the Insured survives the Owner. | 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 If Survivorship Life Plan, the Proposed Insureds may not be named as Beneficiary. If additional space is required, use Special Instructions Section. | When more than one Beneficiary is designated, payments will be made in equal shares to the Beneficiaries surviving the Insured, or in full to the last surviving Beneficiary, unless some other distribution of proceeds is provided. | | | | | |
| | <input type="checkbox"/> Check this box if Trust named in the Owner section is to be the Primary Beneficiary. If a different Trust is named as Primary Beneficiary or Trust is named as Contingent Beneficiary, provide the Trust information below. | | | | | |
| | For Proposed Primary Insured | | | | | |
| | Primary Beneficiary(ies) Name(s) or Trust and Trustee(s) | Share % | Relationship to Insured(s) | Birth Date or Trust Date | SSN/Tax ID # | Address & Phone # |
| | Jane S. Doe | 100 | Wife | 10/08/1975 | 000-00-0000 | One Any Street Any City, Any State 00000 (000) 000-0000 |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | For Proposed Additional Insured | | | | | |
| Primary Beneficiary(ies) Name(s) or Trust and Trustee(s) | Share % | Relationship to Insured(s) | Birth Date or Trust Date | SSN/Tax ID # | Address & Phone # | |
| | | | | | | |
| | | | | | | |

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

| | |
|---|--|
| 7. Taxpayer ID Number  Check box, if applicable | 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 Indexed UL Product.

- | | |
|---|---|
| <input type="checkbox"/> Waddell & Reed Protection VUL II <input type="checkbox"/> Waddell & Reed Accumulation VUL II <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® Indexed UL <input type="checkbox"/> Nationwide YourLife® Current Assumption UL <input type="checkbox"/> Nationwide YourLife® No-Lapse Guarantee UL <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 (this option is not available for VUL products)..... \$ _____

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* \$ _____ *If selected, complete Section 13, Monthly Electronic Draft Authorization. | <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: *Checking *Savings

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

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.

Yes No a. Do you have any other Life Insurance or Annuities either currently in force or that has been sold to a third party? (If "yes", list below.)

Yes No b. Is any person here proposed for coverage now applying for Life Insurance or Annuities with any other company? (If "yes", provide name of Company, amount applied for and purpose of coverage.)

Yes No c. Will any Life Insurance or Annuities for this or any other company be replaced, discontinued, reduced or changed if insurance now applied for is issued? (If "yes", list below and complete appropriate replacement forms. If this is an IRC Sect 1035 Exchange, attach 1035 forms.)

Yes No d. Is any person here proposed for coverage had Life Insurance or Annuities in the past 3 years that is no longer in force? (If "yes", provide name of Company, face amount and reason coverage is no longer in force.)

| Insured | Company | Policy Number | Amount Of Coverage | Year Issued | To Be Replaced | 1035 Exch | Lapsed/ Surrendered/ Sold | Nationwide Term Conversion |
|---------|---------|---------------|--------------------|-------------|--|--------------------------|---------------------------|----------------------------|
| | | | \$ | | <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>This section needs to be completed by each Proposed Insured and Owner/Trustee, if other than Proposed Insured(s).</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>Be sure to answer this section.</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> | | | 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

All questions are to be answered by each Proposed Insured.

Explain all "yes" answers in Section 24 Details box unless instructed otherwise.

To the best of your knowledge and belief, has anyone here proposed for insurance ever consulted a licensed health care provider for, been treated for, taken medication for, or been diagnosed as having:

| | Proposed Primary Insured | | Proposed Additional Insured | | Any Child | |
|---|--------------------------|-------------------------------------|-----------------------------|--------------------------|--------------------------|--------------------------|
| | Yes | No | Yes | No | Yes | No |
| a. AIDS (Acquired Immune Deficiency Syndrome), or 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> |
|---|---|

PART C – FRAUD STATEMENTS AND IMPORTANT NOTICES

WYOMING only: Any person who submits an application or a claim containing a false or deceptive statement, and does so with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, may be guilty of insurance fraud.

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

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

Pre-Notice of Procedures as Required by The Fair Credit Reporting Act of 1970
This notice is to inform you that as part of our normal underwriting procedures in connection with an application for insurance:

- An investigative consumer report may be made whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. This inquiry will include information as to character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation, with respect to you, members of your family, and others having an interest in or closely connected with the insurance transaction; and
- You may elect to be interviewed if an investigative consumer report is prepared in connection with this application. You are entitled to receive a copy of any investigative consumer report by submitting your request in writing.
- Upon your written request, made within a reasonable time after you receive this notice, additional information as to the nature and scope of the investigation, if one is made, will be provided. You may send corrections and requests for additional information addressed to Nationwide Life and Annuity Insurance Company, [P.O. Box 182835, Columbus, Ohio 43218-2835]. In the event of an adverse decision, you will be notified in writing.

MIB, Inc. Disclosure Notice
Information regarding your insurability will be treated as confidential. Nationwide Life and Annuity Insurance Company, or its reinsurer(s) may, however, make a brief report thereon to MIB, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB, Inc. member company for life or health insurance coverage or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB, Inc. file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB, Inc. information office is [50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734, telephone number 866-692-6901 (TTY 866-346-3642).] The e-mail address of the MIB, Inc. information office is www.mib.com. Nationwide Life and Annuity Insurance Company or its reinsurer(s) may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.



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: |
| | 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"/> | 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? |
| 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-A00000</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: 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.</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"/> (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. 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.</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 Complete this section to name an alternative Owner in the event the Insured survives the Owner. | 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 If Survivorship Life Plan, the Proposed Insureds may not be named as Beneficiary. If additional space is required, use Special Instructions Section. | When more than one Beneficiary is designated, payments will be made in equal shares to the Beneficiaries surviving the Insured, or in full to the last surviving Beneficiary, unless some other distribution of proceeds is provided. | | | | | |
| | <input type="checkbox"/> Check this box if Trust named in the Owner section is to be the Primary Beneficiary. If a different Trust is named as Primary Beneficiary or Trust is named as Contingent Beneficiary, provide the Trust information below. | | | | | |
| | For Proposed Primary Insured | | | | | |
| | Primary Beneficiary(ies) Name(s) or Trust and Trustee(s) | Share % | Relationship to Insured(s) | Birth Date or Trust Date | SSN/Tax ID # | Address & Phone # |
| | Jane S. Doe | 100 | Wife | 10/08/1975 | 000-00-0000 | One Any Street Any City, Any State 00000 (000) 000-0000 |
| | | | | | | |
| | | | | | | |
| For Proposed Additional Insured | | | | | | |
| Primary Beneficiary(ies) Name(s) or Trust and Trustee(s) | Share % | Relationship to Insured(s) | Birth Date or Trust Date | SSN/Tax ID # | Address & Phone # | |
| | | | | | | |
| | | | | | | |

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

| | |
|---|--|
| 7. Taxpayer ID Number  Check box, if applicable | 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 Indexed 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 [®] 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 (check plan for availability) | = | Total Specified Amount (including Additional Term Rider/Supplemental Coverage) |
| \$ <u>250,000.00</u> | | \$ _____ | | \$ <u>250,000.00</u> |

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) <input type="checkbox"/> Surrender Charge Waiver Options: <input type="checkbox"/> Full <input type="checkbox"/> Partial (If the Full or Partial option is not selected, standard surrender charges will be applied.) |
|---|---|

- Survivorship Variable or Survivorship Universal Life Plans Only (Subject to Plan availability.)**
- | | |
|--|--|
| <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 (this option is not available for VUL products)..... \$ _____

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 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? (If "yes", list below.) |
| <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? (If "yes", provide name of Company, amount applied for and purpose of coverage.) |
| <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? (If "yes", list below and complete appropriate replacement forms. If this is an IRC Sect 1035 Exchange, attach 1035 forms.) |
| <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? (If "yes", provide name of Company, face amount and reason coverage is no longer in force.) |

| Insured | Company | Policy Number | Amount Of Coverage | Year Issued | To Be Replaced | 1035 Exch | Lapsed/ Surrendered/ Sold | Nationwide Term Conversion |
|---------|---------|---------------|--------------------|-------------|--|--------------------------|---------------------------|----------------------------|
| | | | \$ | | <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>This section needs to be completed by each Proposed Insured and Owner/Trustee, if other than Proposed Insured(s).</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>Be sure to answer this section.</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> | 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

All questions are to be answered by each Proposed Insured.

Explain all "yes" answers in Section 24 Details box unless instructed otherwise.

To the best of your knowledge and belief, has anyone here proposed for insurance ever consulted a licensed health care provider for, been treated for, taken medication for, or been diagnosed as having:

| Proposed Primary Insured | Proposed Additional Insured | Any Child | |
|--|---|---|---|
| | | Yes | No |
| Yes No | Yes No | Yes | No |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input 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> | | | |
|---|---|--|--|--|

PART C – FRAUD STATEMENTS AND IMPORTANT NOTICES

WYOMING only: Any person who submits an application or a claim containing a false or deceptive statement, and does so with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, may be guilty of insurance fraud.

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

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

Pre-Notice of Procedures as Required by The Fair Credit Reporting Act of 1970
This notice is to inform you that as part of our normal underwriting procedures in connection with an application for insurance:

- An investigative consumer report may be made whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. This inquiry will include information as to character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation, with respect to you, members of your family, and others having an interest in or closely connected with the insurance transaction; and
- You may elect to be interviewed if an investigative consumer report is prepared in connection with this application. You are entitled to receive a copy of any investigative consumer report by submitting your request in writing.
- Upon your written request, made within a reasonable time after you receive this notice, additional information as to the nature and scope of the investigation, if one is made, will be provided. You may send corrections and requests for additional information addressed to Nationwide Life and Annuity Insurance Company, [P.O. Box 182835, Columbus, Ohio 43218-2835]. In the event of an adverse decision, you will be notified in writing.

MIB, Inc. Disclosure Notice
Information regarding your insurability will be treated as confidential. Nationwide Life and Annuity Insurance Company, or its reinsurer(s) may, however, make a brief report thereon to MIB, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB, Inc. member company for life or health insurance coverage or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB, Inc. file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB, Inc. information office is [50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734, telephone number 866-692-6901 (TTY 866-346-3642).] The e-mail address of the MIB, Inc. information office is www.mib.com. Nationwide Life and Annuity Insurance Company or its reinsurer(s) may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.



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

| | | | | | | | |
|---|---------------------------------|-------------------------------------|------------------------------------|--------------------------|--------------------------|--------------------------|--|
|  <p>Question must be answered by each Proposed Insured(s).</p> | Proposed Primary Insured | | Proposed Additional Insured | | Any Child | | Has anyone here proposed for insurance: |
| | 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"/> | 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? |
| 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 _____ Signature of Applicant/Owner (if other than the Proposed Insured(s)) | X _____ Signature of Proposed Additional Insured (if to be Insured) | |
| Initial Premium Receipt and Producer's Signature  | 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. | | |
| Be sure to include the amount of the initial premium payment. | X <u>Sam A. Producer</u> Signature of Producer | <u>Any Firm</u> Firm | <u>02-A00000</u> Producer's Nationwide # |



SERFF Tracking #:

NWPA-128719513

State Tracking #:**Company Tracking #:**

LAA-0111M1.1; LAA-0112M1.1; LAA-0113M1.1...

State:

Arkansas

Filing Company:

Nationwide Life and Annuity Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

LAA-0111M1.1; LAA-0112M1.1; LAA-0113M1.1 Applications for Life Insurance

Project Name/Number:

LAA-0111M1.1; LAA-0112M1.1; LAA-0113M1.1 Applications for Life Insurance/LAA-0111M1.1; LAA-0112M1.1; LAA-0113M1.1 Applications for Life Insurance

Supporting Document Schedules

| | | Item Status: | Status Date: |
|-------------------|----------------------|--------------|--------------|
| Satisfied - Item: | Flesch Certification | | |
| Comments: | | | |
| Attachment(s): | | | |
| AR CERT NWLA.pdf | | | |

| | | Item Status: | Status Date: |
|-------------------|--|--------------|--------------|
| Satisfied - Item: | Application | | |
| Comments: | This is an application filing. The applications are submitted under the Forms Tab. | | |

| | | Item Status: | Status Date: |
|---------------------------------|--------------------------|--------------|--------------|
| Satisfied - Item: | Statement of Variability | | |
| Comments: | | | |
| Attachment(s): | | | |
| Statement of Variability-M1.pdf | | | |

| | | Item Status: | Status Date: |
|--|------------------------------------|--------------|--------------|
| Satisfied - Item: | Red-Lined versions of applications | | |
| Comments: | | | |
| Attachment(s): | | | |
| LAA-0111M1 - highlighted.pdf LAA-0112M1.1 - highlighted.pdf LAA-0113M1.1 - highlighted.pdf | | | |



ARKANSAS

Certificate of Compliance

Insurer Nationwide Life and Annuity Insurance Company

Form Numbers: LAA-0111M1.1, Application for Life Insurance
LAA-0112M1.1, Application for Life Insurance
LAA-0113M1.1, 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, reading "James J. Rabenstine". The signature is written in a cursive style and is positioned above a horizontal line.

James J. Rabenstine
Vice President
NF Compliance
Date: 10-12-2012

NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY

(09/2012)

STATEMENT OF VARIABILITY FOR FORMS:

LAA-0111M1.1, Application for Life Insurance

LAA-0112M1.1, Application for Life Insurance

LAA-0113M1.1, 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. |
|--|--|

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. |
|--------------------|--|

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

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

| | | | | | | |
|---|--|--|--|--|--|--|
| 7. Taxpayer ID Number  Check box, if applicable | 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 Indexed UL Product.

- 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® Current Assumption UL
- Nationwide YourLife® No-Lapse Guarantee UL

- Nationwide YourLife® Indexed UL
- 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.)

- | | |
|---|---|
| <ul style="list-style-type: none"> <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) | <ul style="list-style-type: none"> <input type="checkbox"/> Change of Insured Rider <input type="checkbox"/> Other Rider(s) _____ <input type="checkbox"/> Other Rider(s) _____ <p>Can select only one:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Premium Waiver Rider \$ _____ <input type="checkbox"/> Waiver of Monthly Deductions Rider <p>Can select only one:</p> <ul style="list-style-type: none"> <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.)

- | | |
|---|---|
| <ul style="list-style-type: none"> <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 _____ | <ul style="list-style-type: none"> <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 (this option is not available for VUL products) \$ _____

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 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? (If "yes", list below.) |
| <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? (If "yes", provide name of Company, amount applied for and purpose of coverage.) |
| <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? (If "yes", list below and complete appropriate replacement forms. If this is an IRC Sect 1035 Exchange, attach 1035 forms.) |
| <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? (If "yes", provide name of Company, face amount and reason coverage is no longer in force.) |

| Insured | Company | Policy Number | Amount Of Coverage | Year Issued | To Be Replaced | 1035 Exch | Lapsed/ Surrendered/ Sold | Nationwide Term Conversion |
|---------|---------|---------------|--------------------|-------------|--|--------------------------|---------------------------|----------------------------|
| | | | \$ | | <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> | 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

All questions are to be answered by each Proposed Insured.

Explain all "yes" answers in Section 24 Details box unless instructed otherwise.

| | To the best of your knowledge and belief, has anyone here proposed for insurance ever consulted a licensed health care provider for, been treated for, taken medication for, or been diagnosed as having: | Proposed Primary Insured | | Proposed Additional Insured | | Any Child | |
|---|---|---------------------------------|-------------------------------------|------------------------------------|--------------------------|--------------------------|--------------------------|
| | | Yes | No | Yes | No | Yes | No |
| a. | AIDS (Acquired Immune Deficiency Syndrome), or 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> |
|---|---|

PART C – FRAUD STATEMENTS AND IMPORTANT NOTICES

WYOMING only: Any person who submits an application or a claim containing a false or deceptive statement, and does so with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, may be guilty of insurance fraud.

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

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

Pre-Notice of Procedures as Required by The Fair Credit Reporting Act of 1970
This notice is to inform you that as part of our normal underwriting procedures in connection with an application for insurance:

- An investigative consumer report may be made whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. This inquiry will include information as to character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation, with respect to you, members of your family, and others having an interest in or closely connected with the insurance transaction; and
- You may elect to be interviewed if an investigative consumer report is prepared in connection with this application. You are entitled to receive a copy of any investigative consumer report by submitting your request in writing.
- Upon your written request, made within a reasonable time after you receive this notice, additional information as to the nature and scope of the investigation, if one is made, will be provided. You may send corrections and requests for additional information addressed to Nationwide Life and Annuity Insurance Company, [P.O. Box 182835, Columbus, Ohio 43218-2835]. In the event of an adverse decision, you will be notified in writing.

MIB, Inc. Disclosure Notice
Information regarding your insurability will be treated as confidential. Nationwide Life and Annuity Insurance Company, or its reinsurer(s) may, however, make a brief report thereon to MIB, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB, Inc. member company for life or health insurance coverage or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB, Inc. file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB, Inc. information office is [50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734, telephone number 866-692-6901 (TTY 866-346-3642).] The e-mail address of the MIB, Inc. information office is www.mib.com. Nationwide Life and Annuity Insurance Company or its reinsurer(s) may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.



PART D – AGREEMENT, AUTHORIZATION AND SIGNATURE

Agreement

I understand and agree that:

- 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.

HIPAA Compliant Authorization

I authorize: any licensed physician or medical practitioner, any hospital, clinic, any pharmacy or pharmacy benefit managers, and other sources who maintain prescription drug records and related information, or other medical or medically related facility; any insurance company; **MIB, Inc.**; or any other organization, institution, or person, to disclose any information concerning me, including, but not limited to, my entire medical/health record to the Medical Director of Nationwide Life and Annuity Insurance Company or its affiliates, including, but not limited to, RSA Medical, for the purpose of underwriting my application in order to determine eligibility for Life Insurance and to investigate claims.

I also authorize Nationwide to report information to MIB, Inc. By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this form; and I instruct any physician; health care professional; hospital; clinic; pharmacy or pharmacy benefit managers; medical facility, or other health care provider to release and disclose my entire medical/health record without restriction. I understand that any information that is disclosed pursuant to this form may be redisclosed and no longer be covered by federal rules governing privacy and confidentiality of health information. This form, or a copy of it, will be valid for a period of not more than two years (24 months) from the date it was signed. I understand that I have the right to revoke this form in writing, at any time, by sending a written request for revocation to Nationwide Life 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 records, or, if I revoke this authorization before a policy is issued, 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.

Proposed Insured(s) and Owner/Trustee Signatures

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.

Signed at Any City, Any State, on July 28, 2008
 City/State Month/Day Year

STOP

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).

_____ X 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)

_____ X _____
 Full Name of Proposed Additional Insured (print) Signature of Proposed Additional Insured
 (if to be Insured)

X _____ X _____
 Signature of Applicant/Owner Signature of Applicant/Owner
 (if other than the Proposed Insured(s)) (if other than the Proposed Insured(s))

PART E - PRODUCER'S CERTIFICATION

Producer's Certification

STOP

Be sure to answer all three questions.

Yes No a. I have truly and accurately recorded all Proposed Insureds' answers on this application.

Yes No b. I have witnessed his/her/their signature(s) hereon. (If "no", provide details in Special Instructions Section.)

Will Will Not c. To the best of my knowledge, the insurance applied for will or will not replace any Life Insurance, and/or Annuities.

Sam A. Producer X Sam A. Producer
 Producer's Name (print) Signature of Producer

Any Firm 02-A00000
 Firm Producer's Nationwide #



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: |
| | 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"/> | 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? |
| 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-A00000</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: 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.</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"/> (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. 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.</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 Complete this section to name an alternative Owner in the event the Insured survives the Owner. | 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 If Survivorship Life Plan, the Proposed Insureds may not be named as Beneficiary. If additional space is required, use Special Instructions Section. | When more than one Beneficiary is designated, payments will be made in equal shares to the Beneficiaries surviving the Insured, or in full to the last surviving Beneficiary, unless some other distribution of proceeds is provided. | | | | | |
| | <input type="checkbox"/> Check this box if Trust named in the Owner section is to be the Primary Beneficiary. If a different Trust is named as Primary Beneficiary or Trust is named as Contingent Beneficiary, provide the Trust information below. | | | | | |
| | For Proposed Primary Insured | | | | | |
| | Primary Beneficiary(ies) Name(s) or Trust and Trustee(s) | Share % | Relationship to Insured(s) | Birth Date or Trust Date | SSN/Tax ID # | Address & Phone # |
| | Jane S. Doe | 100 | Wife | 10/08/1975 | 000-00-0000 | One Any Street Any City, Any State 00000 (000) 000-0000 |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | For Proposed Additional Insured | | | | | |
| Primary Beneficiary(ies) Name(s) or Trust and Trustee(s) | Share % | Relationship to Insured(s) | Birth Date or Trust Date | SSN/Tax ID # | Address & Phone # | |
| | | | | | | |
| | | | | | | |

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

| | | | | | | |
|---|--|--|--|--|--|--|
| 7. Taxpayer ID Number  Check box, if applicable | 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 Indexed UL Product.

- | | |
|---|---|
| <input type="checkbox"/> Waddell & Reed Protection VUL II <input type="checkbox"/> Waddell & Reed Accumulation VUL II <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® Indexed UL <input type="checkbox"/> Nationwide YourLife® Current Assumption UL <input type="checkbox"/> Nationwide YourLife® No-Lapse Guarantee UL <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 (this option is not available for VUL products)..... \$ _____

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 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? (If "yes", list below.) |
| <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? (If "yes", provide name of Company, amount applied for and purpose of coverage.) |
| <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? (If "yes", list below and complete appropriate replacement forms. If this is an IRC Sect 1035 Exchange, attach 1035 forms.) |
| <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? (If "yes", provide name of Company, face amount and reason coverage is no longer in force.) |

| Insured | Company | Policy Number | Amount Of Coverage | Year Issued | To Be Replaced | 1035 Exch | Lapsed/ Surrendered/ Sold | Nationwide Term Conversion |
|---------|---------|---------------|--------------------|-------------|--|--------------------------|---------------------------|----------------------------|
| | | | \$ | | <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>This section needs to be completed by each Proposed Insured and Owner/Trustee, if other than Proposed Insured(s).</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>Be sure to answer this section.</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

All questions are to be answered by each Proposed Insured.

Explain all "yes" answers in Section 24 Details box unless instructed otherwise.

To the best of your knowledge and belief, has anyone here proposed for insurance ever consulted a licensed health care provider for, been treated for, taken medication for, or been diagnosed as having:

| | Proposed Primary Insured | | Proposed Additional Insured | | Any Child | |
|---|--------------------------|-------------------------------------|-----------------------------|--------------------------|--------------------------|--------------------------|
| | Yes | No | Yes | No | Yes | No |
| a. AIDS (Acquired Immune Deficiency Syndrome), or 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> | | | |
|----------------------------------|---|--|--|--|

PART C – FRAUD STATEMENTS AND IMPORTANT NOTICES

WYOMING only: Any person who submits an application or a claim containing a false or deceptive statement, and does so with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, may be guilty of insurance fraud.

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

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

Pre-Notice of Procedures as Required by The Fair Credit Reporting Act of 1970
 This notice is to inform you that as part of our normal underwriting procedures in connection with an application for insurance:
 • An investigative consumer report may be made whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. This inquiry will include information as to character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation, with respect to you, members of your family, and others having an interest in or closely connected with the insurance transaction; and
 • You may elect to be interviewed if an investigative consumer report is prepared in connection with this application. You are entitled to receive a copy of any investigative consumer report by submitting your request in writing.
 • Upon your written request, made within a reasonable time after you receive this notice, additional information as to the nature and scope of the investigation, if one is made, will be provided. You may send corrections and requests for additional information addressed to Nationwide Life and Annuity Insurance Company, [P.O. Box 182835, Columbus, Ohio 43218-2835]. In the event of an adverse decision, you will be notified in writing.

MIB, Inc. Disclosure Notice
 Information regarding your insurability will be treated as confidential. Nationwide Life and Annuity Insurance Company, or its reinsurer(s) may, however, make a brief report thereon to MIB, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB, Inc. member company for life or health insurance coverage or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB, Inc. file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB, Inc. information office is [50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734, telephone number 866-692-6901 (TTY 866-346-3642).] The e-mail address of the MIB, Inc. information office is www.mib.com. Nationwide Life and Annuity Insurance Company or its reinsurer(s) may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.



PART D – AGREEMENT, AUTHORIZATION AND SIGNATURE

Agreement

I understand and agree that:

- 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.

HIPAA Compliant Authorization

I authorize: any licensed physician or medical practitioner, any hospital, clinic, any pharmacy or pharmacy benefit managers, and other sources who maintain prescription drug records and related information, or other medical or medically related facility; any insurance company; MIB, Inc.; or any other organization, institution, or person, to disclose any information concerning me, including, but not limited to, my entire medical/health record to the Medical Director of Nationwide Life and Annuity Insurance Company or its affiliates, including, but not limited to, RSA Medical, for the purpose of underwriting my application in order to determine eligibility for Life Insurance and to investigate claims. I also authorize Nationwide to report information to MIB, Inc. By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this form; and I instruct any physician; health care professional; hospital; clinic; pharmacy or pharmacy benefit managers; medical facility, or other health care provider to release and disclose my entire medical/health record without restriction. I understand that any information that is disclosed pursuant to this form may be redisclosed and no longer be covered by federal rules governing privacy and confidentiality of health information. This form, or a copy of it, will be valid for a period of not more than two years (24 months) from the date it was signed. I understand that I have the right to revoke this form in writing, at any time, by sending a written request for revocation to Nationwide Life 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 records, or, if I revoke this authorization before a policy is issued, 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.

Proposed Insured(s) and Owner/Trustee Signatures

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.

Signed at Any City, Any State, on July 28, 2008
 City/State Month/Day Year

STOP

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).

_____ X 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)

_____ X _____
 Full Name of Proposed Additional Insured (print) Signature of Proposed Additional Insured
 (if to be Insured)

X _____ X _____
 Signature of Applicant/Owner Signature of Applicant/Owner
 (if other than the Proposed Insured(s)) (if other than the Proposed Insured(s))

PART E - PRODUCER'S CERTIFICATION

Producer's Certification

STOP

Be sure to answer all three questions.

Yes No a. I have truly and accurately recorded all Proposed Insureds' answers on this application.

Yes No b. I have witnessed his/her/their signature(s) hereon. (If "no", provide details in Special Instructions Section.)

Will Will Not c. To the best of my knowledge, the insurance applied for will or will not replace any Life Insurance, and/or Annuities.

Sam A. Producer X Sam A. Producer
 Producer's Name (print) Signature of Producer

Any Firm 02-A00000
 Firm Producer's Nationwide #



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

| | | | | | | | |
|---|---------------------------------|-------------------------------------|------------------------------------|--------------------------|--------------------------|--------------------------|--|
|  <p>Question must be answered by each Proposed Insured(s).</p> | Proposed Primary Insured | | Proposed Additional Insured | | Any Child | | <p align="center">Has anyone here proposed for insurance:</p> <p>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?</p> <p><i>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.</i></p> |
| | 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"/> | |

TERMS AND CONDITIONS

| | |
|--|---|
| <p>Amount of Coverage</p> <p>[\$1,000,000] overall maximum for all applications or agreements.</p> | <p>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:</p> <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. |
| <p>Date Coverage Terminates</p> <p>60 DAYS maximum coverage.</p> | <p>Temporary Life Insurance under this Agreement will terminate automatically on the earliest of:</p> <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. |
| <p>Limitations</p> | <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

| | |
|--|--|
| <p>Proposed Insured(s) and Owner Signatures</p> | <p>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.</p> <p>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)</p> <p>X _____ X _____ Signature of Applicant/Owner (if other than the Proposed Insured(s)) Signature of Proposed Additional Insured (if to be Insured)</p> |
| <p>Initial Premium Receipt and Producer's Signature</p> <p></p> <p>Be sure to include the amount of the initial premium payment.</p> | <p>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.</p> <p>X <u>Sam A. Producer</u> <u>Any Firm</u> <u>02-A00000</u> Signature of Producer Firm Producer's Nationwide #</p> |



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

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

| | | | | | | |
|---|--|--|--|--|--|--|
| 7. Taxpayer ID Number  Check box, if applicable | 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 Indexed 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 [®] 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 (check plan for availability) | = | Total Specified Amount (including Additional Term Rider/Supplemental Coverage) |
| \$ <u>250,000.00</u> | | \$ _____ | | \$ <u>250,000.00</u> |

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) <input checked="" type="checkbox"/> Surrender Charge Waiver Options: <input type="checkbox"/> Full <input type="checkbox"/> Partial (If the Full or Partial option is not selected, standard surrender charges will be applied.) |
|---|--|

- Survivorship Variable or Survivorship Universal Life Plans Only (Subject to Plan availability.)**
- | | |
|--|--|
| <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 (this option is not available for VUL products) \$ _____

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 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? (If "yes", list below.) |
| <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? (If "yes", provide name of Company, amount applied for and purpose of coverage.) |
| <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? (If "yes", list below and complete appropriate replacement forms. If this is an IRC Sect 1035 Exchange, attach 1035 forms.) |
| <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? (If "yes", provide name of Company, face amount and reason coverage is no longer in force.) |

| Insured | Company | Policy Number | Amount Of Coverage | Year Issued | To Be Replaced | 1035 Exch | Lapsed/ Surrendered/ Sold | Nationwide Term Conversion |
|---------|---------|---------------|--------------------|-------------|--|--------------------------|---------------------------|----------------------------|
| | | | \$ | | <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>This section needs to be completed by each Proposed Insured and Owner/Trustee, if other than Proposed Insured(s).</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>Be sure to answer this section.</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"/> Cigars <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Pipe <input type="checkbox"/> Other Tobacco <input type="checkbox"/> Snuff <input type="checkbox"/> Nicotine Products (gum, patch, etc.) | | <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Pipe <input type="checkbox"/> Other Tobacco <input type="checkbox"/> Snuff <input type="checkbox"/> Nicotine Products (gum, patch, etc.) | |

| | | | | |
|--|---------------|-----------------------|--------------------------|---------------------------------------|
| <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

All questions are to be answered by each Proposed Insured.

Explain all "yes" answers in Section 24 Details box unless instructed otherwise.

To the best of your knowledge and belief, has anyone here proposed for insurance ever consulted a licensed health care provider for, been treated for, taken medication for, or been diagnosed as having:

| Proposed Primary Insured | Proposed Additional Insured | Any Child | |
|--|---|---|---|
| | | Yes | No |
| Yes No | Yes No | Yes | No |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input 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:

| | | | |
|--|---|---|---|
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input 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> |
|---|---|

PART C – FRAUD STATEMENTS AND IMPORTANT NOTICES

WYOMING only: Any person who submits an application or a claim containing a false or deceptive statement, and does so with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, may be guilty of insurance fraud.

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

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

Pre-Notice of Procedures as Required by The Fair Credit Reporting Act of 1970
 This notice is to inform you that as part of our normal underwriting procedures in connection with an application for insurance:
 • An investigative consumer report may be made whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. This inquiry will include information as to character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation, with respect to you, members of your family, and others having an interest in or closely connected with the insurance transaction; and
 • You may elect to be interviewed if an investigative consumer report is prepared in connection with this application. You are entitled to receive a copy of any investigative consumer report by submitting your request in writing.
 • Upon your written request, made within a reasonable time after you receive this notice, additional information as to the nature and scope of the investigation, if one is made, will be provided. You may send corrections and requests for additional information addressed to Nationwide Life and Annuity Insurance Company, [P.O. Box 182835, Columbus, Ohio 43218-2835]. In the event of an adverse decision, you will be notified in writing.

MIB, Inc. Disclosure Notice
 Information regarding your insurability will be treated as confidential. Nationwide Life and Annuity Insurance Company, or its reinsurer(s) may, however, make a brief report thereon to MIB, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB, Inc. member company for life or health insurance coverage or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB, Inc. file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB, Inc. information office is [50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734, telephone number 866-692-6901 (TTY 866-346-3642).] The e-mail address of the MIB, Inc. information office is www.mib.com. Nationwide Life and Annuity Insurance Company or its reinsurer(s) may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.



PART D – AGREEMENT, AUTHORIZATION AND SIGNATURE

Agreement

I understand and agree that:

- 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.

HIPAA Compliant Authorization

I authorize: any licensed physician or medical practitioner, any hospital, clinic, any pharmacy or pharmacy benefit managers, and other sources who maintain prescription drug records and related information, or other medical or medically related facility; any insurance company; MIB, Inc.; or any other organization, institution, or person, to disclose any information concerning me, including, but not limited to, my entire medical/health record to the Medical Director of Nationwide Life and Annuity Insurance Company or its affiliates, including, but not limited to, RSA Medical, for the purpose of underwriting my application in order to determine eligibility for Life Insurance and to investigate claims. I also authorize Nationwide to report information to MIB, Inc. By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this form; and I instruct any physician; health care professional; hospital; clinic; pharmacy or pharmacy benefit managers; medical facility, or other health care provider to release and disclose my entire medical/health record without restriction. I understand that any information that is disclosed pursuant to this form may be redisclosed and no longer be covered by federal rules governing privacy and confidentiality of health information. This form, or a copy of it, will be valid for a period of not more than two years (24 months) from the date it was signed. I understand that I have the right to revoke this form in writing, at any time, by sending a written request for revocation to Nationwide Life 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 records, or, if I revoke this authorization before a policy is issued, 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.

Proposed Insured(s) and Owner/Trustee Signatures

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.

Signed at Any City, Any State, on July 28, 2008
City/State Month/Day Year

STOP

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).

_____ X 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)

_____ X _____
Full Name of Proposed Additional Insured (print) Signature of Proposed Additional Insured (if to be Insured)

X _____ X _____
Signature of Applicant/Owner (if other than the Proposed Insured(s)) Signature of Applicant/Owner (if other than the Proposed Insured(s))

PART E - PRODUCER'S CERTIFICATION

Producer's Certification

STOP

Be sure to answer all three questions.

| | |
|--|--|
| <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. (If "no", provide details in Special Instructions Section.) |
| <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. |

_____ X _____
Sam A. Producer Producer's Name (print) Signature of Producer

_____ _____
Any Firm Firm 02-A000000 Producer's Nationwide #



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: |
| | 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"/> | 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? |
| 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-A00000</u> Signature of Producer Firm Producer's Nationwide # |

