

SERFF Tracking Number: NWPA-128275065 State: Arkansas
Filing Company: Nationwide Life and Annuity Insurance Company State Tracking Number:
Company Tracking Number: LAA-0105M1.1, SINGLE PREMIUM UL APPLICATION REVISION
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: LAA-0105M1.1, Single Premium UL Application Revision
Project Name/Number: LAA-0105M1.1, Single Premium UL Application Revision/LAA-0105M1.1, Single Premium UL Application Revision

Filing at a Glance

Company: Nationwide Life and Annuity Insurance Company

Product Name: LAA-0105M1.1, Single Premium SERFF Tr Num: NWPA-128275065 State: Arkansas

UL Application Revision

TOI: L08 Life - Other

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

Sub-TOI: L08.000 Life - Other

Co Tr Num: LAA-0105M1.1, State Status: Approved-Closed
SINGLE PREMIUM UL
APPLICATION REVISION

Filing Type: Form

Reviewer(s): Linda Bird

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

Disposition Date: 04/25/2012

Date Submitted: 04/20/2012

Disposition Status: Approved-Closed

Implementation Date Requested: 06/08/2012

Implementation Date:

State Filing Description:

General Information

Project Name: LAA-0105M1.1, Single Premium UL Application Revision Status of Filing in Domicile: Authorized

Project Number: LAA-0105M1.1, Single Premium UL Application Revision

Date Approved in Domicile: 02/10/2012

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 04/25/2012

State Status Changed: 04/25/2012

Deemer Date:

Created By: Carrie Ruhlen

Submitted By: Carrie Ruhlen

Corresponding Filing Tracking Number: LAA-0105M1.1, Single Premium UL Application Revision

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Filing Description:

Re: LAA-0105M1.1, Application for Individual Life Insurance

Enclosed for filing, subject to your approval, is form LAA-0105M1.1, Application for Individual Life Insurance. This form will replace LAA-0105M1 approved by the Department on 07-25-2008, under SERFF Tracking #NWPA-125735382, State Tracking #39654. The updates being made to this application are to comply with the MIB Inc.'s requirement that all MIB Members include language in their MIB Authorization that elicits an applicant's express written consent to report information to MIB, Inc.

In addition to these required updates we have also made added the following changes:

I. We updated "Medical Information Bureau" or "MIB" to "MIB, Inc." throughout the application.

II. Added the following questions to Part C of the application:

4. Have you ever sold any life insurance policy to a life settlement company, trust, limited liability corporation, viatical, or other secondary market purchaser?

5. Will any portion of the current or future premium for this policy be financed?

6. Will any Insured or Policy Owner receive any payment in connection with the insurance issued on the basis of this application?

III. Updated the Authorization section to include the following language:

• Added to the first sentence:

"or pharmacy benefit managers, and other sources who maintain prescription drug records and related information";
"MIB, Inc.";

"to disclose any information concerning me, including, but not limited to, my entire medical/health record to the" and;
"or its affiliates, including, but not limited to, RSA Medical".

• Added "I also authorize Nationwide to report information to MIB, Inc." as the second sentence.

• Added "pharmacy or pharmacy benefit managers;" and "/health" to the third sentence.

• Added " or, if I revoke this authorization before a policy is issued" to the second to last sentence.

Form LAA-0105M1.1 has been written in a readable fashion and attains a Flesch score of 61.7.

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This form was approved in our state of domicile (Ohio) on 02-10-12.

Thank you in advance for your attention to this matter. Please call 1-800-882-2822 ext. 98042 if you have any questions on this filing.

Enclosures:

1. Certifications
2. LAA-0105M1.1, Application for Life Insurance
3. Statement of Variability

State Narrative:

Company and Contact

Filing Contact Information

Carrie Ruhlen, Compliance Specialist ruhlenc@nationwide.com
 One Nationwide Plaza 614-249-8042 [Phone]
 1-33-102 614-249-1199 [FAX]
 Columbus, OH 43215

Filing Company Information

Nationwide Life and Annuity Insurance 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

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
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Nationwide Life and Annuity Insurance \$50.00 04/20/2012 58240079
Company

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	04/25/2012	04/25/2012

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Disposition

Disposition Date: 04/25/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Statement of Variability		Yes
Supporting Document	Document Showing Highlighted Differences		Yes
Form	Application for Individual Life Insurance		Yes

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Form Schedule

Lead Form Number: LAA-0105M1.1

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	LAA-0105M1.1	Application/ Enrollment Form Individual Life Insurance	Revised	Replaced Form #: LAA-0105M1 Previous Filing #: 39654	61.700	LAA-0105M1.1 JD.pdf

NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY

Application for Life Insurance

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

PART A - CLIENT INFORMATION

Proposed Insured	Name <i>(First, MI, Last)</i> John A. Doe			SSN / Tax ID # 000 - 00 - 0000	
	Address <i>(street/city/state/zip)</i> One Any Street, Any City, Any State 00000-0000				
	Date of Birth <i>(mm/dd/yyyy)</i> 06/07/1973	State of Birth Any State	Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	Driver's License # / State of Issue RL000000 / Any State	
	Occupation Any Occupation	Employer Any Employer	E-Mail Address JDoe@yahoo.com	Phone (000) 000-0000 Best Time to Call: <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM	
Owner <i>Complete ONLY if Owner is not the Proposed Insured</i> <i>If more than one Owner or a Contingent Owner is to be designated, provide details in Special Instructions Section</i>	Name <i>(First, MI, Last)</i>			SSN / Tax ID #	
	Address <i>(street/city/state/zip)</i> <input type="checkbox"/> <i>(If address same as Proposed Insured, check box.)</i>				
	Date of Birth <i>(mm/dd/yyyy)</i>	Relationship to Insured	E-Mail Address	Phone () Best Time to Call: <input type="checkbox"/> AM <input type="checkbox"/> PM	
	If a Trust is named as Owner, complete the trust information below and submit a copy of the first and signature pages of the Trust document.				
	Exact Name of Trust	Trust Tax ID Number	Current Trustee(s)	Date of Trust	
Beneficiary <i>If additional space is required, use Special Instructions Section</i>	<input type="checkbox"/> <i>Check this box if Trust named above is to be the Primary Beneficiary and proceed to "PART B". If a different Trust is named as Primary Beneficiary or Trust is named as Contingent Beneficiary, provide the trust information below.</i>				
	Primary Beneficiary Name(s) or Trust and Trustee(s)	Relationship to Insured	Birth Date or Trust Date	SSN/Tax ID #	%
	Jane Doe	wife	10-08-76	000-00-0000	100
	Contingent Beneficiary Name(s) or Trust and Trustee(s)	Relationship to Insured	Birth Date or Trust Date	SSN/Tax ID #	%
	Bambi Doe	daughter	04-29-00	000-00-0000	50
	Moose Doe	son	07-23-02	000-00-0000	50

PART B - INSURANCE INFORMATION

Plan <i>Check one box</i>	<input type="checkbox"/> Single Premium Universal Life				
	<input type="checkbox"/> Other <i>(Print Product Name)</i> _____				
Total Specified Amount \$ 46,575.90			Single Premium Payment Amount \$ 10,000		
Optional Riders	<input type="checkbox"/> Long Term Care Rider <i>(Long Term Care Rider Section "PART D" MUST be completed.)</i>				
	<input type="checkbox"/> Other Rider(s) _____				
Replacement and Other Policy Information	<input type="checkbox"/> Yes <input type="checkbox"/> No 1. Will any Life Insurance or Annuities for this or any other company be replaced, discontinued, reduced or changed if insurance now applied for is issued? <i>(If "yes", list below.)</i>				
	<input type="checkbox"/> Yes <input type="checkbox"/> No 2. Do you currently have any other Life Insurance or Annuities in force? <i>(If "yes", list below.)</i>				
	Company	Policy Number	Amount	Year Issued	To Be Replaced
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
	<i>(If question 1 above is answered "Yes", complete appropriate replacement forms and any 1035 exchange forms.)</i>				



PART C – PERSONAL/MEDICAL/HEALTH QUESTIONS

<p><i>If question 2 is answered "yes", circle all that apply</i></p>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		1. Have you ever been declined for Life Insurance?						
	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		2. To the best of your knowledge and belief, in the past 5 years, have you ever consulted a physician or any other health care provider for, been treated for, taken medication for, or been diagnosed as having: Chest pain, heart disease or disorder, stroke, insulin dependent diabetes, chronic lung or respiratory disorder, central nervous system or muscular disorder, vascular or circulatory disorder, alcoholism, drug use (except for drugs prescribed by a physician), nervous or mental disorder, Alzheimer's disease or other dementia, emphysema, kidney or liver disorder, or any cancer (other than basal cell skin cancer)?						
	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		3. To the best of your knowledge and belief, have you ever consulted a physician or any other health care provider for, been treated for, taken medication for, or been diagnosed as having 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"/> Yes <input checked="" type="checkbox"/> No		4. 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"/> Yes <input checked="" type="checkbox"/> No		5. Will any portion of the current or future premium for this policy be financed?						
	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		6. Will any Insured or Policy Owner receive any payment in connection with the insurance issued on the basis of this application?						
<p><i>If more space is needed, use Special Instructions Section</i></p>	 If questions 1, 2, 3, 4, 5 or 6 above are answered "Yes", provide COMPLETE details below.								
	Question		Dates		Details				
	<i>Be specific. Give full names, addresses and telephone number (if available) of physicians, hospitals, etc.</i>								
	<table border="1"> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </table>								
Tobacco Use	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Within the past 12 months, have you used tobacco in any form?						
Physical Measurements	Height	Current Weight	Weight 1 Year Ago	Reason for Weight Gain or Loss					
	6 ft. 1 in.	200 lbs.	200 lbs.						

PART D – LONG TERM CARE RIDER (Must be applying for a base policy with a total specified amount of \$50,000 or greater.)

	<input type="checkbox"/> Long Term Care Specified Amount is equal to the total specified amount in "PART B".								
	<input type="checkbox"/> Long Term Care Specified Amount \$ _____								
<p>Specified Amount</p>		If "personal" questions 1, 2, 3, or 4 below are answered "Yes", the Proposed Insured is ineligible for LTC coverage.							
		<input type="checkbox"/> Yes <input type="checkbox"/> No		1. Are you confined to bed or house or require assistance or supervision or limited in any way from performing any of the following daily activities: bathing, continence, eating, dressing, toileting, transferring (moving into or out of a bed, chair, or wheel chair)?					
		<input type="checkbox"/> Yes <input type="checkbox"/> No		2. Do you use any medical appliance such as, but not limited to, respiratory equipment (oxygen or ventilator) or dialysis equipment or are you dependent on the use of a walker, a wheelchair, or motorized ambulatory device?					
		<input type="checkbox"/> Yes <input type="checkbox"/> No		3. Do you currently have a vascular access port, peg or feeding tube?					
		<input type="checkbox"/> Yes <input type="checkbox"/> No		4. Do you have a Power of Attorney in place currently, due to any present or past, mental or physical disability?					
<p>Supplemental Information</p> <p><i>If questions 1, 2, 3, 4, or 5 are answered "yes", then provide details below</i></p> <p><i>If more space is needed, use Special Instructions Section</i></p>	To the best of your knowledge and belief, during the past 5 years have you:								
	<input type="checkbox"/> Yes <input type="checkbox"/> No		1. Been confined to a hospital, nursing home, or residential care facility?						
	<input type="checkbox"/> Yes <input type="checkbox"/> No		2. Received home care services, physical, or rehabilitative therapy?						
	<input type="checkbox"/> Yes <input type="checkbox"/> No		3. Sought medical advice or treatment for loss of appetite, falling, fainting, unstable gait, bladder control, dizziness, or deterioration of vision?						
	<input type="checkbox"/> Yes <input type="checkbox"/> No		4. Been physically limited in any way, or used any equipment such as crutches to aid in mobility?						
	<input type="checkbox"/> Yes <input type="checkbox"/> No		5. Experienced shortness of breath or leg cramps when 4 city blocks are walked at a normal pace?						
Question		Dates		Details					
<i>Be specific. Give full names, addresses and telephone number (if available) of physicians, hospitals, etc.</i>									
<table border="1"> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </table>									



Additional Insurance Information	<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Will the Long Term Care Rider applied for replace existing Long Term Care Insurance? (<i>If "yes", state the Company, policy number and benefit amount.</i>)
	<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Are you covered by Medicaid?

Special Instructions Section

PART E - FRAUD STATEMENTS AND IMPORTANT NOTICES

FRAUD STATEMENTS

NEW HAMPSHIRE and WYOMING only:	Any person who submits an application or a claim containing a false or deceptive statement, and does so with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, may be guilty of insurance fraud.
ARKANSAS and RHODE ISLAND only:	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
COLORADO only:	IMPORTANT NOTICE - IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

NOTICES – IMPORTANT

Pre-Notice of Procedures as Required by The Fair Credit Reporting Act of 1970	<p>This notice is to inform you that as part of our normal underwriting procedures in connection with an application for insurance:</p> <ul style="list-style-type: none"> • An investigative consumer report may be made whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. This inquiry will include information as to character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation, with respect to you, members of your family, and others having an interest in or closely connected with the insurance transaction; and • You may elect to be interviewed if an investigative consumer report is prepared in connection with this application. You are entitled to receive a copy of any investigative consumer report by submitting your request in writing. • Upon your written request, made within a reasonable time after you receive this notice, additional information as to the nature and scope of the investigation, if one is made, will be provided. You may send corrections and requests for additional information addressed to [Nationwide Life and Annuity Insurance Company, P.O. Box 182835, Columbus, Ohio 43218-2835.] In the event of an adverse decision, you will be notified in writing.
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 the 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, the MIB, Inc., upon request, will supply such company with the information in its file. Upon receipt of a request from you, the 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 the 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 F - AGREEMENT AND AUTHORIZATION

Agreement	<p>I understand and agree that:</p> <ul style="list-style-type: none"> • This application, any amendments to it, and any related medical examination(s) will become a part of the Policy and are the basis of any insurance issued upon this application. • The Proposed Insured or Owner has a right to cancel this application at any time by contacting their producer or Nationwide in writing. No producer, medical examiner or other representative of Nationwide may accept risks or make or change any contract; or waive or change any of the Company's rights or requirements. • If the full first premium is made in exchange for a Temporary Insurance Agreement, Nationwide will only be liable to the extent set forth in that Agreement. • If the full first premium is not paid with this application, then insurance will only take effect when (1) a policy is issued by Nationwide and accepted by me; and (2) the full first premium is paid; and (3) all the answers and statements made on the application, medical examination(s) and amendments are true to the best of my knowledge and belief when (1) and (2) have occurred.
Authorization	<p>I authorize: any licensed physician or medical practitioner; any hospital, clinic, 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; the 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 the Nationwide Life and Annuity Insurance Company or its affiliates, including, but not limited to, RSA Medical, for the purpose of underwriting my application in order to determine eligibility for Life Insurance 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.</p>

PART G - SIGNATURES, TAXPAYER'S IDENTIFICATION NUMBER CERTIFICATION AND PRODUCER'S CERTIFICATION

Taxpayer ID Number	<p>I certify under penalties of perjury that:</p> <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). <p><input type="checkbox"/> Check this box if you have been notified by the IRS that you are currently subject to backup withholding because of failure to report interest or dividends on your tax return.</p> <p>The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.</p>
<i>Check box, if applicable</i>	
Proposed Insured, and Owner Signatures	<p>I HAVE RECEIVED A COPY OF AND HAVE READ THIS APPLICATION AND AGREEMENT AND DECLARE THAT THE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND AND AGREE TO ALL ITS TERMS.</p> <p>Signed at _____ Any City, Any State _____, on _____ July 28 _____, 2008 _____ <small>City/State Month/Day Year</small></p> <p>_____ X _____ <small>John A. Doe Signature of Proposed Insured</small></p> <p>_____ X _____ <small>06/07/1973 Signature of Owner (if other than the Proposed Insured)</small></p>
Producer's Certification	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No I have truly and accurately recorded all Proposed Insured's answers on this application.</p> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No I have witnessed his/her/their signature(s) hereon. <i>(If "no", provide details in Special Instructions Section.)</i></p> <p><input type="checkbox"/> Will <input checked="" type="checkbox"/> Will Not To the best of my knowledge, the insurance applied for will or will not replace any Life Insurance, Annuities, and/or Long Term Care Insurance.</p>
 <i>Be sure to answer all three questions</i>	<p>_____ Any Firm _____ <small>Mr. Ed Producer, Jr. Producer's Name (print) Firm</small></p> <p>X _____ 02-A00000 _____ <small>Mr. Ed Producer, Jr. Signature of Producer Producer's Nationwide #</small></p>



TEMPORARY INSURANCE AGREEMENT
NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY, COLUMBUS, OH

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

Receipt of Payment	<i>This receipt must not be detached and in no event will there be any temporary insurance unless the full first premium required by the Company has been paid at the time of application.</i>
	Advance payment is being made in the amount of: \$ _____ For the face amount on the application of: \$ _____ (or [\$1,000,000] whichever is less).
	NOTE: Make all checks payable to NATIONWIDE. Do not make checks payable to the producer or leave the payee blank.

TERMS AND CONDITIONS

Amount of Coverage <i>[\$1,000,000] overall maximum for all applications or agreements</i>	Temporary Insurance under this Agreement will commence on the date of this application if the full first premium for the mode selected has been paid and accepted by Nationwide as advance payment for any 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].
Date Coverage Terminates <i>Maximum of 60 DAYS</i>	Temporary Life Insurance under this Agreement will terminate automatically on the earliest of: <ul style="list-style-type: none"> • 60 days from the date of this signed Agreement, or • the date any policy is offered or issued to the Proposed Insured in connection with the above application, or • the date Nationwide mails notice of termination of coverage and refund of the advance payment to the Proposed Insured, or the Owner, if different than the Proposed Insured.
Limitations	<ul style="list-style-type: none"> • Fraud or material misrepresentation in the application 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 over the age of 70 on the date of the Agreement. • If any Proposed Insured dies by suicide, 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. • No one is authorized to waive or modify any of the provisions of this Agreement.

SIGNATURES AND PRODUCER'S CERTIFICATION

Proposed Insured, and Owner Signatures Producer's Signature	I HAVE RECEIVED A COPY OF THIS AGREEMENT. I UNDERSTAND AND AGREE TO ALL ITS TERMS. Dated (mm/dd/yyyy) <u>07/28/2008</u> X <u>John A. Doe</u> X Signature of Proposed Insured Signature of Owner (if other than the Proposed Insured)
Producer's Signature	X <u>Mr. Ed Producer, Jr.</u> Any Firm <u>02-A00000</u> Signature of Producer Firm Producer's Nationwide #



SERFF Tracking Number: NWPA-128275065 State: Arkansas
 Filing Company: Nationwide Life and Annuity Insurance Company State Tracking Number:
 Company Tracking Number: LAA-0105M1.1, SINGLE PREMIUM UL APPLICATION REVISION
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: LAA-0105M1.1, Single Premium UL Application Revision
 Project Name/Number: LAA-0105M1.1, Single Premium UL Application Revision/LAA-0105M1.1, Single Premium UL Application Revision

Supporting Document Schedules

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

	Item Status:	Status Date:
Satisfied - Item: Application		
Comments: The following form will be used in conjunction with the submitted application form:		

LAD-0100AO, Amendment of Application for Life Insurance, approved 07-26-2004, SERFF #USPH-633NUU529, State Tracking #26954

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

	Item Status:	Status Date:
Satisfied - Item: Document Showing Highlighted Differences		
Comments:		
Attachment: LAA-0105M1.1 HIGHLIGHTED CHANGES.pdf		



ARKANSAS

Certificate of Compliance

Insurer: Nationwide Life and Annuity Insurance Company

Form Numbers: LAA-0105M1.1, 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, 34, and 49 of the Arkansas Statute, ACA 23-80-206, ACA 23-79-138, and Bulletin 11-88.

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

A handwritten signature in black ink that reads "James J. Rabenstine". The signature is written in a cursive style with a horizontal line underneath it.

James J. Rabenstine
Vice President
NF Compliance
Date: 04-20-2012

**NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY
(04/2012)
STATEMENT OF VARIABILITY FOR FORM**

LAA-0105M1.1 - Application for Individual Life Insurance

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

LAA-0105M1.1

Nationwide's Address, Phone Number and Fax Number	Nationwide's address information is bracketed throughout the form in case they change in the future.
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Page 4 – Notices - Important

MIB, INC. DISCLOSURE NOTICE	The address and/or telephone information is bracketed in case either change in the future.
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Page 5, Temporary Insurance Agreement, Receipt of Payment and Terms and Conditions Sections

Amount of Coverage	The current total benefit limit is bracketed in case it changes in the future.
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NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY

Application for Life Insurance

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

PART A - CLIENT INFORMATION

Proposed Insured	Name <i>(First, MI, Last)</i> John A. Doe			SSN / Tax ID # 000 - 00 - 0000	
	Address <i>(street/city/state/zip)</i> One Any Street, Any City, Any State 00000-0000				
	Date of Birth <i>(mm/dd/yyyy)</i> 06/07/1973	State of Birth Any State	Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	Driver's License # / State of Issue RL000000 / Any State	
	Occupation Any Occupation	Employer Any Employer	E-Mail Address JDoe@yahoo.com	Phone (000) 000-0000 Best Time to Call: <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM	
Owner <i>Complete ONLY if Owner is not the Proposed Insured</i> <i>If more than one Owner or a Contingent Owner is to be designated, provide details in Special Instructions Section</i>	Name <i>(First, MI, Last)</i>			SSN / Tax ID #	
	Address <i>(street/city/state/zip)</i> <input type="checkbox"/> <i>(If address same as Proposed Insured, check box.)</i>				
	Date of Birth <i>(mm/dd/yyyy)</i>	Relationship to Insured	E-Mail Address	Phone () Best Time to Call: <input type="checkbox"/> AM <input type="checkbox"/> PM	
	If a Trust is named as Owner, complete the trust information below and submit a copy of the first and signature pages of the Trust document.				
	Exact Name of Trust	Trust Tax ID Number	Current Trustee(s)	Date of Trust	
Beneficiary <i>If additional space is required, use Special Instructions Section</i>	<input type="checkbox"/> <i>Check this box if Trust named above is to be the Primary Beneficiary and proceed to "PART B". If a different Trust is named as Primary Beneficiary or Trust is named as Contingent Beneficiary, provide the trust information below.</i>				
	Primary Beneficiary Name(s) or Trust and Trustee(s)	Relationship to Insured	Birth Date or Trust Date	SSN/Tax ID #	%
	Jane Doe	wife	10-08-76	000-00-0000	100
	Contingent Beneficiary Name(s) or Trust and Trustee(s)	Relationship to Insured	Birth Date or Trust Date	SSN/Tax ID #	%
	Bambi Doe	daughter	04-29-00	000-00-0000	50
	Moose Doe	son	07-23-02	000-00-0000	50

PART B - INSURANCE INFORMATION

Plan <i>Check one box</i>	<input type="checkbox"/> Single Premium Universal Life				
	<input type="checkbox"/> Other <i>(Print Product Name)</i> _____				
Total Specified Amount \$ 46,575.90			Single Premium Payment Amount \$ 10,000		
Optional Riders	<input type="checkbox"/> Long Term Care Rider <i>(Long Term Care Rider Section "PART D" MUST be completed.)</i>				
	<input type="checkbox"/> Other Rider(s) _____				
Replacement and Other Policy Information	<input type="checkbox"/> Yes <input type="checkbox"/> No 1. Will any Life Insurance or Annuities for this or any other company be replaced, discontinued, reduced or changed if insurance now applied for is issued? <i>(If "yes", list below.)</i>				
	<input type="checkbox"/> Yes <input type="checkbox"/> No 2. Do you currently have any other Life Insurance or Annuities in force? <i>(If "yes", list below.)</i>				
	Company	Policy Number	Amount	Year Issued	To Be Replaced
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
	<i>(If question 1 above is answered "Yes", complete appropriate replacement forms and any 1035 exchange forms.)</i>				



PART C – PERSONAL/MEDICAL/HEALTH QUESTIONS

<p><i>If question 2 is answered "yes", circle all that apply</i></p>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	1. Have you ever been declined for Life Insurance?		
	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	2. To the best of your knowledge and belief, in the past 5 years, have you ever consulted a physician or any other health care provider for, been treated for, taken medication for, or been diagnosed as having: Chest pain, heart disease or disorder, stroke, insulin dependent diabetes, chronic lung or respiratory disorder, central nervous system or muscular disorder, vascular or circulatory disorder, alcoholism, drug use (except for drugs prescribed by a physician), nervous or mental disorder, Alzheimer's disease or other dementia, emphysema, kidney or liver disorder, or any cancer (other than basal cell skin cancer)?		
	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	3. To the best of your knowledge and belief, have you ever consulted a physician or any other health care provider for, been treated for, taken medication for, or been diagnosed as having 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"/> Yes <input checked="" type="checkbox"/> No	4. 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"/> Yes <input checked="" type="checkbox"/> No	5. Will any portion of the current or future premium for this policy be financed?		
	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	6. Will any Insured or Policy Owner receive any payment in connection with the insurance issued on the basis of this application?		
<p><i>If more space is needed, use Special Instructions Section</i></p>		If questions 1, 2, 3, 4, 5 or 6 above are answered "Yes", provide COMPLETE details below.		
	Question	Dates	Details <i>Be specific. Give full names, addresses and telephone number (if available) of physicians, hospitals, etc.</i>	
Tobacco Use	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Within the past 12 months, have you used tobacco in any form?		
Physical Measurements	Height	Current Weight	Weight 1 Year Ago	Reason for Weight Gain or Loss
	6 ft. 1 in.	200 lbs.	200 lbs.	

PART D – LONG TERM CARE RIDER (Must be applying for a base policy with a total specified amount of \$50,000 or greater.)

<p></p> <p>Specified Amount</p>	<input type="checkbox"/>	Long Term Care Specified Amount is equal to the total specified amount in "PART B".		
	<input type="checkbox"/>	Long Term Care Specified Amount \$ _____		
<p>Personal Information</p>		If "personal" questions 1, 2, 3, or 4 below are answered "Yes", the Proposed Insured is ineligible for LTC coverage.		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Are you confined to bed or house or require assistance or supervision or limited in any way from performing any of the following daily activities: bathing, continence, eating, dressing, toileting, transferring (moving into or out of a bed, chair, or wheel chair)?		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Do you use any medical appliance such as, but not limited to, respiratory equipment (oxygen or ventilator) or dialysis equipment or are you dependent on the use of a walker, a wheelchair, or motorized ambulatory device?		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Do you currently have a vascular access port, peg or feeding tube?		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Do you have a Power of Attorney in place currently, due to any present or past, mental or physical disability?		
<p>Supplemental Information</p> <p><i>If questions 1, 2, 3, 4, or 5 are answered "yes", then provide details below</i></p> <p><i>If more space is needed, use Special Instructions Section</i></p>		To the best of your knowledge and belief, during the past 5 years have you:		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Been confined to a hospital, nursing home, or residential care facility?		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Received home care services, physical, or rehabilitative therapy?		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Sought medical advice or treatment for loss of appetite, falling, fainting, unstable gait, bladder control, dizziness, or deterioration of vision?		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Been physically limited in any way, or used any equipment such as crutches to aid in mobility?		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	5. Experienced shortness of breath or leg cramps when 4 city blocks are walked at a normal pace?		
	Question	Dates	Details <i>Be specific. Give full names, addresses and telephone number (if available) of physicians, hospitals, etc.</i>	



Additional Insurance Information	<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Will the Long Term Care Rider applied for replace existing Long Term Care Insurance? (<i>If "yes", state the Company, policy number and benefit amount.</i>)
	<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Are you covered by Medicaid?

Special Instructions Section

PART E - FRAUD STATEMENTS AND IMPORTANT NOTICES

FRAUD STATEMENTS

NEW HAMPSHIRE and WYOMING only:	Any person who submits an application or a claim containing a false or deceptive statement, and does so with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, may be guilty of insurance fraud.
ARKANSAS and RHODE ISLAND only:	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
COLORADO only:	IMPORTANT NOTICE - IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

NOTICES – IMPORTANT

Pre-Notice of Procedures as Required by The Fair Credit Reporting Act of 1970	<p>This notice is to inform you that as part of our normal underwriting procedures in connection with an application for insurance:</p> <ul style="list-style-type: none"> • An investigative consumer report may be made whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. This inquiry will include information as to character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation, with respect to you, members of your family, and others having an interest in or closely connected with the insurance transaction; and • You may elect to be interviewed if an investigative consumer report is prepared in connection with this application. You are entitled to receive a copy of any investigative consumer report by submitting your request in writing. • Upon your written request, made within a reasonable time after you receive this notice, additional information as to the nature and scope of the investigation, if one is made, will be provided. You may send corrections and requests for additional information addressed to [Nationwide Life and Annuity Insurance Company, P.O. Box 182835, Columbus, Ohio 43218-2835.] In the event of an adverse decision, you will be notified in writing.
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 the 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, the MIB, Inc., upon request, will supply such company with the information in its file. Upon receipt of a request from you, the 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 the 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 F - AGREEMENT AND AUTHORIZATION

<p>Agreement</p>	<p>I understand and agree that:</p> <ul style="list-style-type: none"> • This application, any amendments to it, and any related medical examination(s) will become a part of the Policy and are the basis of any insurance issued upon this application. • The Proposed Insured or Owner has a right to cancel this application at any time by contacting their producer or Nationwide in writing. No producer, medical examiner or other representative of Nationwide may accept risks or make or change any contract; or waive or change any of the Company's rights or requirements. • If the full first premium is made in exchange for a Temporary Insurance Agreement, Nationwide will only be liable to the extent set forth in that Agreement. • If the full first premium is not paid with this application, then insurance will only take effect when (1) a policy is issued by Nationwide and accepted by me; and (2) the full first premium is paid; and (3) all the answers and statements made on the application, medical examination(s) and amendments are true to the best of my knowledge and belief when (1) and (2) have occurred.
<p>Authorization</p>	<p>I authorize: any licensed physician or medical practitioner; any hospital, clinic, 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; the 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 the Nationwide Life and Annuity Insurance Company or its affiliates, including, but not limited to, RSA Medical, for the purpose of underwriting my application in order to determine eligibility for Life Insurance 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.</p>

PART G - SIGNATURES, TAXPAYER'S IDENTIFICATION NUMBER CERTIFICATION AND PRODUCER'S CERTIFICATION

<p>Taxpayer ID Number</p> <p><i>Check box, if applicable</i></p>	<p>I certify under penalties of perjury that:</p> <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). <p><input type="checkbox"/> Check this box if you have been notified by the IRS that you are currently subject to backup withholding because of failure to report interest or dividends on your tax return.</p> <p>The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.</p>
<p>Proposed Insured, and Owner Signatures</p>	<p>I HAVE RECEIVED A COPY OF AND HAVE READ THIS APPLICATION AND AGREEMENT AND DECLARE THAT THE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND AND AGREE TO ALL ITS TERMS.</p> <p>Signed at _____ Any City, Any State _____, on _____ July 28 _____, 2008 _____ <small>City/State Month/Day Year</small></p> <p>_____ X _____ <small>John A. Doe Signature of Proposed Insured</small></p> <p>_____ X _____ <small>06/07/1973 Signature of Owner (if other than the Proposed Insured)</small></p>
<p>Producer's Certification</p> <p></p> <p><i>Be sure to answer all three questions</i></p>	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No I have truly and accurately recorded all Proposed Insured's answers on this application.</p> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No I have witnessed his/her/their signature(s) hereon. <i>(If "no", provide details in Special Instructions Section.)</i></p> <p><input type="checkbox"/> Will <input checked="" type="checkbox"/> Will Not To the best of my knowledge, the insurance applied for will or will not replace any Life Insurance, Annuities, and/or Long Term Care Insurance.</p> <p>_____ Any Firm _____ <small>Mr. Ed Producer, Jr. Producer's Name (print) Firm</small></p> <p>X _____ 02-A00000 _____ <small>Mr. Ed Producer, Jr. Signature of Producer Producer's Nationwide #</small></p>



