

SERFF Tracking Number: NWPA-128169306 State: Arkansas
Filing Company: Nationwide Life and Annuity Insurance Company State Tracking Number:
Company Tracking Number: LAA-0110M1.1, APPLICATION FOR INDIVIDUAL LIFE INSURANCE
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: LAA-0110M1.1, Application for Individual Life Insurance
Project Name/Number: LAA-0110M1.1, Application for Individual Life Insurance/LAA-0110M1.1, Application for Individual Life Insurance

Filing at a Glance

Company: Nationwide Life and Annuity Insurance Company

Product Name: LAA-0110M1.1, Application for SERFF Tr Num: NWPA-128169306 State: Arkansas

Individual Life Insurance

TOI: L08 Life - Other

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

Sub-TOI: L08.000 Life - Other

Co Tr Num: LAA-0110M1.1, State Status: Approved-Closed
APPLICATION FOR INDIVIDUAL
LIFE INSURANCE

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Amy Burchette, Sandra Disposition Date: 05/10/2012

Davies, Dan Gallion, Cindy Malloy,

Clara Pollard, Carrie Ruhlen,

Georgia Sollars, Darcy L. Spangler,

Drema Wallace, Leslie Hernandez,

Darcy Spangler

Date Submitted: 03/16/2012

Disposition Status: Approved-
Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: LAA-0110M1.1, Application for Individual Life Insurance

Status of Filing in Domicile: Pending

Project Number: LAA-0110M1.1, Application for Individual Life
Insurance

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 05/10/2012

State Status Changed: 03/20/2012

Deemer Date:

Created By: Carrie Ruhlen

Submitted By: Carrie Ruhlen

Corresponding Filing Tracking Number: LAA-
0110M1.1, Application for Individual Life
Insurance

SERFF Tracking Number: NWPA-128169306 State: Arkansas
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Filing Description:

Re: LAA-0110M1.1, Application for Individual Life Insurance

Enclosed for filing, subject to your approval, is form LAA-0110M1.1, Application for Individual Life Insurance. This form will replace LAA-0110M1 approved by the Department on 11-19-2009, under SERFF Tracking #NWPA-126363065, State Tracking #44106. 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 the following changes to the form:

1. Added the Owner's Waiver of Premium Death Benefit Rider to the Whole Life Product Only section of #6
2. Updated #8c to read: "Have you ever been charged with a violation of any criminal law?"
3. Updated #8d to read: "have you in the past 10 years, had your driver's license suspended or revoked; or in the past 10 years been convicted of driving while impaired or intoxicated; or in the past 3 years been convicted of three or more moving violations?"
4. Updated #9b to read: " In the past 3 years, has any Proposed Insured ever consulted a physician or any other health care provider for, been treated for, taken medication for or been diagnosed as having diabetes, epilepsy, seizures, depression, anxiety disorders, or any other mental, nervous, or brain disorder, Dementia, Parkinson's, lupus or connective tissue disorder, asthma, emphysema, or any chronic respiratory disorder, chronic liver or kidney disease, Crohn's Disease or ulcerative colitis, or any blood disorder?"
5. Added question #9d to section 9. Medical Questions
6. We have updated "Medical Information Bureau" or "MIB" to "MIB, Inc." throughout the application

Form LAA-0110M1.1 has been written in a readable fashion and attains a Flesch score of 58.7.

These forms are being filed concurrently in our state of domicile.

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.

State Narrative:

SERFF Tracking Number: NWPA-128169306 State: Arkansas
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Company and Contact

Filing Contact Information

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

Filing Company Information

Nationwide Life and Annuity Insurance CoCode: 92657 State of Domicile: Ohio
 Company
 One Nationwide Plaza Group Code: 140 Company Type:
 1-10-03 Group Name: State ID Number:
 Columbus, OH 43215 FEIN Number: 31-1000740
 (800) 882-2822 ext. [Phone]

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Nationwide Life and Annuity Insurance Company	\$50.00	03/16/2012	57199190

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	05/10/2012	05/10/2012
Approved-Closed	Linda Bird	03/20/2012	03/20/2012

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Application for Individual Life Insurance	Carrie Ruhlen	05/09/2012	05/09/2012
Supporting Document	REDLINED CHANGES	Carrie Ruhlen	05/09/2012	05/09/2012

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Request to reopen	Note To Filer	Linda Bird	05/09/2012	05/09/2012
Request to Reopen	Note To Reviewer	Carrie Ruhlen	05/09/2012	05/09/2012

SERFF Tracking Number: NWPA-128169306 State: Arkansas
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Disposition

Disposition Date: 05/10/2012

Implementation Date:

Status: Approved-Closed

Comment: Corrections made to the original application.

Rate data does NOT apply to filing.

SERFF Tracking Number: NWPA-128169306 State: Arkansas
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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 (revised)	REDLINED CHANGES		Yes
Supporting Document	REDLINED CHANGES		Yes
Form (revised)	Application for Individual Life Insurance		Yes
Form	Application for Individual Life Insurance	Replaced	Yes

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Disposition

Disposition Date: 03/20/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Supporting Document	Application		Yes
Supporting Document	Statement of Variability		Yes
Supporting Document (revised)	REDLINED CHANGES		Yes
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Amendment Letter

Submitted Date: 05/09/2012

Comments:

Correction to Application LAA-0110M1.1

We discovered a typographical error in which we inadvertently placed a checkbox under "Any Child" in question 8a. under the Personal Information on page 3 of the application . It has now been corrected and the checkbox has been removed.

We have also placed checkboxes next to Owner's Waiver of Premium Death Benefit Rider and Owner's Waiver of Premium Death or Disability Benefit Rider located under the Whole Life Product Only section on page 2 of the application.

You have our assurance that these are the only corrections and that no other changes were made to this application. We have not yet begun using this application, so the form number will remain the same.

We apologize for an inconvenience this may have caused. Thank you in advance for your prompt attention to this filing.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
LAA-0110M1.1	Application/EApplication nrollment Form	Application for Individual Life Insurance	Revised		44106	LAA-0110M158.700		LAA-0110M1.1 JD.pdf

Supporting Document Schedule Item Changes:

User Added -Name: REDLINED CHANGES

Comment:

LAA-0110M1.1 Highlighted.pdf

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Note To Filer

Created By:

Linda Bird on 05/09/2012 09:03 AM

Last Edited By:

Linda Bird

Submitted On:

05/09/2012 09:03 AM

Subject:

Request to reopen

Comments:

Filing has been re-opened in order for correction to be made.

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Note To Reviewer

Created By:

Carrie Ruhlen on 05/09/2012 07:10 AM

Last Edited By:

Carrie Ruhlen

Submitted On:

05/09/2012 07:10 AM

Subject:

Request to Reopen

Comments:

We've discovered an error on this application. We have not used this application yet. Can you reopen this filing so we can replace or should we refile?

Thanks!

Carrie Ruhlen

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Form Schedule

Lead Form Number: LAA-0110M1.1

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	LAA-0110M1.1	Application/ Enrollment Form Individual Life Insurance	Revised	Replaced Form #: LAA-0110M1 Previous Filing #: 44106	58.700	LAA-0110M1.1 JD.pdf

NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY

Application for Individual Life Insurance

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

Page 1 of 5

(Please print)

1. Proposed Primary Insured

First Name: MI: Last Name:

Soc. Sec. No. or Tax ID: Sex: M F

Citizenship: U.S./ Canada: Yes No If no, please complete the Foreign Supplement.

Date of Birth: State of Birth: Email Address:

Street: City: State: ZIP:

Phone: Occupation: Driver's License No./ State of Issue:

Height: Weight:

2. Proposed Insured (Spouse/Children)

Full Name of Insured(s)	Date of Birth	Sex	Height	Weight	State of Birth	Soc. Sec. No. or Tax ID	Relationship to Insured
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="- -"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="- -"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="- -"/>	<input type="text"/>

Spouse Address: Same as Proposed Primary Insured Street:

City: State: ZIP: Occupation:

Spouse Driver's License No./State of Issue:

Citizenship: U.S./ Canada: Yes No If no, please complete the Foreign Supplement.

3. Owner (The Primary Insured will own the policy unless indicated here.)

First Name: MI: Last Name:

Soc. Sec. No. or Tax ID: Sex: M F Date of Birth:

Address: Same as Proposed Primary Insured Street:

City: State: ZIP: Occupation:

Phone: Relationship to Insured

4. Beneficiaries

4a. Proposed Primary Insured's Beneficiary (If more than two beneficiaries, please attach additional sheets.)

%	Primary	Contingent	Beneficiary Name	Date of Birth	Relationship to Insured(s)
<input type="text"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="text" value="Jane Doe"/>	<input type="text" value="10/08/1967"/>	<input type="text" value="Wife"/>
<input type="text"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="text" value="Bambi Doe"/>	<input type="text" value="12/23/1989"/>	<input type="text" value="Daughter"/>

4b. Proposed Spouse Insured's Beneficiary (If more than two beneficiaries, please attach additional sheets.)

<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

(If multiple beneficiaries, payments to the beneficiaries surviving the Insured will be made in equal shares, or in full to the last surviving beneficiary, unless some other distribution of proceeds is provided.)

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

First Name: MI: Last Name:

Street: City: State: ZIP:



6. Life Insurance Product and EFT Authorization Information (Include the full name of the desired product below.)

Product: 20 Pay Whole Life Specified Amount: \$ 99,000 Initial Premium Payment (Paid with application): \$ 10,000

Planned Premium (Check product for availability.)

Billing Advantage # \$ Quarterly \$ Semi-Annual \$ Annual \$10,000 Single Premium \$ Other \$ Monthly: Monthly EFT Amt: \$ Transit/ABA Number: Draft Date:

Financial Institution Name: Account Number:

Financial Institution Address:

Transit/ABA Number: Monthly EFT Amt: Draft Date:

*Checking (A copy of a voided check is required. Starter Checks will not be accepted.) (Note: Do not use 29th, 30th, or 31st as a draft date) *Savings (A voided deposit slip with account number and routing number is required.)

(Make all checks payable to NATIONWIDE. Do not make checks payable to the producer or leave the payee blank.)

*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

Whole Life Product Only (Check product for availability.)

Optional Benefit Riders

Owner's Waiver of Premium Death Benefit Rider (Complete sections 8 & 9 for Owner) Occupation Height Weight State of Birth Driver's License number

Owner's Waiver of Premium Death or Disability Benefit Rider (Complete sections 8 & 9 for Owner) Occupation Height Weight State of Birth Driver's License number

20 Year Spouse Rider \$ Accidental Death - Amount \$ Child Rider \$

Waiver of Premium Benefit Guaranteed Insurability - Amount \$

Other Rider(s) \$

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

No, do not issue with APL

Term Life Product Only (Check product for availability.)

Optional Benefit Riders

20 Year Spouse Rider \$ Child Rider \$ Other Rider(s) \$

Waiver of Premium Benefit

Universal Life Product Only (Check product for availability.)

Death Benefit Option (If no option is selected here, Option 1 is elected.)

Option 1 (The Specified Amount, or a multiple of the Accumulated Value, whichever is greater.) Option 2 (The Specified Amount, plus the Accumulated Value, or a multiple of the Accumulated Value, whichever is greater.)

Optional Benefit Riders

Guaranteed Option to Increase Specified Amount \$ Other Rider(s) \$

Accidental Death - Amount \$ Spouse Rider \$ Child Rider \$

Waiver of Monthly Deduction Rider



7. Insurance Information

- a. 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) Yes No
- b. Do you currently have any Life Insurance or Annuities in force? Yes No (If yes, please list below.)

Person	Company	Policy Number	Amount	Year Issued	To Be Replaced	1035	Accidental Death
<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="text"/>

8. Personal Information (All questions are to be answered by each Proposed Insured.)
(Explain all "yes" answers in Details box below unless instructed otherwise.)

- | | Proposed Insured | Proposed Insured Spouse | Any Child |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|
| a. Have you used tobacco or nicotine in any form in the last 12 months?..... | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| b. Except as prescribed by a physician, have you ever used, or been convicted for sale or possession of cocaine or any other narcotic or illegal drug? (If yes, complete Drug Questionnaire.)..... | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. Have you ever been charged with a violation of any criminal law?..... | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. Have you in the past 10 years, had your driver's license suspended or revoked; or in the past 10 years been convicted of driving while impaired or intoxicated; or in the past 3 years been convicted of three or more moving violations?..... | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. In the past 3 years have you engaged in, or do you intend to engage in:
flying as a pilot, student pilot, or crew member; organized racing of an automobile, motorcycle, or any type of motor-powered vehicle; scuba diving, mountain climbing, hang gliding, parachuting, sky diving, or bungee jumping? (If yes, please complete an Aviation/Hazardous Activities Questionnaire.)..... | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f. Is any Proposed Insured currently disabled or receiving disability payments?..... | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| g. Do you belong to any active or reserve military or naval organizations? (If yes, please complete Military Status Questionnaire.)..... | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| h. Do you plan to travel or reside outside of the United States or Canada within the next 12 months? (If Yes, please complete Foreign Supplement)..... | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

9. Medical Questions (All questions are to be answered by each Proposed Insured.)
(Explain all "yes" answers in Details box below unless instructed otherwise.)

- | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|
| a. Has any Proposed Insured ever consulted a physician or any other health care provider for, been treated for, taken medication for, or been diagnosed as having: | | | |
| 1. Heart disease, vascular disease, stroke, or cancer (other than basal cell skin cancer), or substance abuse (alcohol or drugs)?..... | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. 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 | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. In the past 3 years, has any Proposed Insured ever consulted a physician or any other health care provider for, been treated for, taken medication for or been diagnosed as having diabetes, epilepsy, seizures, depression, anxiety disorders or any mental, nervous, or brain disorder, dementia, Parkinson's disease, lupus or connective tissue disorder, asthma, emphysema, or any chronic respiratory disorder, chronic liver or kidney disease, Crohn's disease or ulcerative colitis, or any blood disorder?..... | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. Has any Proposed Insured been medically advised within the last 5 years to have any surgery, hospitalization, treatment, or test that has not been completed; or has any Proposed Insured not yet received the results of any medical test that he/she has taken?... | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. In the past 5 years, have you been prescribed, given or advised to take any medications by a physician or health care provider? (If yes, provide details of dosage, frequency, and prescriber.)..... | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |





10. Additional Details

Please provide additional details in this section from questions 8 and 9. (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.)

Multiple empty rectangular boxes for providing additional details.

11. Special Instructions

(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.)

Two empty rectangular boxes for special instructions.

12. Notices - Important

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 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, MIB, Inc., upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information in your file. Please contact MIB, Inc. at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in the MIB, Inc's 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 MIB, Inc's information office is 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734. 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. Information for consumers about MIB, Inc. may be obtained on its website at www.mib.com.]

FRAUD NOTICES - Notice to Proposed Insured's:

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

13. Taxpayer Identification Number - Certification

I certify under penalties of perjury that: (1) The number shown on this form is my correct taxpayer identification number and, (2) I am not subject to backup withholding because (a) 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 (b) 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 (3) I am a U.S. person (including a U.S. resident alien).



[] Please 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.



14. Temporary Insurance Agreement - Terms and Conditions/Limitations

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 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 (a) 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 (b) [\$100,000]. Temporary Life Insurance under this Agreement will terminate automatically on the earliest of: A.) 60 days from the date of this signed Agreement, or B.) the date any policy is offered or issued to the Proposed Insured in connection with the above application, or C.) the date Nationwide mails notice of termination of coverage and refund of the advance payment to the premium notice address designated in such application. 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 Insureds who are under 15 days of age or over the age of 70 (nearest birthday) 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 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.)

15. Agreement and Authorization

I understand and agree that: (A.) This application, and any amendments to it, will become a part of the Policy and are the basis of any insurance issued upon this application. (B.) The Proposed Insured has a right to cancel this application at any time by contacting their producer or Nationwide in writing. (C.) No producer 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. (D.) If the full first premium payment is made in exchange for a Temporary Insurance Agreement, Nationwide will only be liable to the extent set forth in that Agreement. (E.) Insurance will only take effect if first premium is paid with this application and all the answers and statements made on the application are true to the best of my knowledge and belief.

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; the MIB, Inc.; or any other organization, institution, government 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.

16. Signatures

I, THE PROPOSED INSURED(S), HAVE RECEIVED AND READ A COPY OF THIS APPLICATION 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: January 3, 2012
City/State Month/Day/Year

X John Doe
Signature of Proposed Insured
(or parent if Proposed Insured is under age 15)

X
Signature of Proposed Insured Spouse (if to be insured)

X
Signature of Payor (if other than Proposed Insured)

X
Signature of Owner (if other than Proposed Insured)

I have truly and accurately recorded all Proposed Insureds' answers on this application.

STOP (CHECK ONE) To the best of my knowledge, the insurance applied for () will [X] will not) replace any life insurance, and/or annuity.

X Agent Producer
Signature of Agent/Producer

Any Firm 02-A000000
Firm Agent/Producer's Nationwide Number



SERFF Tracking Number: NWPA-128169306 State: Arkansas
 Filing Company: Nationwide Life and Annuity Insurance Company State Tracking Number:
 Company Tracking Number: LAA-0110M1.1, APPLICATION FOR INDIVIDUAL LIFE INSURANCE
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: LAA-0110M1.1, Application for Individual Life Insurance
 Project Name/Number: LAA-0110M1.1, Application for Individual Life Insurance/LAA-0110M1.1, Application for Individual Life Insurance

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 Application forms can be used in conjunction with LAA-0110M1.1:		

LAA-0101AR, Short Form Application for Life Insurance, Part 1, approved 02-19-2004, SERFF #USPH-5WAJBZ992, State Tracking #25566
 LAA-0102AR, Short Form Application for Life Insurance, Part 2, approved 02-19-2004, SERFF #USPH-5WAJBZ992, State Tracking #25566
 LAD-0100AO, Amendment of Application Form, 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 NWLA.pdf		

	Item Status:	Status Date:
Satisfied - Item: REDLINED CHANGES		
Comments:		
Attachment: LAA-0110M1.1 Highlighted.pdf		



ARKANSAS

Certificate of Compliance

Insurer: Nationwide Life and Annuity Insurance Company

Form Numbers: LAA-0110M1.1, Application for Individual 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: 03-16-2012

**NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY
(01/2012)
STATEMENT OF VARIABILITY FOR FORM**

LAA-0110M1.1 - Application for Individual Life Insurance

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

LAA-0110M1.1

Nationwide's Address, Phone Number and Fax Number	Nationwide's address, fax and/or telephone information is bracketed throughout the form in case they change in the future.
---------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------

Page 4, Section 12 – Notices - Important

MIB, INC. DISCLOSURE NOTICE	The address and/or telephone information is bracketed in case either change in the future.
--------------------------------	--------------------------------------------------------------------------------------------

NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY

Application for Individual Life Insurance

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

Page 1 of 5

(Please print)

1. Proposed Primary Insured

First Name: MI: Last Name:

Soc. Sec. No. or Tax ID: Sex: M F

Citizenship: U.S./ Canada: Yes No If no, please complete the Foreign Supplement.

Date of Birth: State of Birth: Email Address:

Street: City: State: ZIP:

Phone: Occupation: Driver's License No./ State of Issue:

Height: Weight:

2. Proposed Insured (Spouse/Children)

Full Name of Insured(s)	Date of Birth	Sex	Height	Weight	State of Birth	Soc. Sec. No. or Tax ID	Relationship to Insured
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="- -"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="- -"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="- -"/>	<input type="text"/>

Spouse Address: Same as Proposed Primary Insured Street:

City: State: ZIP: Occupation:

Spouse Driver's License No./State of Issue:

Citizenship: U.S./ Canada: Yes No If no, please complete the Foreign Supplement.

3. Owner (The Primary Insured will own the policy unless indicated here.)

First Name: MI: Last Name:

Soc. Sec. No. or Tax ID: Sex: M F Date of Birth:

Address: Same as Proposed Primary Insured Street:

City: State: ZIP: Occupation:

Phone: Relationship to Insured

4. Beneficiaries

4a. Proposed Primary Insured's Beneficiary (If more than two beneficiaries, please attach additional sheets.)

%	Primary	Contingent	Beneficiary Name	Date of Birth	Relationship to Insured(s)
<input type="text"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="text" value="Jane Doe"/>	<input type="text" value="10/08/1967"/>	<input type="text" value="Wife"/>
<input type="text"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="text" value="Bambi Doe"/>	<input type="text" value="12/23/1989"/>	<input type="text" value="Daughter"/>

4b. Proposed Spouse Insured's Beneficiary (If more than two beneficiaries, please attach additional sheets.)

<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

(If multiple beneficiaries, payments to the beneficiaries surviving the Insured will be made in equal shares, or in full to the last surviving beneficiary, unless some other distribution of proceeds is provided.)

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

First Name: MI: Last Name:

Street: City: State: ZIP:



6. Life Insurance Product and EFT Authorization Information (Include the full name of the desired product below.)

Product: 20 Pay Whole Life Specified Amount: \$ 99,000 Initial Premium Payment (Paid with application): \$ 10,000

Planned Premium (Check product for availability.)

Billing Advantage # \$ Quarterly \$ Semi-Annual \$ Annual \$10,000 Single Premium \$ Other \$ Monthly: Monthly EFT Amt: \$ Transit/ABA Number: Draft Date:

Financial Institution Name: Account Number:

Financial Institution Address:

Transit/ABA Number: Monthly EFT Amt: Draft Date:

*Checking (A copy of a voided check is required. Starter Checks will not be accepted.) (Note: Do not use 29th, 30th, or 31st as a draft date) *Savings (A voided deposit slip with account number and routing number is required.)

(Make all checks payable to NATIONWIDE. Do not make checks payable to the producer or leave the payee blank.)

*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

Whole Life Product Only (Check product for availability.)

Optional Benefit Riders

Owner's Waiver of Premium Death Benefit Rider (Complete sections 8 & 9 for Owner)

Occupation Height Weight State of Birth Driver's License number

Owner's Waiver of Premium Death or Disability Benefit Rider (Complete sections 8 & 9 for Owner)

Occupation Height Weight State of Birth Driver's License number

20 Year Spouse Rider \$ Accidental Death - Amount \$ Child Rider \$

Waiver of Premium Benefit Guaranteed Insurability - Amount \$

Other Rider(s) \$

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

No, do not issue with APL

Term Life Product Only (Check product for availability.)

Optional Benefit Riders

20 Year Spouse Rider \$ Child Rider \$ Other Rider(s) \$

Waiver of Premium Benefit

Universal Life Product Only (Check product for availability.)

Death Benefit Option (If no option is selected here, Option 1 is elected.)

Option 1 (The Specified Amount, or a multiple of the Accumulated Value, whichever is greater.)

Option 2 (The Specified Amount, plus the Accumulated Value, or a multiple of the Accumulated Value, whichever is greater.)

Optional Benefit Riders

Guaranteed Option to Increase Specified Amount \$ Other Rider(s) \$

Accidental Death - Amount \$ Spouse Rider \$ Child Rider \$

Waiver of Monthly Deduction Rider



7. Insurance Information

- a. 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) Yes No
- b. Do you currently have any Life Insurance or Annuities in force? Yes No (If yes, please list below.)

Person	Company	Policy Number	Amount	Year Issued	To Be Replaced	1035	Accidental Death
			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	

8. Personal Information (All questions are to be answered by each Proposed Insured.)
(Explain all "yes" answers in Details box below unless instructed otherwise.)

	Proposed Insured	Proposed Insured Spouse	Any Child
a. Have you used tobacco or nicotine in any form in the last 12 months?.....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
b. Except as prescribed by a physician, have you ever used, or been convicted for sale or possession of cocaine or any other narcotic or illegal drug? (If yes, complete Drug Questionnaire.).....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Have you ever been charged with a violation of any criminal law?.....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Have you in the past 10 years, had your driver's license suspended or revoked; or in the past 10 years been convicted of driving while impaired or intoxicated; or in the past 3 years been convicted of three or more moving violations?.....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. In the past 3 years have you engaged in, or do you intend to engage in: flying as a pilot, student pilot, or crew member; organized racing of an automobile, motorcycle, or any type of motor-powered vehicle; scuba diving, mountain climbing, hang gliding, parachuting, sky diving, or bungee jumping? (If yes, please complete an Aviation/Hazardous Activities Questionnaire.).....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Is any Proposed Insured currently disabled or receiving disability payments?.....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Do you belong to any active or reserve military or naval organizations? (If yes, please complete Military Status Questionnaire.).....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Do you plan to travel or reside outside of the United States or Canada within the next 12 months? (If Yes, please complete Foreign Supplement).....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

9. Medical Questions (All questions are to be answered by each Proposed Insured.)
(Explain all "yes" answers in Details box below unless instructed otherwise.)

a. Has any Proposed Insured ever consulted a physician or any other health care provider for, been treated for, taken medication for, or been diagnosed as having:			
1. Heart disease, vascular disease, stroke, or cancer (other than basal cell skin cancer), or substance abuse (alcohol or drugs)?.....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. In the past 3 years, has any Proposed Insured ever consulted a physician or any other health care provider for, been treated for, taken medication for or been diagnosed as having diabetes, epilepsy, seizures, depression, anxiety disorders or any mental, nervous, or brain disorder, dementia, Parkinson's disease, lupus or connective tissue disorder, asthma, emphysema, or any chronic respiratory disorder, chronic liver or kidney disease, Crohn's disease or ulcerative colitis, or any blood disorder?.....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Has any Proposed Insured been medically advised within the last 5 years to have any surgery, hospitalization, treatment, or test that has not been completed; or has any Proposed Insured not yet received the results of any medical test that he/she has taken?...	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. In the past 5 years, have you been prescribed, given or advised to take any medications by a physician or health care provider? (If yes, provide details of dosage, frequency, and prescriber.).....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No



10. Additional Details

Please provide additional details in this section from questions 8 and 9.

(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.)

Multiple empty rectangular boxes for providing additional details.

11. Special Instructions

(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.)

Two empty rectangular boxes for special instructions.

12. Notices - Important

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 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, MIB, Inc., upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information in your file. Please contact MIB, Inc. at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in the MIB, Inc's 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 MIB, Inc's information office is 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734. 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. Information for consumers about MIB, Inc. may be obtained on its website at www.mib.com.]

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

13. Taxpayer Identification Number - Certification

I certify under penalties of perjury that: (1) The number shown on this form is my correct taxpayer identification number and, (2) I am not subject to backup withholding because (a) 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 (b) 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 (3) I am a U.S. person (including a U.S. resident alien).



Please 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.



14. Temporary Insurance Agreement - Terms and Conditions/Limitations

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 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 (a) 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 (b) [\$100,000]. Temporary Life Insurance under this Agreement will terminate automatically on the earliest of: A.) 60 days from the date of this signed Agreement, or B.) the date any policy is offered or issued to the Proposed Insured in connection with the above application, or C.) the date Nationwide mails notice of termination of coverage and refund of the advance payment to the premium notice address designated in such application. 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 Insureds who are under 15 days of age or over the age of 70 (nearest birthday) 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 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.)

15. Agreement and Authorization

I understand and agree that: (A.) This application, and any amendments to it, will become a part of the Policy and are the basis of any insurance issued upon this application. (B.) The Proposed Insured has a right to cancel this application at any time by contacting their producer or Nationwide in writing. (C.) No producer 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. (D.) If the full first premium payment is made in exchange for a Temporary Insurance Agreement, Nationwide will only be liable to the extent set forth in that Agreement. (E.) Insurance will only take effect if first premium is paid with this application and all the answers and statements made on the application are true to the best of my knowledge and belief.

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; the MIB, Inc.; or any other organization, institution, government 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.

16. Signatures

I, THE PROPOSED INSURED(S), HAVE RECEIVED AND READ A COPY OF THIS APPLICATION 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: January 3, 2012
City/State Month/Day/Year

X John Doe
Signature of Proposed Insured
(or parent if Proposed Insured is under age 15)

X
Signature of Proposed Insured Spouse (if to be insured)

X
Signature of Payor (if other than Proposed Insured)

X
Signature of Owner (if other than Proposed Insured)

I have truly and accurately recorded all Proposed Insureds' answers on this application.

STOP (CHECK ONE) To the best of my knowledge, the insurance applied for () will [X] will not) replace any life insurance, and/or annuity.

X Agent Producer
Signature of Agent/Producer

Any Firm 02-A000000
Firm Agent/Producer's Nationwide Number



SERFF Tracking Number: NWPA-128169306 State: Arkansas
 Filing Company: Nationwide Life and Annuity Insurance Company State Tracking Number:
 Company Tracking Number: LAA-0110M1.1, APPLICATION FOR INDIVIDUAL LIFE INSURANCE
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: LAA-0110M1.1, Application for Individual Life Insurance
 Project Name/Number: LAA-0110M1.1, Application for Individual Life Insurance/LAA-0110M1.1, Application for Individual Life Insurance

Superseded Schedule Items

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

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
03/14/2012	Form	Application for Individual Life Insurance	05/09/2012	LAA-0110M1.1 JD.pdf (Superseded)
03/14/2012	Supporting Document	REDLINED CHANGES	05/09/2012	LAA-0110M1.1 HIGHLIGHTED.pdf (Superseded)

NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY

Application for Individual Life Insurance

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

Page 1 of 5

(Please print)

1. Proposed Primary Insured

First Name: MI: Last Name:

Soc. Sec. No. or Tax ID: Sex: M F

Citizenship: U.S./ Canada: Yes No If no, please complete the Foreign Supplement.

Date of Birth: State of Birth: Email Address:

Street: City: State: ZIP:

Phone: Occupation: Driver's License No./ State of Issue:

Height: Weight:

2. Proposed Insured (Spouse/Children)

Full Name of Insured(s)	Date of Birth	Sex	Height	Weight	State of Birth	Soc. Sec. No. or Tax ID	Relationship to Insured
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="- -"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="- -"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="- -"/>	<input type="text"/>

Spouse Address: Same as Proposed Primary Insured Street:

City: State: ZIP: Occupation:

Spouse Driver's License No./State of Issue:

Citizenship: U.S./ Canada: Yes No If no, please complete the Foreign Supplement.

3. Owner (The Primary Insured will own the policy unless indicated here.)

First Name: MI: Last Name:

Soc. Sec. No. or Tax ID: Sex: M F Date of Birth:

Address: Same as Proposed Primary Insured Street:

City: State: ZIP: Occupation:

Phone: Relationship to Insured

4. Beneficiaries

4a. Proposed Primary Insured's Beneficiary (If more than two beneficiaries, please attach additional sheets.)

%	Primary	Contingent	Beneficiary Name	Date of Birth	Relationship to Insured(s)
<input type="text"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="text" value="Jane Doe"/>	<input type="text" value="10/08/1967"/>	<input type="text" value="Wife"/>
<input type="text"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="text" value="Bambi Doe"/>	<input type="text" value="12/23/1989"/>	<input type="text" value="Daughter"/>

4b. Proposed Spouse Insured's Beneficiary (If more than two beneficiaries, please attach additional sheets.)

<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

(If multiple beneficiaries, payments to the beneficiaries surviving the Insured will be made in equal shares, or in full to the last surviving beneficiary, unless some other distribution of proceeds is provided.)

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

First Name: MI: Last Name:

Street: City: State: ZIP:



6. Life Insurance Product and EFT Authorization Information (Include the full name of the desired product below.)

Product: 20 Pay Whole Life Specified Amount: \$ 99,000 Initial Premium Payment (Paid with application): \$ 10,000

Planned Premium (Check product for availability.)

Billing Advantage # \$ Quarterly \$ Semi-Annual \$ Annual \$10,000 Single Premium \$ Other \$ Monthly: Monthly EFT Amt: \$ Transit/ABA Number: Draft Date:

Financial Institution Name: Account Number:

Financial Institution Address:

Transit/ABA Number: Monthly EFT Amt: Draft Date:

*Checking (A copy of a voided check is required. Starter Checks will not be accepted.) (Note: Do not use 29th, 30th, or 31st as a draft date) *Savings (A voided deposit slip with account number and routing number is required.)

(Make all checks payable to NATIONWIDE. Do not make checks payable to the producer or leave the payee blank.)

*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

Whole Life Product Only (Check product for availability.)

Optional Benefit Riders

Owner's Waiver of Premium Death Benefit Rider (Complete sections 8 & 9 for Owner)

Occupation Height Weight State of Birth Driver's License number

Owner's Waiver of Premium Death or Disability Benefit Rider (Complete sections 8 & 9 for Owner)

Occupation Height Weight State of Birth Driver's License number

20 Year Spouse Rider \$ Accidental Death - Amount \$ Child Rider \$

Waiver of Premium Benefit Guaranteed Insurability - Amount \$

Other Rider(s) \$

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

No, do not issue with APL

Term Life Product Only (Check product for availability.)

Optional Benefit Riders

20 Year Spouse Rider \$ Child Rider \$ Other Rider(s) \$

Waiver of Premium Benefit

Universal Life Product Only (Check product for availability.)

Death Benefit Option (If no option is selected here, Option 1 is elected.)

Option 1 (The Specified Amount, or a multiple of the Accumulated Value, whichever is greater.)

Option 2 (The Specified Amount, plus the Accumulated Value, or a multiple of the Accumulated Value, whichever is greater.)

Optional Benefit Riders

Guaranteed Option to Increase Specified Amount \$ Other Rider(s) \$

Accidental Death - Amount \$ Spouse Rider \$ Child Rider \$

Waiver of Monthly Deduction Rider





7. Insurance Information

- a. 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) Yes No
- b. Do you currently have any Life Insurance or Annuities in force? Yes No (If yes, please list below.)

Person	Company	Policy Number	Amount	Year Issued	To Be Replaced	1035	Accidental Death
			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	

8. Personal Information (All questions are to be answered by each Proposed Insured.)
(Explain all "yes" answers in Details box below unless instructed otherwise.)

- | | Proposed Insured | Proposed Insured Spouse | Any Child |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|
| a. Have you used tobacco or nicotine in any form in the last 12 months?..... | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Except as prescribed by a physician, have you ever used, or been convicted for sale or possession of cocaine or any other narcotic or illegal drug? (If yes, complete Drug Questionnaire.)..... | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. Have you ever been charged with a violation of any criminal law?..... | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. Have you in the past 10 years, had your driver's license suspended or revoked; or in the past 10 years been convicted of driving while impaired or intoxicated; or in the past 3 years been convicted of three or more moving violations?..... | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. In the past 3 years have you engaged in, or do you intend to engage in:
flying as a pilot, student pilot, or crew member; organized racing of an automobile, motorcycle, or any type of motor-powered vehicle; scuba diving, mountain climbing, hang gliding, parachuting, sky diving, or bungee jumping? (If yes, please complete an Aviation/Hazardous Activities Questionnaire.)..... | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f. Is any Proposed Insured currently disabled or receiving disability payments?..... | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| g. Do you belong to any active or reserve military or naval organizations? (If yes, please complete Military Status Questionnaire.)..... | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| h. Do you plan to travel or reside outside of the United States or Canada within the next 12 months? (If Yes, please complete Foreign Supplement)..... | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

9. Medical Questions (All questions are to be answered by each Proposed Insured.)
(Explain all "yes" answers in Details box below unless instructed otherwise.)

- | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|
| a. Has any Proposed Insured ever consulted a physician or any other health care provider for, been treated for, taken medication for, or been diagnosed as having: | | | |
| 1. Heart disease, vascular disease, stroke, or cancer (other than basal cell skin cancer), or substance abuse (alcohol or drugs)?..... | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. 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 | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. In the past 3 years, has any Proposed Insured ever consulted a physician or any other health care provider for, been treated for, taken medication for or been diagnosed as having diabetes, epilepsy, seizures, depression, anxiety disorders or any mental, nervous, or brain disorder, dementia, Parkinson's disease, lupus or connective tissue disorder, asthma, emphysema, or any chronic respiratory disorder, chronic liver or kidney disease, Crohn's disease or ulcerative colitis, or any blood disorder?..... | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. Has any Proposed Insured been medically advised within the last 5 years to have any surgery, hospitalization, treatment, or test that has not been completed; or has any Proposed Insured not yet received the results of any medical test that he/she has taken?... | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. In the past 5 years, have you been prescribed, given or advised to take any medications by a physician or health care provider? (If yes, provide details of dosage, frequency, and prescriber.)..... | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |





10. Additional Details

Please provide additional details in this section from questions 8 and 9.

(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.)

Multiple empty rectangular boxes for providing additional details.

11. Special Instructions

(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.)

Two empty rectangular boxes for special instructions.

12. Notices - Important

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 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, MIB, Inc., upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information in your file. Please contact MIB, Inc. at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in the MIB, Inc's 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 MIB, Inc's information office is 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734. 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. Information for consumers about MIB, Inc. may be obtained on its website at www.mib.com.]

FRAUD NOTICES - Notice to Proposed Insured's:

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

MONTANA 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.

13. Taxpayer Identification Number - Certification

I certify under penalties of perjury that: (1) The number shown on this form is my correct taxpayer identification number and, (2) I am not subject to backup withholding because (a) 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 (b) 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 (3) I am a U.S. person (including a U.S. resident alien).



Please 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.



14. Temporary Insurance Agreement - Terms and Conditions/Limitations

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 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 (a) 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 (b) [\$100,000]. Temporary Life Insurance under this Agreement will terminate automatically on the earliest of: A.) 60 days from the date of this signed Agreement, or B.) the date any policy is offered or issued to the Proposed Insured in connection with the above application, or C.) the date Nationwide mails notice of termination of coverage and refund of the advance payment to the premium notice address designated in such application. 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 Insureds who are under 15 days of age or over the age of 70 (nearest birthday) 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 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.)

15. Agreement and Authorization

I understand and agree that: (A.) This application, and any amendments to it, will become a part of the Policy and are the basis of any insurance issued upon this application. (B.) The Proposed Insured has a right to cancel this application at any time by contacting their producer or Nationwide in writing. (C.) No producer 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. (D.) If the full first premium payment is made in exchange for a Temporary Insurance Agreement, Nationwide will only be liable to the extent set forth in that Agreement. (E.) Insurance will only take effect if first premium is paid with this application and all the answers and statements made on the application are true to the best of my knowledge and belief.

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; the MIB, Inc.; or any other organization, institution, government 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.

16. Signatures

I, THE PROPOSED INSURED(S), HAVE RECEIVED AND READ A COPY OF THIS APPLICATION 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: January 3, 2012
City/State Month/Day/Year

X John Doe
Signature of Proposed Insured
(or parent if Proposed Insured is under age 15)

X
Signature of Proposed Insured Spouse (if to be insured)

X
Signature of Payor (if other than Proposed Insured)

X
Signature of Owner (if other than Proposed Insured)

I have truly and accurately recorded all Proposed Insureds' answers on this application.

STOP (CHECK ONE) To the best of my knowledge, the insurance applied for () will [X] will not) replace any life insurance, and/or annuity.

X Agent Producer
Signature of Agent/Producer

Any Firm 02-A000000
Firm Agent/Producer's Nationwide Number



NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY

Application for Individual Life Insurance

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

Page 1 of 5

(Please print)

1. Proposed Primary Insured

First Name: MI: Last Name:
 Soc. Sec. No. or Tax ID: Sex: M F
 Citizenship: U.S./ Canada: Yes No If no, please complete the Foreign Supplement.
 Date of Birth: State of Birth: Email Address:
 Street: City: State: ZIP:
 Phone: Occupation: Driver's License No./ State of Issue:
 Height: Weight:

2. Proposed Insured (Spouse/Children)

Full Name of Insured(s)	Date of Birth	Sex	Height	Weight	State of Birth	Soc. Sec. No. or Tax ID	Relationship to Insured
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="- -"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="- -"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="- -"/>	<input type="text"/>

Spouse Address: Same as Proposed Primary Insured Street:
 City: State: ZIP: Occupation:
 Spouse Driver's License No./State of Issue:
 Citizenship: U.S./ Canada: Yes No If no, please complete the Foreign Supplement.

3. Owner (The Primary Insured will own the policy unless indicated here.)

First Name: MI: Last Name:
 Soc. Sec. No. or Tax ID: Sex: M F Date of Birth:
 Address: Same as Proposed Primary Insured Street:
 City: State: ZIP: Occupation:
 Phone: Relationship to Insured

4. Beneficiaries

4a. Proposed Primary Insured's Beneficiary (If more than two beneficiaries, please attach additional sheets.)

%	Primary	Contingent	Beneficiary Name	Date of Birth	Relationship to Insured(s)
<input type="text"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="text" value="Jane Doe"/>	<input type="text" value="10/08/1967"/>	<input type="text" value="Wife"/>
<input type="text"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="text" value="Bambi Doe"/>	<input type="text" value="12/23/1989"/>	<input type="text" value="Daughter"/>

4b. Proposed Spouse Insured's Beneficiary (If more than two beneficiaries, please attach additional sheets.)

<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

(If multiple beneficiaries, payments to the beneficiaries surviving the Insured will be made in equal shares, or in full to the last surviving beneficiary, unless some other distribution of proceeds is provided.)

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

First Name: MI: Last Name:
 Street: City: State: ZIP:



6. Life Insurance Product and EFT Authorization Information (Include the full name of the desired product below.)

Product: 20 Pay Whole Life Specified Amount: \$ 99,000 Initial Premium Payment (Paid with application): \$ 10,000

Planned Premium (Check product for availability.)

Billing Advantage # \$ Quarterly \$ Semi-Annual \$ Annual \$10,000 Single Premium \$ Other \$ Monthly: Monthly EFT Amt: \$ Transit/ABA Number: Draft Date:

Financial Institution Name: Account Number:

Financial Institution Address:

Transit/ABA Number: Monthly EFT Amt: Draft Date:

- *Checking (A copy of a voided check is required. Starter Checks will not be accepted.) (Note: Do not use 29th, 30th, or 31st as a draft date) *Savings (A voided deposit slip with account number and routing number is required.)

(Make all checks payable to NATIONWIDE. Do not make checks payable to the producer or leave the payee blank.)

*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

Whole Life Product Only (Check product for availability.)

Optional Benefit Riders

Owner's Waiver of Premium Death Benefit Rider (Complete sections 8 & 9 for Owner)

Occupation Height Weight State of Birth Driver's License number

Owner's Waiver of Premium Death or Disability Benefit Rider (Complete sections 8 & 9 for Owner)

Occupation Height Weight State of Birth Driver's License number

20 Year Spouse Rider \$ Accidental Death - Amount \$ Child Rider \$

Waiver of Premium Benefit Guaranteed Insurability - Amount \$

Other Rider(s) \$

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

No, do not issue with APL

Term Life Product Only (Check product for availability.)

Optional Benefit Riders

20 Year Spouse Rider \$ Child Rider \$ Other Rider(s) \$

Waiver of Premium Benefit

Universal Life Product Only (Check product for availability.)

Death Benefit Option (If no option is selected here, Option 1 is elected.)

- Option 1 (The Specified Amount, or a multiple of the Accumulated Value, whichever is greater.) Option 2 (The Specified Amount, plus the Accumulated Value, or a multiple of the Accumulated Value, whichever is greater.)

Optional Benefit Riders

Guaranteed Option to Increase Specified Amount \$ Other Rider(s) \$

Accidental Death - Amount \$ Spouse Rider \$ Child Rider \$

Waiver of Monthly Deduction Rider



7. Insurance Information

- a. 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) Yes No
- b. Do you currently have any Life Insurance or Annuities in force? Yes No (If yes, please list below.)

Person	Company	Policy Number	Amount	Year Issued	To Be Replaced	1035	Accidental Death
			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	

8. Personal Information (All questions are to be answered by each Proposed Insured.)
(Explain all "yes" answers in Details box below unless instructed otherwise.)

- | | Proposed Insured | Proposed Insured Spouse | Any Child |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|
| a. Have you used tobacco or nicotine in any form in the last 12 months?..... | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Except as prescribed by a physician, have you ever used, or been convicted for sale or possession of cocaine or any other narcotic or illegal drug? (If yes, complete Drug Questionnaire.)..... | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. Have you ever been charged with a violation of any criminal law?..... | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. Have you in the past 10 years, had your driver's license suspended or revoked; or in the past 10 years been convicted of driving while impaired or intoxicated; or in the past 3 years been convicted of three or more moving violations?..... | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. In the past 3 years have you engaged in, or do you intend to engage in: flying as a pilot, student pilot, or crew member; organized racing of an automobile, motorcycle, or any type of motor-powered vehicle; scuba diving, mountain climbing, hang gliding, parachuting, sky diving, or bungee jumping? (If yes, please complete an Aviation/Hazardous Activities Questionnaire.)..... | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f. Is any Proposed Insured currently disabled or receiving disability payments?..... | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| g. Do you belong to any active or reserve military or naval organizations? (If yes, please complete Military Status Questionnaire.)..... | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| h. Do you plan to travel or reside outside of the United States or Canada within the next 12 months? (If Yes, please complete Foreign Supplement)..... | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

9. Medical Questions (All questions are to be answered by each Proposed Insured.)
(Explain all "yes" answers in Details box below unless instructed otherwise.)

- | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|
| a. Has any Proposed Insured ever consulted a physician or any other health care provider for, been treated for, taken medication for, or been diagnosed as having: | | | |
| 1. Heart disease, vascular disease, stroke, or cancer (other than basal cell skin cancer), or substance abuse (alcohol or drugs)?..... | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. 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 | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. In the past 3 years, has any Proposed Insured ever consulted a physician or any other health care provider for, been treated for, taken medication for or been diagnosed as having diabetes, epilepsy, seizures, depression, anxiety disorders or any mental, nervous, or brain disorder, dementia, Parkinson's disease, lupus or connective tissue disorder, asthma, emphysema, or any chronic respiratory disorder, chronic liver or kidney disease, Crohn's disease or ulcerative colitis, or any blood disorder?..... | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. Has any Proposed Insured been medically advised within the last 5 years to have any surgery, hospitalization, treatment, or test that has not been completed; or has any Proposed Insured not yet received the results of any medical test that he/she has taken?... | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. In the past 5 years, have you been prescribed, given or advised to take any medications by a physician or health care provider? (If yes, provide details of dosage, frequency, and prescriber.)..... | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |





10. Additional Details

Please provide additional details in this section from questions 8 and 9.

(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.)

Multiple empty rectangular boxes for providing additional details.

11. Special Instructions

(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.)

Two empty rectangular boxes for special instructions.

12. Notices - Important

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 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, MIB, Inc., upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information in your file. Please contact MIB, Inc. at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in the MIB, Inc's 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 MIB, Inc's information office is 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734. 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. Information for consumers about MIB, Inc. may be obtained on its website at www.mib.com.]

FRAUD NOTICES - Notice to Proposed Insured's:

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

MONTANA 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.

13. Taxpayer Identification Number - Certification

I certify under penalties of perjury that: (1) The number shown on this form is my correct taxpayer identification number and, (2) I am not subject to backup withholding because (a) 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 (b) 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 (3) I am a U.S. person (including a U.S. resident alien).



Please 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.



14. Temporary Insurance Agreement - Terms and Conditions/Limitations

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 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 (a) 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 (b) [\$100,000]. Temporary Life Insurance under this Agreement will terminate automatically on the earliest of: A.) 60 days from the date of this signed Agreement, or B.) the date any policy is offered or issued to the Proposed Insured in connection with the above application, or C.) the date Nationwide mails notice of termination of coverage and refund of the advance payment to the premium notice address designated in such application. 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 Insureds who are under 15 days of age or over the age of 70 (nearest birthday) 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 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.)

15. Agreement and Authorization

I understand and agree that: (A.) This application, and any amendments to it, will become a part of the Policy and are the basis of any insurance issued upon this application. (B.) The Proposed Insured has a right to cancel this application at any time by contacting their producer or Nationwide in writing. (C.) No producer 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. (D.) If the full first premium payment is made in exchange for a Temporary Insurance Agreement, Nationwide will only be liable to the extent set forth in that Agreement. (E.) Insurance will only take effect if first premium is paid with this application and all the answers and statements made on the application are true to the best of my knowledge and belief.

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; the MIB, Inc.; or any other organization, institution, government 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.

16. Signatures

I, THE PROPOSED INSURED(S), HAVE RECEIVED AND READ A COPY OF THIS APPLICATION 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: On:
City/State Month/Day/Year

Signature of Proposed Insured Signature of Proposed Insured Spouse (if to be insured)
(or parent if Proposed Insured is under age 15)

Signature of Payor (if other than Proposed Insured) Signature of Owner (if other than Proposed Insured)

I have truly and accurately recorded all Proposed Insureds' answers on this application.

STOP (CHECK ONE) To the best of my knowledge, the insurance applied for (will will not) replace any life insurance, and/or annuity.

Signature of Agent/Producer Firm Agent/Producer's Nationwide Number

