



Supplemental Health | Policyholder Application

Nationwide Specialty Health™

To be completed by the proposed policyholder

Thank you for choosing Nationwide Life Insurance Company for your company's health plan needs. The information given below shall be the basis of the agreement with your company (the Plan Sponsor) forming the final contract.

Requested Effective Date ____ / ____ / ____ (Must be 1st of a month, and on or after the application date)

Notification of Annual Enrollment Month _____

Your group will have an "annual enrollment" period that will consist of the calendar month immediately preceding your anniversary date based on the above **Requested Effective Date**. During this period, eligible employees will be permitted to enroll for coverage and will be made effective on the anniversary date.

Legal Company Policyholder Name _____

	Main Office Address	Billing Address (if different than Main Office Address)
Street/ PO Box	_____	_____
City, State, Zip	_____	_____

	Primary Contact	Administrative Contact
Name	_____	_____
Title	_____	_____
Phone Number	_____	_____
Fax Number	_____	_____
E-mail Address	_____	_____

In order to apply for this coverage, your company must have a minimum of 51 employees working at least 25 hours per week. Eligible Employees are full-time year-round employees working a minimum of 25 hours per week. Employees of employee leasing firms or professional employee organizations are not eligible employees.

Number of Eligible Employees _____

Waiting Period Yes No If "Yes", Number of days 30 60 90 Other _____

New hires will be effective on the first of the month following the waiting period.

Note: These products are not intended to replace comprehensive major medical insurance.

Employees are categorized by class of employment. Please provide a brief description after "Class". The following material may be copied to additional sheets if necessary to describe additional classes.

Accident Product	Class 1 (Describe)	Class 2 (Describe)	Class 3 (Describe)
Please check the box of the benefit amount you are applying for by class in the boxes to the right. <ul style="list-style-type: none"> The available benefit range is \$1,100 - \$5,000 per employee with specific amounts available as shown here. Benefits are provided up to a calendar year maximum. 	Employee Only <input type="checkbox"/> \$1,100 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$1,200 <input type="checkbox"/> \$3,500 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$4,500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000	Employee Only <input type="checkbox"/> \$1,100 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$1,200 <input type="checkbox"/> \$3,500 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$4,500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000	Employee Only <input type="checkbox"/> \$1,100 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$1,200 <input type="checkbox"/> \$3,500 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$4,500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000
Employee plus family coverage is equal to up to the elected employee benefit, per calendar year per covered individual, not to exceed 3 times the employee benefit.	Employee Plus Family <input type="checkbox"/> Elect <input type="checkbox"/> Refuse	Employee Plus Family <input type="checkbox"/> Elect <input type="checkbox"/> Refuse	Employee Plus Family <input type="checkbox"/> Elect <input type="checkbox"/> Refuse
Policyholder Contribution to Premium	Employee _____% Family _____%	Employee _____% Family _____%	Employee _____% Family _____%

Hospital Indemnity Product	Class 1 (Describe)		Class 2 (Describe)		Class 3 (Describe)	
Please check the box of the benefit amount you are applying for by class in the boxes to the right. <ul style="list-style-type: none"> Daily in-hospital indemnity benefits are provided in \$100 increments up to a 30 day calendar year maximum Intensive care benefits are 2x the semi-private benefit 	Employee Only <input type="checkbox"/> \$100/day <input type="checkbox"/> \$200/day <input type="checkbox"/> \$300/day <input type="checkbox"/> \$400/day <input type="checkbox"/> \$500/day	Employee Plus Family <input type="checkbox"/> Elect <input type="checkbox"/> Refuse	Employee Only <input type="checkbox"/> \$100/day <input type="checkbox"/> \$200/day <input type="checkbox"/> \$300/day <input type="checkbox"/> \$400/day <input type="checkbox"/> \$500/day	Employee Plus Family <input type="checkbox"/> Elect <input type="checkbox"/> Refuse	Employee Only <input type="checkbox"/> \$100/day <input type="checkbox"/> \$200/day <input type="checkbox"/> \$300/day <input type="checkbox"/> \$400/day <input type="checkbox"/> \$500/day	Employee Plus Family <input type="checkbox"/> Elect <input type="checkbox"/> Refuse
Policyholder Contribution to Premium	Employee _____%	Family _____%	Employee _____%	Family _____%	Employee _____%	Family _____%

Combination Accident/Hospital Product (Benefits are pre-packaged as follows):				
<ul style="list-style-type: none"> Accident Benefit: up to \$500 per calendar year Ambulance Benefit: Air – up to \$1,000; Ground – up to \$300 Hospital Confinement Benefit: up to \$300/day; maximum 30 days per calendar year 			Employee Only <input type="checkbox"/> Elect	Employee Plus Family <input type="checkbox"/> Elect <input type="checkbox"/> Refuse
Policyholder Contribution to Premium			Employee _____%	Family _____%

Please enter the Monthly Rates from the current Rate Guide below:

	Accident Product	Hospital Product	Combination Product
Employee			
Employee + Family			

1. Payment of the first premium by the policyholder after delivery of the Policy by us shall constitute acceptance of the terms and conditions contained in the Policy so issued.
2. It is understood and agreed that:
 - (a) all necessary administrative information concerning all Covered Persons shall be subject to the provisions of the Policy and shall be furnished to us by the Policyholder.
 - (b) this Application is subject to the approval of Nationwide Life Insurance Company at its Home Office and that nothing contained herein shall be binding upon said Company until this Application has been so approved.
 - (c) all benefits will be in accordance with the benefits proposed and agreed upon between Nationwide Life Insurance Company and the Policyholder as set forth in the Policy, subject to the Policyholder's approval.
 - (d) benefits are not provided unless otherwise provided in the Policy; (a) in case of bodily injury or sickness arising out of or in the course of any employment for wage or profit; or (b) for any bodily injury or sickness for which the person on whom the claim is presented has or had a right to compensation under Workers' Compensation or similar occupational disease law.

Policyholder (herein referred to as "We") responsibilities under this policy

We agree (1) to maintain the records necessary to the administration of the Policy(s); (2) to report additions, changes, terminations and other information necessary to the administration of the Policy(s) to the insurer within 30 days after the Effective Date of such additions, changes and terminations; (3) that if we do not notify the insurer of any insured ineligibility or termination within 30 days, we shall forfeit any premium refund/credit that would otherwise have been due; (4) to make all such records, including payroll records, tax returns, and personnel files and other documentation as determined by the insurer available upon request to the insurer or its authorized representative; (5) to notify the insurer of claims within 20 days after they are incurred; (6) to pay all premiums in accordance with the terms of this Policy; and (7) to notify all Employees of any termination or rescission of coverage which affects them and refund the appropriate premium.

By the signature below of its duly authorized representative, the proposed Policyholder hereby applies for the Nationwide Life Insurance Company Policy and the proposed Policyholder understands and agrees that it shall be subject to the provisions set forth herein.

It is understood that all of the answers We have provided are representations and not warranties.

For Nationwide Use Only

Agent of Record:

Producer Number:

Application Signatures

Before signing the application, please read the fraud warning(s) applicable to your state(s) below and continued on the next page.

(California) For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

(Louisiana) 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.



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(Missouri) An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether an insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question(s) appears in this application, you should not renew it.

(Ohio) Any person who submits an application or a claim containing a false or deceptive statement, and does so with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, is guilty of insurance fraud.

(Pennsylvania) Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

(Puerto Rico) Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggregated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a maximum of two (2) years.

(Washington) Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

(All Other States) Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties.

(New York) Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Employer Representative

Agent of Record
(Original ink signature required for MS, NC, NH)

Signature

Signature

Title

Title

___ / ___ / ___
Date

___ / ___ / ___
Date

Nationwide Life Insurance Company
Home Office: One Nationwide Plaza
Columbus, OH 43215

Send Completed Application to:
Nationwide – Supplemental Health Products
PO Box 1199
Newark, OH 43058-1199

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