

POLICY APPLICATION (please print or type)

which, upon acceptance and approval by **NATIONWIDE LIFE INSURANCE COMPANY — Columbus, Ohio 43216**, will become a part of **SPECIFIED HAZARD INSURANCE POLICY NUMBER 502-95-**_____

Office Use Only

1. **Name of Plan Sponsor** _____
Group's Name

Permanent Mailing Address _____
Number Street City State Zip County

2. **Policy Term:** The policy term starts at **12:01 A.M.** on ____ / ____ / ____ which is the effective date and ends at **12:01 A.M.** on ____ / ____ / ____ which is the first renewal date.

3. **Covered Activities**

On duty under the direction of the plan sponsor and/or the government or private unit for which the insured is serving; those activities sponsored and directly supervised by the plan sponsor; training courses, tests, drills or trials of a piece of apparatus connected directly with such duties; and direct travel to and/or from such activities. (500)

4. **Maximum Benefit Amounts**—the word “None” means the benefit is not included.

Benefit Provisions	Maximum Benefit Amounts			
	Class 1	Class 2	Class 3	Class 4
ACCIDENTAL DEATH AND SPECIFIC LOSS with a \$250,000 overall maximum for any one accident.				
Death - - - - -	\$5,000	\$12,500	\$5,000	\$12,500
Specific Loss (Face Amount) - - - - -	10,000	25,000	10,000	25,000
MEDICAL EXPENSE				
Accident				
Deductible - - - - -	None	None	None	None
Overall Maximum - - - - -	25,000	50,000	25,000	50,000
WEEKLY ACCIDENT INCOME starting on the first day of disability for up to 52 weeks - - - - -	None	None	100	200
OFFICE USE ONLY	2220P 4220E	5011E	2220P 4220E	5011E

5. **Premium Rates by Class(es) of Eligible Persons** – check Class(es) and Medical Expense Plan desired.

Policy Term Premium Rates per Eligible Person			
Class	Eligible Persons	<input type="checkbox"/> Medical Expense Primary Plan	<input type="checkbox"/> Medical Expense Excess Plan
	All auxiliary and all volunteer members of the plan sponsor (check only one box):		
1	<input type="checkbox"/> Class 1 Benefits (C13) - - - - -	\$4.25	\$3.10
2	<input type="checkbox"/> Class 2 Benefits (C13) - - - - -	NOT AVAILABLE	6.25
3	<input type="checkbox"/> Class 3 Benefits (C13) - - - - -	10.75	9.50
4	<input type="checkbox"/> Class 4 Benefits (C13) - - - - -	NOT AVAILABLE	18.75
The minimum premium per policy term is \$225 if the medical expense primary plan has been elected and \$175 if the medical expense excess plan has been elected.			

6. **The Policy is to cover all eligible persons** (05).

7. **It is understood and agreed that:** (a) the premium will be paid entirely by the plan sponsor with no contribution made by the eligible persons toward the cost of the insurance; and (b) **premium will be paid annually in advance based on the total number of eligible persons anticipated to be insured during the policy term** (BF50).

(NY) 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.

By signing below, you agree that you have read all of the Fraud Warnings contained within this document.

Previous Policy Number _____
 Date _____
 Agent's Signature and Number _____
 Agent's Phone Number _____
 Agent's E-mail Address _____

Signature of Applicant _____
 Printed Name and Title of Applicant _____
 Address of Applicant _____
 Applicant's Phone Number _____
 Applicant's E-mail Address _____

FRAUD WARNINGS

- (CA) 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.
- (LA) 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.
- (NY) Please read statement located at bottom of application (reverse side) above signature section.
- (PA) 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.
- (PR) 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.
- (WA) 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.

NOTE: These plans are available in DC, PR, VI and all 50 states, EXCEPT for Class 3 and 4 benefits in PA. Excess medical is NOT available in NJ or NY. Please contact our Special Risks Department in our Home Office for Class 3 and 4 benefits in PA.

<p style="text-align: center;">PREMIUM REPORT</p> <p style="text-align: center;">Must be completed for Application to be accepted</p> <p>Type of Group: _____ _____</p> <p>Group Activities Include: _____ _____</p> <p>Age Range: _____ _____ to _____ years of age</p>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="3" style="text-align: center; color: red;">Anticipated Number of Eligible Persons to be Insured During the Policy Term</td> <td style="text-align: center;">Annual Premium Rate per Eligible Person</td> <td style="text-align: center;">Premium Due Subject to Annual Minimum</td> </tr> <tr> <td style="text-align: center; color: red;">Auxiliary Members</td> <td style="text-align: center; color: red;">+ Volunteer Members</td> <td style="text-align: center;">= Total Members</td> <td style="text-align: center;">× \$</td> <td style="text-align: center;">= \$</td> </tr> <tr> <td style="border-top: 1px solid black; width: 20%;"></td> <td style="border-top: 1px solid black; width: 20%;"></td> <td style="border-top: 1px solid black; width: 20%;"></td> <td style="border-top: 1px solid black; width: 20%;"></td> <td style="border-top: 1px solid black; width: 20%;"></td> </tr> </table> <div style="background-color: #f0f0f0; padding: 5px; margin-top: 5px;"> <p style="text-align: center;">The minimum premium per policy term is \$225 for primary medical coverage and \$175 for excess medical coverage.</p> </div> <p>I certify that to the best of my knowledge and belief: (1) the preceding information is correct and complete; (2) premium is being paid for the total number of eligible persons who are anticipated to be insured during the policy term; and (3) the premium is being paid entirely by the plan sponsor with no contribution made by the eligible persons toward the cost of the insurance.</p> <p>Date _____ by _____ Applicant's Signature and Title</p> <p>Day Telephone Number _____ Fax Number _____</p> <p>E-mail Address _____</p>	Anticipated Number of Eligible Persons to be Insured During the Policy Term			Annual Premium Rate per Eligible Person	Premium Due Subject to Annual Minimum	Auxiliary Members	+ Volunteer Members	= Total Members	× \$	= \$					
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Note: If additional space is required, use a separate sheet. For authorized checking account withdrawal (also called Automated Clearing House or "ACH") call 1-800-525-8669, option 5.

HERE ARE THE BENEFITS

DEATH BENEFIT - If, as a result of injury, an insured dies within one year from the date of the accident causing the injury, we will pay the death benefit less any specific loss benefit paid because of the same accident. The one year limit does not apply in a PA or WV contract.

SPECIFIC LOSS BENEFIT - If, as a result of injury, an insured suffers a specific loss within one year from the date of the accident causing the injury, we will pay:

- 75% of the face amount for loss of each arm or leg**
- 50% of the face amount for loss of each hand or foot, sight of an eye or speech**
- 25% of the face amount for loss of hearing of each ear or the thumb and index finger of the same hand**

The total payment for all of the specific losses of an insured because of any one accident will not be more than the face amount. No specific loss benefit will be paid if the death benefit applies. The loss of the thumb and index finger of the same hand benefit will not be paid if the loss of the hand or arm benefit applies. The loss of the hand or foot benefit will not be paid if the loss of the arm or leg benefit applies.

MEDICAL EXPENSE BENEFIT - If, as a result of injury, an insured incurs covered expenses starting within 90 days from the date of the accident causing the injury, we will pay, less the deductible (if any) shown in the application and not to exceed the overall maximum benefit amount, all covered expenses incurred within 3 years from such date.

Covered expenses means the reasonable and customary charges for local ("local" not applicable in a CT contract) professional ambulance service to or from a hospital and/or surgical center as well as the following reasonable and customary charges for treatment, services and supplies provided or prescribed by a doctor: (1) hospital or surgical center care; (2) medical treatment; (3) nursing care provided by a licensed nurse; (4) X-rays and lab exams; (5) prescription drugs and therapeutic services and supplies; (6) dental treatment as a result of injury to sound, natural teeth (natural teeth in SC); and (7) the following licensed home health care agency services and supplies provided instead of an otherwise required hospital or skilled nursing home confinement: (a) physical, occupational, respiratory and speech therapy, (b) the services of a home health aide and (c) medical supplies.

If excess medical has been elected, we will not pay benefits for, nor can this plan's deductible (if any) be satisfied by, covered expenses to the extent that they are collectible under certain other policies and/or health plans as stated in the policy.

(Coverage is provided under policy form No. GR-9051-2. Certain provisions of the policy are summarized in this brochure. All benefits are subject to the policy, which alone constitutes the agreement under which payments are made.)