IF A SICKNESS BENEFIT IS NOT SHOWN IN ITEM 4 OF THE APPLICATION, THE POLICY PROVIDES ACCIDENT INSURANCE ONLY. IF A SICKNESS BENEFIT IS SHOWN, THE POLICY PROVIDES LIMITED BENEFITS HEALTH INSURANCE ONLY. The policy does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Insurance Department.

IMPORTANT NOTICE

THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS (UNLESS A SICKNESS BENEFIT IS SHOWN IN ITEM 4 OF THE APPLICATION) OR FOR LEGAL LIABILITY.

WARNING

(NY) The insurance offered in this brochure is: (1) not a deposit; (2) not insured by the Federal Deposit Insurance Corporation; and (3) not guaranteed by the bank, trust company, savings bank, savings and loan associations, federal savings association or national bank.

A.M. BEST'S RATING FOR NATIONWIDE LIFE IS A+ (SUPERIOR). A.M. Best Co. has been a leading independent source of insurer financial ratings since 1899.

NOTE TO AGENT: Mail completed application, Premium Report (if short-term coverage) and premium payment to:

Special Risks
Nationwide Insurance
P.O. Box 2399
Columbus, OH 43216-2399

CONTACT US:

Local: 1-614-854-2196
Toll Free: 1-800-525-8669 (option 5)
Fax: 1-614-854-3753
E-Mail: specrsks@nationwide.com
Website: www.grouprotector.com

UNDERWRITTEN BY:

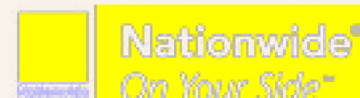
Nationwide Life Insurance Company
P.O. Box 2399
Columbus, OH 43216-2399

GPL-4005-M

NATIONWIDE LIFE INSURANCE COMPANY
Home Office: Columbus, Ohio

General Purpose
Insurance

All cases are subject to the acceptance of the risk. Cases producing over $15,000 of premium are also subject to our review of prior claims experience.



Nationwide's GrouProtector Insurance

General Purpose

WHAT IS IT?

Nationwide's GrouProtector Insurance is a highly practical insurance plan that provides greater peace-of-mind to individuals and groups engaged in a wide variety of activities. It gives all eligible persons the security they need and deserve.

Individual names are not required as ***100% of all eligible persons must be insured.*** Each person is protected — as well as the group itself — because all eligible persons are automatically covered.

Voluntary enrollment plans are not available.

WHAT ARE THE COVERED ACTIVITIES?

The covered activities are described in item 3 of the application.

WHAT ARE THE BENEFIT AMOUNTS?

The benefit amounts are shown in item 4 of the application.

WHO IS COVERED?

Eligible persons are described in item 5 of the application.

WHAT IS THE DIFFERENCE BETWEEN OUR PRIMARY MEDICAL AND EXCESS MEDICAL PLANS?

– **Our Primary Plan** - is usually "first in line" to pay a claim. It pays covered expenses **regardless** of most other plans.

Other plans, however, may reduce their payments based on what we pay.

– **Our Excess Plan** - is usually "last in line" to pay a claim. ***It does not pay covered expenses to the extent they are collectible under most other plans.*** Thus, we need to know what others pay before we will pay. If there is no coverage, we will pay the same as primary.

Excess essentially "fills in" other plans' deductibles and coinsurance as well as pays remaining covered expenses after others have exhausted their benefits. If our excess plan has a deductible, it is "out-of-pocket" and cannot be satisfied by other plans.

Availability of Primary and Excess plans varies. Please refer to Item 5 of the application and "Note" at the bottom of the application.

WHAT ARE THE POLICY EXCLUSIONS AND LIMITATIONS?

We will not pay benefits for expenses incurred for: (1) the examination, prescription, purchase or fitting of eye-glasses, contact lenses or hearing aids; or (2) treatment by a person employed or retained by the plan sponsor or its subsidiaries or affiliates and for which no charge is normally made; or (3) care or treatment by a person who ordinarily lives in the insured's home or is a parent, grandparent, spouse, brother, sister or child of either the insured or the insured's spouse (if a NJ contract, care or treatment furnished by a member of the insured's immediate family). Nor will we pay benefits for loss or expenses resulting from: (4) intentional self-destruction or an attempt at it, or intentional self-inflicted injury (if MO contract, while sane); (5) war or an act of war, declared or undeclared; or (6) air travel unless the insured is a passenger on a regularly scheduled flight of a properly licensed commercial airline.

HOW DO YOU APPLY FOR COVERAGE?

1. Complete items 1, 2, 5 and, if applicable, 6 and/or 7 on the attached application. Date and sign where indicated.
2. **Complete the "Premium Report" on the reverse side of the application.** Date and sign where indicated.
3. Send the completed application and Premium Report, along with your check made payable to Nationwide Insurance, to your Nationwide agent **before the desired effective date.**

When we receive your completed application, Premium Report (if applicable) and premium payment, we will send your policy, certificates (if required in your state), claim forms and instructions.

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:	**50% of the face amount for loss of:**	**25% of the face amount for loss of:**
Each Arm	Each Hand or Foot	Hearing of Each Ear
Each Leg	Sight of Each Eye	Thumb and Index Finger of the Same Hand
	Speech	

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 or sickness, an insured incurs covered expenses starting within 90 days from the date of the accident causing the injury or the date sickness (if applicable) begins, 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.

WEEKLY ACCIDENT INCOME BENEFIT (reductions do not apply in a NJ or NY contract) — If, as a result of injury, an insured becomes totally disabled within 90 days from the date of the accident causing the injury we will pay **(subject to any reduction — see below)** the weekly accident income benefit (if applicable) on the following basis: (1) benefits start on the day shown in the application; (2) weekly benefit amounts are shown in the application. If payment is for part of a week, the daily rate will be 1/7 of the weekly benefit; and (3) benefits for a period of disability will end on the first of these to occur: (a) the death of the insured, (b) when the total disability ends, (c) when the number of weeks for which benefits have been paid equals the maximum number of weeks shown in the application, or (d) when the insured is age 70.

Total disability or **totally disabled** means disability caused by an injury: (1) which keeps the insured from performing, with reasonable continuity, the substantial and material duties of his or her regular job; and (2) during which the insured is either under the regular care of a doctor, or at the maximum point of recovery as determined by competent medical authority.

Period of disability means the period of time when the insured is totally disabled. Successive periods of disability are treated as one unless the latest is because of an unrelated cause and begins after the insured returns to active work for at least one full day. (If a NJ contract, successive periods of disability are also not treated as one if the disabilities are separated by at least 6 months.)

Reduction means that the weekly accident income benefit amount payable to an insured for total disability will be reduced as much as is necessary to keep the total of the amount payable plus all of the insured's income from other sources from being more than 75% of his or her gross average weekly earnings from all salaries, wages, commissions, bonuses and other direct regular job income.

Income from other sources means periodic benefits for loss of time payable or provided for the same period of disability or a part of that period under: (1) certain other insurance contracts or retirement plans as stated in the policy; (2) an employer, labor management, and/or union sponsored salary continuance, disability or retirement plan; (3) Workers' Compensation, Unemployment Compensation, or similar occupational laws; and (4) the Social Security Act, the Railroad or Civil Service Retirement Act (not applicable in SC), any compulsory state disability benefit law, or any other loss of time or retirement plan provided by a government authority of any country (including any state, province, or political subdivision). Increases in the amounts paid under items (3) and (4) above which occur after the benefit period begins will not be used to further reduce the amount we will pay.

Regular Job means either: the insured's job at the time the injury occurred; or if, at the time the injury occurred, the insured is not working because of layoff, employer termination, general strike, unionized labor dispute or lockout, his or her job immediately before such action.

(**Coverage is provided under policy form No. GR-9051-1** if renewable sickness benefits are included, **GR-9051-2** if renewable accident only benefits are provided, **GR-9051-3** if non-renewable sickness benefits are included or **GR-9051-4** if non-renewable accident only benefits are provided. 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.)

THE RENEWAL AND TERMINATION CONDITIONS

A short-term policy will terminate at 12:01 A.M. on the termination date shown in the policy application.

A renewable policy may be renewed without consent for future terms of one year each by payment of the premium due at the rates in effect at the time of renewal. We may terminate the policy (subject to certain conditions in WV) at 12:01 A.M. on any renewal date by giving the plan sponsor 31 days (60 days in LA, NV or WI) prior written notice.

An insured's coverage will end on the first of these to occur:
– when he or she is no longer an eligible person
– the date to which premium has been paid
– or the termination date of the policy.

Termination of coverage will not affect a claim which occurs before the coverage ends.

(ATTACH POLICY APPLICATION TO THE APPROPRIATE PREMIUM REPORT AND REMIT TO US)

PREMIUM REPORT*

This report must be completed when individual DAILY premiums are used for Application to be accepted.

Age Range of Participants (not staff):

_____ to _____ years of age

*** Not required if policy is renewable and has "in arrears" billings.**

Covered Activity(ies)	Date(s) of Activity(ies)	Daily Premium Rate		Total Number of Days		Total Premium per Eligible Person		Maximum Number of Eligible Persons		Premium Due
________	________	$ ________	×	________	=	$ ________	×	________	=	$ ________
________	________	$ ________	×	________	=	$ ________	×	________	=	$ ________
________	________	$ ________	×	________	=	$ ________	×	________	=	$ ________
________	________	$ ________	×	________	=	$ ________	×	________	=	$ ________

Total premium due (subject to policy minimum*) .... $____________________

If renewable, the estimated number of eligible persons per billing frequency is ______________.

***The minimum premium per policy term is $225 for primary medical coverage and $175 for excess medical coverage.**

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.**

____________________ by ____________________

Date — Applicant's Signature and Title

Day Telephone Number — Fax Number

E-mail Address

Note: If additional space is required, use a separate sheet. For authorized checking account withdrawal (also called Automated Clearing House "ACH") call 1-800-525-8669, option 5.

PREMIUM REPORT*

This report must be completed when term (MONTHLY, QUARTERLY, SEMI-ANNUAL, ANNUAL) premiums are used for Application to be accepted.

Age Range of Participants (not staff):

_____ to _____ years of age

*** Not required if policy is renewable and has "in arrears" billings.**

Covered Activity(ies)	Number of Eligible Persons		Premium Rates per Eligible Person		Premium Due
____________________	________	×	$ ________	=	$ ________
____________________	________	×	$ ________	=	$ ________
____________________	________	×	$ ________	=	$ ________

Total premium due (subject to policy minimum*) .... $____________________

If renewable, the estimated number of eligible persons per billing frequency is ______________.

***The minimum premium per policy term is $225 for primary medical coverage and $175 for excess medical coverage.**

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.**

____________________ by ____________________

Date — Applicant's Signature and Title

Day Telephone Number — Fax Number

E-mail Address

Note: If additional space is required, use a separate sheet. For authorized checking account withdrawal (also called Automated Clearing House "ACH") call 1-800-525-8669, option 5.

PREMIUM REPORT*

This report **must** be completed when **BOXING AND/OR WRESTLING BOUT premiums** are used for Application to be accepted.

Age Range of Participants (not staff):

_____ to _____ years of age

*** Not required if policy is renewable and has "in arrears" billings.**

Covered Activity	Number of Bout(s)*	Number of Participants per Bout	Number of Individual Bouts	Premium Rate per Bout	Premium Due
______	______	x ______	= ______	× $ ______	=$______
______	______	x ______	= ______	× $ ______	=$______
______	______	x ______	= ______	× $ ______	=$______

Total premium due (subject to policy minimum*) .... $______

***The minimum premium per policy term is $225 for primary medical coverage and $175 for excess medical coverage.**

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 individual bouts 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.**

______ Date by ______ Applicant's Signature and Title

______ Day Telephone Number ______ Fax Number

______ E-mail Address

Note: If additional space is required, use a separate sheet. For authorized checking account withdrawal (also called Automated Clearing House "ACH") call 1-800-525-8669, option 5.

PREMIUM REPORT*

This report **must** be completed when **HOURLY premiums** are used for Application to be accepted.

Age Range of Participants (not staff):

_____ to _____ years of age

*** Not required if policy is renewable and has "in arrears" billings.**

Covered Activity	Number of Participant Exposure Hours	Hourly Premium Rate	Premium Due Subject to Policy Minimum*
______	______	× $ ______	=$______

If renewable, the estimated number of eligible persons per billing frequency is ______.

***The minimum premium per policy term is $225 for primary medical coverage and $175 for excess medical coverage.**

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 participant exposure hours 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.**

______ Date by ______ Applicant's Signature and Title

______ Day Telephone Number ______ Fax Number

______ E-mail Address

Note: If additional space is required, use a separate sheet. For authorized checking account withdrawal (also called Automated Clearing House "ACH") call 1-800-525-8669, option 5.