

**NATIONWIDE LIFE INSURANCE COMPANY
NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY
Columbus, Ohio 43215-2220**

Policy No. _____

Policy Adjustment to an Existing Life Insurance Policy And Reinstatement

Policy Conversion to Individual Life Policy

This Application should be used for the following in-force policy changes

- | | | |
|---|---|--|
| <input type="checkbox"/> Change Death Benefit Option | <input type="checkbox"/> Change Premium or Mode | <input type="checkbox"/> Change Tobacco Status |
| <input type="checkbox"/> Decrease Face Amount or Specified Amount | <input type="checkbox"/> Increase Specified Amount | <input type="checkbox"/> Rate Reduction (Table/Flat Extra) |
| <input type="checkbox"/> Reinstatement Policy | <input type="checkbox"/> Riders and Benefits: add, increase, reduce, remove | <input type="checkbox"/> Other _____ |

***If Premium or Beneficiary/Ownership changes are the ONLY changes being made, do NOT use this form. Please use the "Beneficiary/Ownership Change" form**

Should you have questions or need assistance, please contact us on our application help-line at 866-678-LIFE (5433). Hours of operations: 8:00 a.m. to 9:00 p.m., Monday through Friday Eastern Standard Time.

Provide the customer with a copy of all forms, retain a copy for your files, and mail the originals to the Home Office:

Regular Mail
Nationwide Financial
Life Underwriting
P.O. Box 182835
Columbus, OH 43218-2835

Overnight Mail
Nationwide Financial
Life Underwriting, RR1-04-D4
5100 Rings Road
Dublin, OH 43017-1522

Medical and Financial Underwriting Requirements – If applicable, you will be notified of any medical or financial requirements needed to complete the underwriting of the requested change, The underwriter may order a report from the proposed insured's attending physician if it is determined that this information is.

Have the Medical Underwriting Requirements been ordered? Yes No

If yes, which paramedical provider? _____ Date Scheduled _____

Producers Certificate

"Insured" refers to the person whose insurance coverage is being adjusted. It is not necessary to complete the Producer's Certificate when coverage's are only being removed or reduced.

Name of Insured _____ SSN _____

Other _____

Marital Status _____ Annual Income _____ Net Worth _____

Was everyone proposed for insurance present at the time of application? Yes No

If no, please explain _____

Producer's Name (please print) _____

Date _____ Firm _____

Phone Number _____ Fax Number _____

Email Address _____

INSTRUCTIONS FOR COMPLETING THE CONVERSION AND POLICY ADJUSTMENT APPLICATION

Filling Out The Application For Conversions

PART A – Sections 1 through 4

- Fully complete Section 1 (and sections 2 and 3 if applicable).
- Fully complete Section 4.

PART A – Sections 5 through 7

- Fully complete Section 5, provide all applicable policy numbers being converted.
- Fully complete Section 6, write in name of the product and fully complete based on plan chosen. Indicate premium submitted and complete planned premium and mode (Check plan for availability)
- **The beneficiary, Section 7, must be completed as the conversion revokes the designation in effect on the existing term coverage.** This must be completed even if the beneficiary is to be the same as on the original policy.
- Term conversions are not issued on a COD basis. If premium will be paid by Electronic Fund Transfer, Section 8l, must be completed and at least three months premium along with a voided check or deposit slip are required.
- Riders –check plan for availability– **riders** (except for the spouse rider), **which are currently in force on the policy and eligible on the new plan, subject to evidence of insurability will be carried over unless requested that they be removed.** If adding new riders and or to carry over the spouse rider complete the policy adjustment section of this application. If not converting current riders indicate in section 8m.
- To add the Waiver of Monthly Deductions / Waiver of Premium Rider to the new policy, please complete the Policy Adjustment section. A conversion policy will not be issued with the Waiver of Monthly deduction, if the insured requesting the converted policy is totally disabled at the time of application for conversion of the term coverage.

PART C –

- This section must be completed on all applications.
- The new policy or rider will be issued at the attained age as of the date of the Application.
- Follow replacement regulations for the state in which the new application is signed in.
- Signatures – Conversions – If an individual other than the insured under this conversion owns the coverage being converted, then the Owner's signature is required in addition to the Insured's. If the original policy is assigned, the assignee must sign, or we must receive a Release of Assignment

PART D –

- This should be detached and left with the applicant

Filling Out The Application For Policy Adjustments

PART A – Sections 1 through 4

- Fully complete Section 1 (and sections 2 and 3 if applicable).
- Fully complete Section 4 if requesting increase in coverage.

PART B –

- The questions in this part should be answered by any adult (or for any child) whose coverage is being considered for policy reinstatement, rate reduction, or any increase in coverage. The Primary Insured should answer all questions in PART B on any reinstatement, rate reduction, rider addition, or policy increase.
- Complete Section 8 for the policy change requested. Be certain to indicate the Amount of coverage desired where applicable. Note: complete PART B for all applicants were requested.
- **Reinstatements** – check 8a and complete PART B of this application for all applicants
- **Rate Reductions** (Table and Flat Extra)– check 8b, and fully complete PART B of this application
- **Riders and Benefits – Check Plan for Availability**, Complete PART B for the primary insured and the person or persons to be covered.
- **Note:** Children born or legally adopted after the effective date of a policy that has an in force child rider are automatically covered. Please provide name, date of birth and social security number. If adopted please provide date of adoption.
- Policy adjustment from Tobacco to Nontobacco class may only be made on Universal Life, Variable Universal Life and Guaranteed Term Products.
- Specified Amounts may only be increased on Universal Life, Variable Universal Life products.
- Long Term Care Rider; submit the Long Term Care supplement in addition to this application

PART C –

- This section must be completed on all applications.
- The new policy or rider will be issued at the attained age as of the date of the Application.
- Follow replacement regulations for the state in which the new application is written.
- Signatures – Adjustments – All requests for policy changes must be signed by the primary insured, and the owner of the policy if someone other than the primary insured.

PART D –

- This should be detached and left with the applicant

***If Premium or Beneficiary/Ownership changes are the ONLY changes being made, do not use this form. Use the “Beneficiary/Ownership Change” form.**

Questions should be addressed to the application Help-Line at 866-678-LIFE (5433)

NATIONWIDE LIFE INSURANCE COMPANY
 NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY

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

Application for Conversions/Policy Adjustments to an Existing Life Insurance Policy

Print current Policy Number and the Primary Insured's Full Name below.

PART A

Policy Number _____

1. PROPOSED PRIMARY INSURED							
a. Name (First, MI, Last)					b. Social Security Number - -		
c. Residence Street Address (include city, state and zip code)							
d. County			e. Date of Birth			f. State of Birth	
g. Sex <input type="checkbox"/> M <input type="checkbox"/> F		h. Age	i. Marital Status			j. Driver's License # and State of Issue	
k. Telephone (Home) ()		l. Best time to call _____ A.M. / P.M.		m. Telephone (Business) ()		n. Best time to call _____ A.M. / P.M.	
o. Occupation			p. Employer			q. Height	r. Weight

2. PROPOSED INSURED (JOINT/SPOUSE/CHILDREN) (Complete if applicable.)								
NAME OF INSURED(S)	DATE OF BIRTH	AGE	SEX	HEIGHT	WEIGHT	STATE OF BIRTH	SOCIAL SECURITY NUMBER - -	RELATIONSHIP TO INSURED
							- -	
							- -	
							- -	
							- -	

3. JOINT/SPOUSE PROPOSED INSURED ADDITIONAL INFORMATION (Complete if applicable.)							
a. Residence Street Address (include city, state and zip code)							
b. Driver's License # and State of Issue			c. County			d. Marital Status	
e. Can you read and understand English? <input type="checkbox"/> Yes <input type="checkbox"/> No		f. Citizenship (If other, submit Foreign Supplement.) <input type="checkbox"/> U.S. <input type="checkbox"/> Canada <input type="checkbox"/> Other			g. How long have you been in the U.S.?		
h. Telephone (Home) ()		i. Best time to call _____ A.M. / P.M.		j. Telephone (Business) ()		k. Best time to call _____ A.M. / P.M.	
l. Former Name (if applicable)			m. Occupation			n. Employer	

4. INSURANCE INFORMATION							
a. Will the insurance applied for replace existing Life Insurance or Annuities on any person proposed for coverage? If "yes", state person, company, policy number, and amount. Yes No <input type="checkbox"/> <input type="checkbox"/>							
* Submit All Required State Forms.							
b. List all Life Insurance now in force on each person proposed for Life Insurance. If none, write "NONE".							

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

(IF YOU ARE APPLYING FOR A CONVERSION, PLEASE FILL OUT THIS SECTION.)

5. APPLICATION TO CONVERT INDIVIDUAL OR GROUP TERM INSURANCE FROM: *(Check one of the following.)*

- a. Individual Term Insurance Policy No(s) _____, and/or
 b. Individual Term Insurance Rider(s) attached to Base Policy No(s) _____, and/or
 c. Individual Term Insurance for: Spouse Child Additional Insured *(check which)* now covered on a
 Spouse Rider Children's Rider Family Rider Additional Insured Rider *(check which)* on Policy
 No. _____. If the Spouse is being converted from a Family Rider, or one Child is being converted
 from a Children's Rider, is a Children's rider to be retained? Yes No and/or
 d. Group Policy No. _____ Group Certificate No. _____
 issued to *(Name of Employer)*: _____
- e. If not converting the full amount of term insurance, will the remaining term insurance remain in force?..... Yes No
- f. The Waiver of Monthly Deduction/Waiver of Monthly Premium Rider is not available if the Proposed Insured is totally disabled at the time this conversion application is made. Is the Proposed Insured now totally disabled? Yes No

6. LIFE INSURANCE PLAN

a. Plan *(If a Variable Life product is being applied for, the Variable Life Fund Supplement **MUST** be completed in conjunction with this application.)*

b. Total Specified/Face Amount <i>(including Additional Protection Rider)</i>		c. Additional Protection Rider Amount <i>(Individual-Life case only)</i>	d. Supplemental Coverage Percentage <i>(Survivorship case only)</i>
e. Initial Premium Deposit <i>(paid with application)</i> \$ _____	f. Planned Premium <i>(Check plan for availability.)</i> <input type="checkbox"/> Single Premium \$ _____ <input type="checkbox"/> Annual \$ _____ <input type="checkbox"/> Monthly EFT <i>(Complete Part 8I.)</i>		<input type="checkbox"/> Semi-Annual \$ _____ <input type="checkbox"/> Quarterly \$ _____ <input type="checkbox"/> _____ \$ _____

FOR INDIVIDUAL VARIABLE UNIVERSAL LIFE PLAN ONLY *(Check plan for availability.)*

- g. Death Benefit Option *(If no option is selected here, Option 1 is elected.)*
 Option 1 *(The Specified Amount, or a multiple of the Cash Value, whichever is greater.)*
 Option 2 *(The Specified Amount, plus the Cash Value, or a multiple of the Cash Value, whichever is greater.)*
 Option 3 *(The Specified Amount, plus the Premium Accumulation at _____% interest or a multiple of the Cash Value, whichever is greater.)*
- h. Internal Revenue Code Life Insurance Qualification Test *(If no selection is made here, Guideline Premium/Cash Value Corridor Test is elected.)*
 Guideline Premium/Cash Value Corridor Test Cash Value Accumulation Test
- i. Optional Benefit Riders
 Accidental Death Benefit Rider \$ _____ Maturity Extension Endorsement for Specified Amount
 Adjusted Sales Load Rider Premium Waiver Rider \$ _____
 _____% *(in whole percentages only)* waived for _____ years Spouse Rider \$ _____
 Child Rider \$ _____ Waiver of Monthly Deduction Rider
 Long Term Care Rider* \$ _____ Other Rider(s) _____
 *Complete Supplement for Long Term Care Rider.

FOR UNIVERSAL LIFE PLAN ONLY *(Check plan for availability.)*

- j. 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.)*
- k. Internal Revenue Code Life Insurance Qualification Test *(If no selection is made here, Guideline Premium/Cash Value Corridor Test is elected.)*
 Guideline Premium/Cash Value Corridor Test Cash Value Accumulation Test
- l. Optional Benefit Riders
 Accidental Death – Amount \$ _____ Maturity Extension Endorsement for Specified Amount
 Child Rider \$ _____ Spouse Rider \$ _____
 Guaranteed Option to Increase Specified Amount \$ _____ Waiver of Monthly Deduction Rider
 Lapse Protection Rider Other Rider(s) _____
 Long Term Care Rider* \$ _____
 *Complete Supplement for Long Term Care Rider.

FOR WHOLE LIFE PLAN ONLY *(Check plan for availability.)*

- m. Optional Benefit Riders
 10 Year Spouse Rider \$ _____ Guaranteed Insurability – Amount \$ _____
 20 Year Spouse Rider \$ _____ Owner's Death *(Complete Part A Section 2, Part B)*
 Accidental Death – Amount \$ _____ Owner's Death or Disability *(Complete Part A Section 2, Part B)*
 Child Rider \$ _____ Waiver of Premium Benefit
 Excess Credit Option _____ Other Rider(s) _____

If available, issue with Automatic Premium Loan, unless indicated by checking this box.

7. BENEFICIARY DESIGNATIONS (If Joint Plan, specify each Primary Insured's beneficiary designation—use space provided on #8m, if necessary. When more than one beneficiary is designated, 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. If the Beneficiary is a Trust, complete the Trust Information Section below.)

%	PRIMARY	CONTINGENT	BENEFICIARY NAME	DATE OF BIRTH	RELATIONSHIP TO INSURED(S)	SOCIAL SECURITY NUMBER
a. Proposed Primary Insured						
	<input type="checkbox"/>	<input type="checkbox"/>				- -
	<input type="checkbox"/>	<input type="checkbox"/>				- -
	<input type="checkbox"/>	<input type="checkbox"/>				- -
b. Proposed Insured (Joint/Spouse)						
	<input type="checkbox"/>	<input type="checkbox"/>				- -
	<input type="checkbox"/>	<input type="checkbox"/>				- -
	<input type="checkbox"/>	<input type="checkbox"/>				- -
c. Trust Information						
EXACT NAME OF TRUST			TRUST TAX ID NUMBER	CURRENT TRUSTEE(S)		DATE OF TRUST

(IF YOU ARE APPLYING FOR A POLICY ADJUSTMENT, PLEASE FILL OUT THIS SECTION.)

8. POLICY ADJUSTMENTS

- a. REINSTATE POLICY (See Policy Reinstatement Provisions.) – Complete Parts A and B for all covered persons.
- b. RATE REDUCTION (TABLE/FLAT EXTRA) – Remove or reduce rating on _____ (rated insured person, plan) For all rate reductions, complete Part B (list the physicians with the most current information on the related condition) and all of Part B for the person who is rated-up. For occupational ratings, provide details of new occupation in Part A, Section 1 or 3. Attach an Aviation Questionnaire or Hazardous Activities Questionnaire when applicable.
- c. RIDERS and BENEFITS – When adding or increasing a rider, always complete Part A and B on the Primary Insured and on the person or persons covered by the rider (if someone other than the Primary Insured). CHECK PLAN FOR AVAILABILITY.

	ADD Rider or Benefit for	REDUCE Existing Rider / Benefit to	REMOVE Rider or Benefit
1) Spouse Rider – Complete Part A, Section 2 and all of Part B.	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____	<input type="checkbox"/>
2) Child's Rider – Complete Part A, Section 2 and all of Part B.	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____	<input type="checkbox"/>
3) Waiver of Premium / Waiver of Monthly Deduction	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____	<input type="checkbox"/>
4) Premium Waiver (VUL only)	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____	<input type="checkbox"/>
5) Accidental Death Benefit / Rider	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____	<input type="checkbox"/>
6) GIB / GOISA	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____	<input type="checkbox"/>
7) Owner's Death Benefit – Complete Part A, Section 2, Part B.	<input type="checkbox"/> (Whole Life only)	XXXXXX	<input type="checkbox"/>
8) Owner's Death or Disability Benefit – Complete Part A, Section 2, Part B.	<input type="checkbox"/> (Whole Life only)	XXXXXX	<input type="checkbox"/>
9) Long Term Care (Complete supplement.)	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____	<input type="checkbox"/>

Other Riders Give full rider name, face amount, term interest rate, etc., where applicable.

- 10) _____ \$ _____ \$ _____
- d. Change Tobacco class to Non-Tobacco class. Complete Part A, Question 1 and all of Part B for the Insured whose class is to be changed. (Not available on all products.)
- e. Add Child to an in force Child's Rider – Complete Part A, Section 2 and all of Part B. (Complete for any child to be added that was not born or legally adopted after the effective date of the Rider.)
- f. Increase Specified Amount to \$ _____ Complete Part A and all of Part B. (Available on UL and VUL only. Minimum \$10,000.)
- g. Decrease Face Amount or Specified Amount to \$ _____
- h. Change Planned Periodic Premium to \$ _____ (Available on UL and VUL only.)
- i. Change Premium Payment Mode to: A SA Q Other _____ EFT (Complete #8l Authorization Section.)
- j. Change to Reduced Paid Up or Extended Term Insurance \$ _____ (Available on WL only.)
- k. Change to Death Benefit Option (Available on VL and UL only.)
 - From Option 1 Level to Option 2 Increasing
 - From Option 2 Increasing to Option 1 Level

l. Electronic Funds Transfer Authorization

Financial Institution Name: _____

Financial Institution Address: _____

Financial Institution Phone Number: _____

Account Number: _____ Transit/ABA Number: _____

Monthly EFT Amount \$ _____ *Checking (*Attach a pre-printed Voided Check. Starter Checks will not be accepted.*)

Draft Date _____ *Savings (*Attach a Voided Deposit Slip with account number and routing number.*)

By providing my financial institution name and account information, I hereby authorize Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company (*hereafter called the "Company"*) to initiate debit entries to my checking/savings account indicated above and the Financial Institution to debit the same such account.

m. Other Policy Adjustments:

DO NOT SEND POLICY.

*If Premium or Beneficiary/Ownership changes are the ONLY changes being made, do NOT use this form.
Use the "Life Policyowner's Service Request" form.*

9. TAXPAYER IDENTIFICATION NUMBER

Under the Interest and Dividend Compliance Act of 1983, persons owning insurance policies are required to provide the Company with certification that their taxpayer identification number (TIN) is correct. (Your TIN will either be your Social Security Number or Employer Identification Number.) If you do not provide us with certification of this number, you may be subject to a \$50 penalty imposed by the Internal Revenue Service. In addition, backup withholding from interest and other payments we make to you will be done in accordance with the requirements of the Internal Revenue Code. It is not an additional tax, since the amount withheld may be applied against any tax you owe. If withholding results in an overpayment of taxes, a refund may be available.

Check this box if the Internal Revenue Service has notified you that you are subject to backup withholding.

Otherwise, your signature on this application is certification that the taxpayer identification number on this application is true, correct, and complete. The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

10. NOTICE

The following fraud statement is for Applicants in the state(s) of: OHIO.

Fraud Statement: 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, is guilty of insurance fraud.

PART B

Complete this part of the application only if evidence of insurability is required. The questions in this part should be answered by any adult (or for any child) whose coverage is being considered for policy reinstatement, rate reduction, or any increase in coverage. The Primary Insured should answer all questions in Part B on any reinstatement, rate reduction, rider addition, or policy increase.

11. PERSONAL INFORMATION						
All questions are to be answered by each Proposed Insured. For each yes answer, provide details below.	PROPOSED INSURED		JOINT/SPOUSE PROPOSED INSURED		ANY CHILD	
	Yes	No	Yes	No	Yes	No
a. Have you ever had any application for Life or Health Insurance (or for reinstatement for Life or Health Insurance) declined, postponed, rated-up or limited? (If yes, provide details.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Have you ever applied for or received disability payments for any illness or injury? (If yes, provide details.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. 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, bungee jumping, or any type of body-contact or life-threatening sport? (If yes, complete an Aviation/Hazardous Activities Questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Have you ever had your driver's license suspended or revoked; or been convicted of driving while impaired or intoxicated, or been convicted in the past 3 years of more than one moving violation? (If yes, provide details.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. 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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Have you ever been charged with a violation of any criminal law? (If yes, provide details.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Have you had any bankruptcies in the past 7 years or have any suits or judgments pending against you at this time? (If yes, provide details.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Do you plan to travel or reside outside of the United States or Canada? (If yes, complete Supplement for Foreign Nationals or Travel.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Do you belong to or intend to join any active or reserve military or naval organization? (If yes, complete Military Status Questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Do you have a parent or sibling who died from cancer or cardiovascular disease prior to age 60? (If yes, provide relationship to Proposed Insured(s), age at death and cause of death, and if cancer, provide type.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Details of any yes answers (indicate name of person). (If more space is needed, an additional blank sheet may be attached.):						
12. TOBACCO USE						
a. PROPOSED INSURED:						
Have you used tobacco or nicotine in any form in the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No Last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No						
If yes, specify the form of tobacco or nicotine products used. <input type="checkbox"/> cigarettes <input type="checkbox"/> pipe <input type="checkbox"/> cigars <input type="checkbox"/> chewing tobacco <input type="checkbox"/> snuff						
<input type="checkbox"/> other tobacco <input type="checkbox"/> nicotine products (gum, patch, etc.)						
b. JOINT/SPOUSE PROPOSED INSURED:						
Have you used tobacco or nicotine in any form in the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No Last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No						
If yes, specify the form of tobacco or nicotine products used. <input type="checkbox"/> cigarettes <input type="checkbox"/> pipe <input type="checkbox"/> cigars <input type="checkbox"/> chewing tobacco <input type="checkbox"/> snuff						
<input type="checkbox"/> other tobacco <input type="checkbox"/> nicotine products (gum, patch, etc.)						
13. PERSONAL PHYSICIANS						
	PROPOSED INSURED	JOINT/SPOUSE PROPOSED INSURED		ANY CHILD		
Name of Personal Physician:						
Address:						
Telephone Number:						
Date last consulted:						
Reason last consulted:						
Treatment given or medication prescribed.						

PART C

17. CONVERSIONS

I agree that:

- A. The new policy applied for will be in force as of the date of conversion; and the original policy or rider will end on that date, except where a part of the original coverage is to remain in force; if
 - 1) The new policy meets the conversion rules of the original policy; and
 - 2) The first full premium for the new policy has been paid.
- B. The Suicide Clause and the Incontestability Clause of the new policy shall run from the issue date of the original policy or rider; except for increases in specified amount or additional riders issued as applied for in Part A, Section 8, in which case the Suicide Clause and Incontestability Clause shall run from the issue date of the new policy; and except that the Waiver of Monthly Deduction or Waiver of Premium Rider may be removed from the policy at any time if the Insured was totally disabled at the time of conversion.
- C. Copies of the original policy or rider application and of this application shall be made a part of the new policy.

18. AGREEMENT, AUTHORIZATION AND SIGNATURES

I have read this application. I understand each of the questions. All of the answers and statements on this form are complete and true to the best of my knowledge and belief. I understand and agree that:

- A. This application, any amendments to it, and any related medical examinations will become a part of the Policy Contract.
- B. No medical examiner, 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.
- C. That any additional premium cost resulting from this adjustment will be added to the premium due.
- D. That any policy adjustment here applied for will not be in effect until this application is approved by Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company in its Home Office in Columbus, Ohio.

The applicant has a right to cancel this application at any time by contacting their agent or Nationwide in writing. I have received the pre-notice form of the Fair Credit Reporting act of 1970 and the Medical Information Bureau disclosure form. I certify that the Social Security Number given is correct and complete.

I authorize: any licensed physician or medical practitioner; any hospital, clinic, pharmacy or other medical or medically related facility; any insurance company; the Medical Information Bureau; or any other organization, institution or person who has knowledge of me; to give that information to the Medical Director of the Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company, or its reinsurers, for the purpose of underwriting my application in order to determine eligibility for Life Insurance and to investigate claims. By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization; and I instruct any physician; health care professional; hospital; clinic; medical facility; or other health care provider to release and disclose my entire medical record without restriction. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer be covered by federal rules governing privacy and confidentiality of health information. This authorization, or a copy of it, will be valid for a period of not more than two and one-half years (30 months) from the date it was signed. I understand that I have the right to revoke this authorization in writing, at anytime, by sending a written request for revocation to Nationwide Life Insurance Company/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 authorization; or to the extent that Nationwide Life Insurance Company/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 authorization to release my complete medical records, Nationwide Life Insurance Company/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 authorization by sending a request to Nationwide in writing.

Signed at _____, on _____, _____.
City/State Month/Day Year

I have truly and accurately recorded all Proposed Insured's answers on this application and have witnessed his/her/their signature(s) hereon. To the best of my knowledge, the insurance applied for will will not (CHECK ONE) replace any life insurance, and/or annuity.

Producer's Name (please print)

Producer's Signature

Firm

Producer's Nationwide Number

Social Security Number

Name of Proposed Insured (please print)

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

Name of Joint/Spouse Proposed Insured (please print)

Signature of Joint/Spouse Proposed Insured (if to be Insured)

Signature of Applicant/Owner (if other than the Insured)

**IMPORTANT NOTICE
DETACH AND GIVE TO PROPOSED INSURED**

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:

1. 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
2. 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.
3. 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 Insurance Company/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.

MEDICAL INFORMATION BUREAU DISCLOSURE NOTICE

Information regarding your insurability will be treated as confidential. Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company, or its reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

Nationwide Life Insurance Company/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.

NATIONWIDE LIFE INSURANCE COMPANY
 NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY

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

VARIABLE LIFE FUND SUPPLEMENT

PROPOSED INSURED NAME *(please print)*

SOCIAL SECURITY NUMBER

1. SUITABILITY *(Must be answered to issue policy.)*

	Yes	No
a. Do you understand that the Death Benefit and Surrender Value may increase or decrease depending on the investment experience of the Variable Account?.....	<input type="checkbox"/>	<input type="checkbox"/>
b. Do you believe that this policy will meet your insurance needs and financial objectives?	<input type="checkbox"/>	<input type="checkbox"/>
c. Have you received a current copy of the prospectus?	<input type="checkbox"/>	<input type="checkbox"/>

2. ALLOCATIONS

FOR CONTRACTS ISSUED IN STATES WHICH REQUIRE A RETURN OF PREMIUM TO A POLICY OWNER EXERCISING THE SHORT TERM RIGHT TO CANCEL; NET PREMIUMS WILL BE ALLOCATED TO THE GARTMORE GVIT MONEY MARKET FUND OR TO THE FIXED ACCOUNT IF SELECTED UNTIL THE END OF THE RIGHT TO CANCEL PERIOD. AT THE END OF THIS PERIOD, YOUR CONTRACT VALUE WILL BE ALLOCATED TO THE SUBACCOUNTS INDICATED BELOW. FOR STATES REQUIRING A RETURN OF CASH VALUE YOUR NET PREMIUM WILL BE ALLOCATED TO THE SUBACCOUNTS AT THE BEGINNING OF THE SHORT TERM RIGHT TO CANCEL PERIOD. YOUR SELECTIONS MUST TOTAL 100%. MINIMUM INITIAL ALLOCATION TO ANY SINGLE SUBACCOUNT IS 1%. NO FRACTIONAL PERCENTAGES. THESE PERCENTAGES WILL APPLY IN FUTURE YEARS BUT MAY BE CHANGED AT ANY TIME BY THE POLICY OWNER. (IF NO ALLOCATION INDICATED, MONEY MARKET WILL BE AUTOMATICALLY SELECTED.)

AIM VI (Series I)

- ____ % Basic Value Fund
- ____ % Capital Appreciation Fund
- ____ % Capital Development Fund

AMERICAN CENTURY

- ____ % VP Inflation Protection Fund - Class II
- ____ % VP International – Class I
- ____ % VP Ultra – Class I
- ____ % VP Value – Class I

MFS® VIT (Initial Class)

- ____ % Investors Growth Stock Series
- ____ % Value Series

OPPENHEIMER (Initial Class)

- ____ % Capital Appreciation Fund/VA
- ____ % Global Securities Fund/VA
- ____ % High Income Fund/VA
- ____ % Main Street® Fund/VA
- ____ % Main Street® Small Cap Fund/VA

PUTNAM VT (Class IB)

- ____ % Growth & Income Fund
- ____ % Voyager Fund

VAN KAMPEN (Class I)

- ____ % Core Plus Fixed Income Port.
- ____ % U. S. Real Estate Port.

FEDERATED (Primary Shares)

- ____ % Quality Bond Fund II

FIDELITY (Service Class)

- ____ % VIP Equity-Income Port.
- ____ % VIP Growth Port.
- ____ % VIP Overseas Port.
- ____ % VIP II Contrafund Port.
- ____ % VIP II Investment Grade Bond Port.
- ____ % VIP III Mid Cap Port.
- ____ % VIP III Value Strategies Port.

FRANKLIN TEMPLETON VIPT (Class I)

- ____ % Foreign Securities Fund
- ____ % Rising Dividends Securities Fund
- ____ % Small Cap Value Securities Fund

GARTMORE GVIT

- ____ % Emerging Markets Fund
- ____ % Global Health Sciences Fund – Class I
- ____ % Global Technology and Communications Fund
- ____ % Government Bond Fund
- ____ % Mid Cap Growth Fund – Class I
- ____ % Money Market Fund
- ____ % Nationwide® Fund – Class I
- ____ % U. S. Growth Leaders Fund – Class I

NEUBERGER BERMAN AMT

- ____ % Fasciano Port. – Class S
- ____ % Limited Maturity Bond Port. – Class I
- ____ % Socially Responsive Port.

DREYFUS

- ____ % Small Cap Stock Index Port. – Service Class
- ____ % Stock Index Fund – Initial Shares
- ____ % VIF Appreciation Port.

GARTMORE GVIT INVESTOR DESTINATIONS

- ____ % Aggressive Fund - Class II
- ____ % Conservative Fund - Class II
- ____ % Moderate Fund - Class II
- ____ % Moderately Aggressive Fund - Class II
- ____ % Moderately Conservative Fund - Class II

GARTMORE GVIT SUBADVISED FUNDS

- Fund Name (Subadviser)
- ____ % Comstock Value Fund (Van Kampen)
- ____ % High Income Bond Fund (Federated)
- ____ % International Value Fund – Class I (Dreyfus)
- ____ % Mid Cap Index Fund (Dreyfus)
- ____ % Multi Sector Bond Fund – Class I (Van Kampen)
- ____ % Small Cap Growth Fund – Class I (Multi Managers)
- ____ % Small Cap Value Fund (Multi Managers)
- ____ % Small Company Fund (Multi Managers)

NATIONWIDE LIFE INSURANCE CO.

- ____ % Fixed Account

OTHER AVAILABLE FUNDS

- ____ % _____
- ____ % _____
- ____ % _____

3. OPTIONAL ELECTIONS

	Yes	No
a. Do you elect that monthly cost of insurance charges be deducted solely from the Money Market Fund as long as it is adequately funded?	<input type="checkbox"/>	<input type="checkbox"/>
b. Do you elect Automated Dollar Cost Averaging? (If yes, complete Automated Dollar Cost Averaging form.)	<input type="checkbox"/>	<input type="checkbox"/>
c. Do you elect Asset Rebalancing? (If yes, complete Asset Rebalancing form.)	<input type="checkbox"/>	<input type="checkbox"/>

4. IMPORTANT NOTICE

I UNDERSTAND THAT THE DEATH BENEFIT UNDER A VARIABLE LIFE INSURANCE POLICY MAY INCREASE OR DECREASE, DEPENDING ON THE INVESTMENT RETURN ON THE SUBACCOUNT(S) I SELECT. REGARDLESS OF INVESTMENT RETURN, THE DEATH BENEFIT CAN NEVER BE LESS THAN THE SPECIFIED AMOUNT, AS LONG AS THE POLICY IS IN FORCE. THE CONTRACT VALUE MAY INCREASE OR DECREASE ON ANY DAY, DEPENDING ON THE INVESTMENT RETURN FOR THE POLICY. NO MINIMUM CONTRACT VALUE IS GUARANTEED. ON REQUEST, WE WILL FURNISH ILLUSTRATIONS OF BENEFITS, INCLUDING DEATH BENEFITS AND CONTRACT VALUES FOR A VARIABLE LIFE INSURANCE POLICY AND A FIXED LIFE INSURANCE POLICY FOR THE SAME PREMIUM.

Signed at _____ on _____, _____
City and State Month Day Year

Signature of Producer

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

Signature of Applicant/Owner (if other than Primary Insured)

Signature of Joint/Spouse Proposed Insured (if to be Insured)