

INSTRUCTIONS TO PRODUCER

Filling Out Application

- Completely fill out forms including the "Application Information" page
- Complete Life Financial Supplement or provide financial statements justifying the amount for the following cases:
 - Specified amount of \$1,000,000 or more for ages 18 – 70
 - Specified amount of \$100,000 or more ages 71+
- Have the client sign **PART C**
- If applicable, check the appropriate box(es) in the Life Insurance Plan section on the application and indicate the amount of benefit. Check Rider Reference section for riders and optional benefits available on each product.

Ordering Medical Requirements

- Nationwide Underwriting may be able to order the necessary medical requirements for you but contacting the paramedical provider yourself at the time of application can speed the process.
- The medical underwriting requirements are based on each Proposed Insured's age and face amount of coverage, and should be ordered through one of the Nationwide authorized paramedical providers:

American Para Professional Systems (APPS)	800-635-1677
Examination Management Systems, Inc. (EMSI)	800-USA-EMSI (872-3674)
Exam One	800-333-9947
Portamedic	800-782-7373
- When determining the medical requirements for age and amount, "AMOUNT" is equal to the amount of insurance applied for currently, plus any amount of insurance placed in force within the past 3 years with Nationwide.
- Nationwide Underwriting may request a report from the proposed insured(s)'s attending physician if it is determined that this information is needed to assess the risk.

Providing Temporary Agreement

Temporary Agreement, **Part E**, should be given to the applicant except in the following situations:

1. The applicant has not paid the full first premium for the mode selected at the time of application. Monthly modes of payment require collection of three months premium. (See "Collecting Premium" section below.)
2. The Proposed Insured(s) has/have been treated for, consulted a physician for, or diagnosed with any of the medical conditions shown on the Temporary Insurance Agreement.
3. The face amount requested exceeds \$1,000,000.

Collecting Premium

Modal premium may be collected if the Proposed Insured(s) answered "No" to all health question(s) in **PART E**. Monthly modes of payment require collection of three months premium (two months premium for UL Protector). A customer-elected draft date may impact draft start month.

Submitting Application

- Provide the customer with a copy of all forms and retain a copy for your files.
- Mail the originals to Nationwide Underwriting in the return envelope provided, or to the address below:

Regular Mail:
Nationwide Life Insurance Company
P.O. Box 182835
Columbus, OH 43218-2835

Express Mail:
Nationwide Financial Life Operations
RR1-04-D4
5100 Rings Road
Dublin, OH 43017-1522

Questions?

Please call our application help-line at **866-678-LIFE (5433)**.

Hours of operation (Eastern Time): Monday – Friday 8:00 a.m. – 9:00 p.m.

RIDER REFERENCE (check for state availability):**INDIVIDUAL VARIABLE UNIVERSAL LIFE POLICY**

▪ Accidental Death Benefit Rider	<i>Ages 5-65; Minimum: \$10,000, Maximum: base policy face amount (ages 5-14); two times the base policy face amount (ages 15-65); \$200,000 is the total maximum benefit payable (amount issued and applied for with all Nationwide companies).</i>
▪ Additional Protection Rider	<i>Ages 0-85; Minimum Total Specified Amount: \$250,000</i>
▪ Adjusted Sales Load Rider	<i>Next Gen II/Next Gen FPVUL: up to 4%. Protection FPVUL: up to 6%. In whole percentages. Adjustment Period up to 7 whole policy years</i>
▪ Child Rider	<i>Ages 0-17 (child), Ages 18-55 (primary insured); Minimum Amount: \$5,000, Maximum Amount: \$25,000</i>
▪ Long Term Care Rider	<i>Ages 21-80; 10 – 100% of the Specified Amount</i>
▪ Maturity Extension for Specified Amount	<i>Next Gen FPVUL: up to age 70. Next Gen II/Protection FPVUL: automatically included</i>
▪ Negative Charge to Earnings	<i>For business insurance only</i>
▪ Policy Guard Rider	<i>Next Gen II Only: automatically included (Not available for CVAT policies)</i>
▪ Premium Waiver Rider	<i>Ages 21-59</i>
▪ Spouse Rider	<i>Ages 21-59; Minimum Face Amount \$25,000, Maximum Face Amount \$500,000</i>
▪ Waiver of Monthly Deductions Rider	<i>Ages 15-59</i>

SURVIVORSHIP VARIABLE UNIVERSAL LIFE POLICY

▪ Adjusted Sales Load Rider	<i>Next Gen SVL: up to 5%. Protection SVL: up to 6%. In whole percentages. Adjustment Period up to 7 whole policy years</i>
▪ Estate Protection Rider	<i>Up to 122.22% of initial specified amount</i>
▪ Maturity Extension for Specified Amount	<i>Next Gen SVL: up to age 70 of the younger insured. Protection SVL: automatically included</i>
▪ Policy Guard Rider:	<i>Next Gen SVL Only: automatically included (Not available for CVAT policies)</i>
▪ Policy Split Option Rider	<i>Ages 21-79</i>

UNIVERSAL LIFE POLICY

▪ Accidental Death Benefit Rider	<i>Ages 5-65; Minimum: \$10,000, Maximum: base policy face amount (ages 5-14); two times the base policy face amount (ages 15-65); \$200,000 is the total maximum benefit payable (amount issued and applied for with all Nationwide companies).</i>
▪ Child Rider	<i>Ages 0-17 (child), Ages 18-55 (primary insured); Minimum Amount: \$5,000, Maximum Amount: \$25,000</i>
▪ Guaranteed Option to Increase Specified Amount Rider	<i>UL Protector only: Ages 18-37; Minimum: \$10,000, Maximum: \$25,000</i>
▪ Lapse Protection Rider	<i>UL Protector only at issue: Ages 18-80 Standard & Non Tobacco; Ages 18-75 Preferred & Preferred Plus</i>
▪ Long Term Care Rider	<i>Legacy Provider only: Ages 21-80; 10 – 100% of the Specified Amount</i>
▪ Maturity Extension for Specified Amount	<i>UL Protector only at issue: up to age 70. Legacy Provider UL: automatically included</i>
▪ Spouse Rider	<i>Ages 18-59 Tobacco; 21-59 Non-tobacco; Minimum Face Amount: \$25,000, Maximum Face Amount: \$100,000 on UL Protector; \$500,000 on Legacy Provider</i>
▪ Waiver of Monthly Deductions Rider	<i>Ages 15-59</i>

SURVIVORSHIP UNIVERSAL LIFE POLICY

▪ Policy Split Option Rider	<i>Ages 21-79</i>
▪ Estate Protection Rider	<i>Up to 122.22% of initial specified amount</i>
▪ Maturity Extension for Specified Amount	<i>Automatically included</i>

WHOLE LIFE POLICY

▪ 10-Year Spouse Rider	<i>Ages 18-60 (spouse & primary insured); Minimum Specified Amount: \$25,000 Standard & Non-tobacco, \$100,000 Preferred, \$250,000 Preferred Plus</i>
▪ 20-Year Spouse Rider	<i>Ages 18-50 (spouse), Ages 18-60 (primary insured); Minimum Specified Amount: \$25,000 Standard & Non-tobacco, \$100,000 Preferred, \$250,000 Preferred Plus</i>
▪ Accidental Death Benefit Rider	<i>Ages 5-65; Minimum: \$10,000, Maximum: base policy face amount (ages 5-14); two times the base policy face amount (ages 15-65); \$200,000 is the total maximum benefit payable (amount issued and applied for with all Nationwide companies).</i>
▪ Child Rider	<i>Ages 0-17 (child), Ages 17-55 (primary insured); Minimum Amount: \$5,000, Maximum Amount: \$25,000</i>
▪ Guaranteed Insurability Benefit Rider	<i>Ages 0-37: Minimum: \$10,000, Maximum: \$50,000 or the face amount of the base policy, if less.</i>
▪ Owner's Death Benefit Rider	<i>Ages 0-14 (primary insured), Ages 18-55 (policyowner)</i>
▪ Owner's Death or Disability Benefit Rider	<i>Ages 0-14 (primary insured), Ages 18-55 (policyowner)</i>
▪ Waiver of Premium Benefit Rider	<i>Ages 18-59</i>

TERM LIFE POLICY

▪ 10-Year Spouse Rider	<i>Ages 18-60 (spouse & primary insured); Minimum Specified Amount: \$25,000 Standard & Non-tobacco, \$100,000 Preferred, \$250,000 Preferred Plus (\$100,00 Preferred Plus for GLT 10,20,30)</i>
▪ 20-Year Spouse Rider	<i>Ages 18-50 (spouse), Ages 18-60 (primary insured); Minimum Specified Amount: \$25,000 Standard & Non-tobacco, \$100,000 Preferred, \$250,000 Preferred Plus (\$100,00 Preferred Plus for GLT 10,20,30)</i>
▪ Child Rider	<i>Ages 0-17 (child), Ages 18-55 (primary insured); Minimum Amount: \$5,000, Maximum Amount: \$25,000</i>
▪ Waiver of Premium Benefit Rider	<i>Ages 18-59</i>

AVAILABLE DEATH BENEFIT OPTIONS

- *All Variable Account Universal Life plans, both individual and survivorship, offer all 3 death benefit options.*
- *All Fixed Account Universal Life plans, both individual and survivorship, offer only Death Benefit Option 1 and Death Benefit Option 2*
- *There are no Death Benefit Option choices for Traditional Life plans, both whole life and term.*

AVAILABLE INTERNAL REVENUE CODE LIFE INSURANCE QUALIFICATION TESTS

- *All Variable Account Universal Life plans, both individual and survivorship, offer both Life Insurance Qualification Tests.*
- *The Nationwide Legacy Provider Universal Life offers both Life Insurance Qualification Tests*
- *There are no Life Insurance Qualification Test choices for all other Fixed Account Universal Life plans, both individual and survivorship and for Traditional Life plans, both whole life and term.*

APPLICATION INFORMATION

1. Check one, as available in your state and **write in the name of the product in Question 6a of the application under Plan.** This application should be used for:

INDIVIDUAL VARIABLE UNIVERSAL LIFE	<input type="checkbox"/> Next Generation® II FPVUL (Check for state availability) <input type="checkbox"/> Next Generation® FPVUL (Only available in states where NG II is not approved) <input type="checkbox"/> Protection SM FPVUL
SURVIVORSHIP VARIABLE UNIVERSAL LIFE	<input type="checkbox"/> Next Generation® Survivorship Variable Universal Life <input type="checkbox"/> Protection SM Survivorship Variable Universal Life
UNIVERSAL LIFE	<input type="checkbox"/> Protector® Universal Life <input type="checkbox"/> Legacy Provider Universal Life SM (Nationwide Life & Annuity Insurance Co.) <input type="checkbox"/> Survivorship Legacy Provider Universal Life SM (Nationwide Life & Annuity)
WHOLE LIFE	<input type="checkbox"/> Non-Par Whole Life paid up at 100 <input type="checkbox"/> 20-pay Whole Life
TERM LIFE	<input type="checkbox"/> 10-year Guaranteed Term <input type="checkbox"/> 20-year Guaranteed Term <input type="checkbox"/> 30-year Guaranteed Term New Term (Replacing sales of Guaranteed Term - check for state availability) <input type="checkbox"/> 10-year Guaranteed Level Term - GLT (Nationwide Life & Annuity) <input type="checkbox"/> 20-year Guaranteed Level Term - GLT (Nationwide Life & Annuity) <input type="checkbox"/> 30-year Guaranteed Level Term - GLT (Nationwide Life & Annuity)

*All products are in **Nationwide Life Insurance Company** unless otherwise noted above.*

2. Distribution Channel (select one):

Investment Dealer
 Financial Institutions

3. Have the Medical Underwriting Requirements been ordered? Yes No

If yes, which paramedical provider? _____ Date Scheduled _____

4. Other forms submitted with this application:

Required Forms	<input type="checkbox"/> HIV Consent Form <input type="checkbox"/> Additional HIV Consent Form for Joint/Spouse Rider, <i>if applicable</i> <input type="checkbox"/> Mandated State Forms, <i>required: AL, AZ, CA, CT, GA, IL, ME, MT, MS, NV, NJ, NC, NY, OR, PA, RI, VA</i> <input type="checkbox"/> Fund Supplement Form, <i>for variable life contracts only, must be signed</i> <input type="checkbox"/> Producer's Certificate <input type="checkbox"/> Illustration <input type="checkbox"/> Licensing Agent Data Sheet, <i>if you are not yet appointed with Nationwide</i>
SITUATIONAL UNDERWRITING FORMS	<input type="checkbox"/> Life Financial Supplement, <i>\$1 million+ for ages 18 – 70, \$100,000+ for ages 71+</i> <input type="checkbox"/> Long Term Care Life Insurance Supplement, <i>When applying for LTC rider</i> <input type="checkbox"/> Long Term Care Personal Worksheet Disclosure, <i>When applying for LTC rider</i> <input type="checkbox"/> Replacement Notice for Long Term Care Life Insurance, <i>if applicable for LTC rider</i> <input type="checkbox"/> Alcohol Questionnaire <input type="checkbox"/> Drug Questionnaire <input type="checkbox"/> Civil Aviation Questionnaire <input type="checkbox"/> Military Aviation Questionnaire <input type="checkbox"/> Military Status Questionnaire <input type="checkbox"/> Hazardous Avocation Questionnaire <input type="checkbox"/> Foreign Nationals or Foreign Travel Supplement
SUPPLEMENTAL FORMS	<input type="checkbox"/> 1035 Replacement Forms <input type="checkbox"/> Commission Election Form <input type="checkbox"/> Split Commission Form <input type="checkbox"/> Limited Power of Attorney <input type="checkbox"/> Asset Rebalancing Program Form <input type="checkbox"/> Dollar Cost Averaging Form <input type="checkbox"/> Other _____

This page must be completed and submitted with application when mailing or faxing.

NATIONWIDE LIFE INSURANCE COMPANY
 NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY

Application for Life Insurance

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

PART A

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. Former Name (if applicable)			l. Occupation			m. Employer			
n. Can you read and understand English? <input type="checkbox"/> Yes <input type="checkbox"/> No			o. Citizenship (If other, submit Foreign Supplement.) <input type="checkbox"/> U.S. <input type="checkbox"/> Canada <input type="checkbox"/> Other			p. How long have you been in the U.S.?			
q. Telephone (Home) ()		r. Best time to call _____ A.M. / P.M.		s. Telephone (Business) ()		t. Best time to call _____ A.M. / P.M.			
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. Former Name (if applicable)			c. Occupation			d. Employer			
e. Driver's License # and State of Issue				f. County		g. Marital Status			
h. Can you read and understand English? <input type="checkbox"/> Yes <input type="checkbox"/> No			i. Citizenship (If other, submit Foreign Supplement.) <input type="checkbox"/> U.S. <input type="checkbox"/> Canada <input type="checkbox"/> Other			j. How long have you been in the U.S.?			
k. Telephone (Home) ()		l. Best time to call _____ A.M. / P.M.		m. Telephone (Business) ()		n. Best time to call _____ A.M. / P.M.			
4. OWNER (The Primary Insured (Joint Insureds in case of Survivorship) will own the policy unless indicated here. If the Owner is a Trust, complete the Trust Information Section below.)									
a. Name (First, MI, Last)						b. Social Security Number or Tax ID - -			
c. Residence Street Address (include city, state and zip code)									
d. County		e. Relationship to Insured(s)		f. Telephone Number		g. Date of Birth			
<i>(Only complete h, i, j and k for traditional life policies on juveniles (ages 0-14) when applying for Owner's Death or for Owner's Death or Disability Benefits.)</i>									
h. Occupation			i. Height		j. Weight	k. State of Birth			
l. Trust Information (Please submit copy of first and signature pages of Trust document.)									
EXACT NAME OF TRUST			TRUST TAX ID NUMBER		CURRENT TRUSTEE(S)		DATE OF TRUST		
5. CONTINGENT OWNER									
a. Name (First, MI, Last)						b. Social Security Number or Tax ID - -			
c. Residence Street Address (include city, state and zip code)									
d. County		e. Relationship to Insured(s)		f. Telephone Number		g. Date of Birth			

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 (including Additional Protection Rider)	c. Additional Protection Rider Amount (Individual-Life case only)	d. Supplemental Coverage Percentage (Survivorship case only)
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e. Initial Premium Deposit (paid with application) \$ _____	f. Planned Premium (Check plan for availability.) <input type="checkbox"/> Single Premium \$ _____ <input type="checkbox"/> Annual \$ _____ <input type="checkbox"/> Monthly EFT (Complete Part A, #7.) <input type="checkbox"/> Semi-Annual \$ _____ <input type="checkbox"/> Quarterly \$ _____ <input type="checkbox"/> _____ \$ _____
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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 \$ _____
 Adjusted Sales Load Rider _____% (in whole percentages only) waived for _____ years
 Child Rider \$ _____
 Long Term Care Rider* \$ _____
 Maturity Extension Endorsement for Specified Amount
 Premium Waiver Rider \$ _____
 Spouse Rider \$ _____
 Waiver of Monthly Deduction Rider
 Other Rider(s) _____
*Complete Supplement for Long Term Care Rider.

FOR SURVIVORSHIP 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 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.)

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
 Adjusted Sales Load Rider _____% (in whole percentages only) waived for _____ years
 Estate Protection Rider \$ _____
 Maturity Extension Endorsement for Specified Amount
 Policy Split Option Rider
 Other Rider(s) _____

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

m. 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.)

n. 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

o. Optional Benefit Riders
 Accidental Death - Amount \$ _____
 Child Rider \$ _____
 Guaranteed Option to Increase Specified Amount \$ _____
 Lapse Protection Rider
 Maturity Extension Endorsement for Specified Amount
 Spouse Rider \$ _____
 Waiver of Monthly Deduction Rider
 Other Rider(s) _____

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

p. Optional Benefit Riders
 10 Year Spouse Rider \$ _____
 20 Year Spouse Rider \$ _____
 Accidental Death - Amount \$ _____
 Child Rider \$ _____
 Excess Credit Option _____
 Guaranteed Insurability - Amount \$ _____
 Owner's Death (Complete Part B, #14 for Owner)
 Owner's Death or Disability (Complete Part B, #14 for Owner)
 Waiver of Premium Benefit
 Other Rider(s) _____

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

FOR TERM LIFE PLAN ONLY (Check plan for availability.)

q. Optional Benefit Riders
 10 Year Spouse Rider \$ _____
 20 Year Spouse Rider \$ _____
 Other Rider(s) _____
 Child Rider \$ _____
 Waiver of Premium Benefit

7. ELECTRONIC FUNDS TRANSFER AUTHORIZATION

Financial Institution Name		Financial Institution Phone Number	
Financial Institution Address			
Account Number		Transit/ABA Number	
Monthly EFT Amount	Draft Date	<input type="checkbox"/> *Checking (Attach a pre-printed Voided Check. Starter Checks will not be accepted.) <input type="checkbox"/> *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 to initiate debit entries to my checking/savings account indicated above and the Financial Institution to debit the same such account.

8. BENEFICIARY DESIGNATIONS (If Joint Plan, specify each Primary Insured's beneficiary designation-use #19, 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

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

a. Name (First, MI, Last) _____

b. Residence Street Address (include city, state and zip code) _____

10. 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? Yes No (If yes, please complete appropriate replacement. If this is an Internal Revenue Code Section 1035 Exchange, please check above and attach 1035 forms. If this is a Nationwide Term Conversion and you are not the Owner of the term policy or you are not converting the entire amount of the term policy, please enclose a term conversion application.)

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	ACCIDENTAL DEATH	NW TERM CONVERSION	TO BE REPLACED	1035
			\$		\$	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
			\$		\$	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
			\$		\$	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
			\$		\$	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
			\$		\$	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
			\$		\$	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
			\$		\$	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>

c. Is any person here proposed for coverage now applying for Life Insurance or Annuities with any other company? Yes No
 (If yes, please provide name of company, amount applied for and purpose of coverage.) _____

PART B

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

<p>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.)</p>
<p>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.)</p>

13. PHYSICAL MEASUREMENTS

INSURED	HEIGHT		WEIGHT		REASON FOR WEIGHT GAIN OR LOSS
			CURRENT	1 YEAR AGO	
Proposed Insured	ft.	in.	lbs.	lbs.	

14. 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

18. 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 is correct. (For most individuals, this is their Social Security 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, we will be forced to withhold 31% from interest and other payments we make to you (known as backup withholding). 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.

19. SPECIAL INSTRUCTIONS *(if more space is needed, an additional blank sheet may be attached.)*

20. NOTICE

The following fraud statement is for Applicants in the states of: **ALABAMA, HAWAII, IDAHO, ILLINOIS, INDIANA, MISSISSIPPI, NEVADA, OHIO, and SOUTH DAKOTA.**

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, may be guilty of insurance fraud.

THE FOLLOWING STATE(S) REQUIRE THAT WE PROVIDE THESE NOTICES:

DISTRICT OF COLUMBIA

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

LOUISIANA

CAUTION: If your answers on this application are incorrect or untrue, Nationwide has the right to deny benefits or rescind your policy.

Any person who knowingly presents 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.

TENNESSEE

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

21. 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 and are the basis of any insurance issued upon this application.
- 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. If the full first premium payment is made in exchange for a Temporary Insurance Receipt, Nationwide will only be liable to the extent set forth in that receipt.
- D. **If the full first premium is not paid with this application, then insurance will only take effect when all of the following conditions are met:**
 - 1. **a Policy is issued by Nationwide and is accepted by me; and**
 - 2. **the full first premium is paid; and**
 - 3. **all the answers and statements made on the application, medical examination(s) and amendments continue to be true to the best of my knowledge and belief.**

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)

Signature of Payor (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 866-692-6901 (TTY 866-346-3642).

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.

PART E

This receipt must not be detached and in no event will there be any temporary insurance unless the full first premium required by the Company has been paid or authorized by Electronic Funds Transfer at the time of this application.

TEMPORARY INSURANCE AGREEMENT

NATIONWIDE LIFE INSURANCE COMPANY/NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY, COLUMBUS, OHIO

This Agreement provides a Limited Amount of Life Insurance coverage, for a Limited Period of time, subject to the terms of this Agreement. Advance payment in the amount of \$ _____ is made for \$ _____ (face amount on the application or [\$1,000,000] whichever is less) on the life of _____.

Name(s) of Proposed Insured(s)

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

HEALTH QUESTION

Has anyone here proposed for insurance: Yes No

within the past 10 years, been treated for, consulted a physician, or been medically diagnosed by a physician as having: angina, or chest pain or discomfort; heart attack, heart murmur, or any other heart disorder; epilepsy, stroke or diabetes; Acquired Immune Deficiency Syndrome (AIDS), any AIDS-related disorder or positive HIV (Human Immunodeficiency Virus) test result; any brain, nervous, or mental disorder, any drug or alcohol addiction; any kidney disorder (other than kidney stones); or any cancer or other malignancy?

If the above question is answered YES or LEFT BLANK, NO COVERAGE will take effect under this Agreement and no representative of Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company is authorized to accept money, and/or provide a temporary insurance receipt to the applicant.

TERM AND CONDITIONS

AMOUNT OF COVERAGE – [\$1,000,000] OVERALL MAXIMUM FOR ALL APPLICATIONS OR AGREEMENTS

If money has been accepted by Nationwide as advance payment for an application for Life Insurance and 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) **[\$1,000,000]**. This total benefit limit applies to all insurance applied for under this and any other current applications to Nationwide and any other Temporary Insurance Agreements for Life Insurance whether applied for on the life or lives of one or more Proposed Insureds.

DATE COVERAGE TERMINATES - 60 DAY MAXIMUM COVERAGE

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 to the Applicant in connection with the above application, or
- C. Nationwide mails notice of termination of coverage and refund of the advance payment to the premium notice address designated in such application.

LIMITATIONS

- This Agreement does not provide benefits unless a full first premium for the mode selected has been paid at the time of this application.
- Fraud or material misrepresentation in the application or in the answers to the Health question of this Agreement invalidate this agreement and Nationwide's only liability is for refund of any payment made.
- No one is authorized to accept money on Proposed Insureds under 15 days of age or over the age of 70 (nearest birthday) on the date of the Agreement, nor will any coverage take effect.
- 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.
- No one is authorized to waive or modify any of the provisions of this Agreement.

I HAVE RECEIVED A COPY OF AND HAVE READ THIS AGREEMENT AND DECLARE THAT THE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND AND AGREE TO ALL ITS TERMS.

Dated _____
Month Day Year

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

X _____
Applicant/Owner's Signature (if other than Proposed Insured)

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

Please make a copy of the application, temporary insurance agreement, and other applicable forms. Return originals to the Home Office and provide the customer with a copy. The original temporary insurance agreement must remain with the application and will be retained by Nationwide.

X _____
Signature of Producer

Firm Producer's Nationwide Number

COPY 1 – SEND TO HOME OFFICE WITH APPLICATION

COPY 2 – RETAINED BY PROPOSED INSURED

PART E

This receipt must not be detached and in no event will there be any temporary insurance unless the full first premium required by the Company has been paid or authorized by Electronic Funds Transfer at the time of this application.

TEMPORARY INSURANCE AGREEMENT

NATIONWIDE LIFE INSURANCE COMPANY/NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY, COLUMBUS, OHIO

This Agreement provides a Limited Amount of Life Insurance coverage, for a Limited Period of time, subject to the terms of this Agreement. Advance payment in the amount of \$ _____ is made for \$ _____ (face amount on the application or [\$1,000,000] whichever is less) on the life of _____.

Name(s) of Proposed Insured(s)

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

HEALTH QUESTION

Has anyone here proposed for insurance: Yes No

within the past 10 years, been treated for, consulted a physician, or been medically diagnosed by a physician as having: angina, or chest pain or discomfort; heart attack, heart murmur, or any other heart disorder; epilepsy, stroke or diabetes; Acquired Immune Deficiency Syndrome (AIDS), any AIDS-related disorder or positive HIV (Human Immunodeficiency Virus) test result; any brain, nervous, or mental disorder, any drug or alcohol addiction; any kidney disorder (other than kidney stones); or any cancer or other malignancy?

If the above question is answered YES or LEFT BLANK, NO COVERAGE will take effect under this Agreement and no representative of Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company is authorized to accept money, and/or provide a temporary insurance receipt to the applicant.

TERM AND CONDITIONS

AMOUNT OF COVERAGE – [\$1,000,000] OVERALL MAXIMUM FOR ALL APPLICATIONS OR AGREEMENTS

If money has been accepted by Nationwide as advance payment for an application for Life Insurance and 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) **[\$1,000,000]**. This total benefit limit applies to all insurance applied for under this and any other current applications to Nationwide and any other Temporary Insurance Agreements for Life Insurance whether applied for on the life or lives of one or more Proposed Insureds.

DATE COVERAGE TERMINATES - 60 DAY MAXIMUM COVERAGE

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 to the Applicant in connection with the above application, or
- C. Nationwide mails notice of termination of coverage and refund of the advance payment to the premium notice address designated in such application.

LIMITATIONS

- This Agreement does not provide benefits unless a full first premium for the mode selected has been paid at the time of this application.
- Fraud or material misrepresentation in the application or in the answers to the Health question of this Agreement invalidate this agreement and Nationwide's only liability is for refund of any payment made.
- No one is authorized to accept money on Proposed Insureds under 15 days of age or over the age of 70 (nearest birthday) on the date of the Agreement, nor will any coverage take effect.
- 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.
- No one is authorized to waive or modify any of the provisions of this Agreement.

I HAVE RECEIVED A COPY OF AND HAVE READ THIS AGREEMENT AND DECLARE THAT THE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND AND AGREE TO ALL ITS TERMS.

Dated _____
Month Day Year

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

X _____
Applicant/Owner's Signature (if other than Proposed Insured)

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

Please make a copy of the application, temporary insurance agreement, and other applicable forms. Return originals to the Home Office and provide the customer with a copy. The original temporary insurance agreement must remain with the application and will be retained by Nationwide.

X _____
Signature of Producer

Firm Producer's Nationwide Number

COPY 1 – SEND TO HOME OFFICE WITH APPLICATION

COPY 2 – RETAINED BY PROPOSED INSURED

Variable Life Fund Supplement for Use with:

Next Generation FPVUL

Protection FPVUL

Next Generation Survivorship Variable Universal Life

Protection Survivorship Variable Universal Life

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 <i>(please print)</i>	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 Fund - Class I
- ___ % VP Ultra Fund - Class I
- ___ % VP Value Fund - 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 *(Class I)*

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

NEUBERGER BERMAN AMT

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

DREYFUS

- ___ % Small Cap Stock Index Port. - Service Shares
- ___ % Stock Index Fund - Initial Shares
- ___ % VIF Appreciation Port. - Initial Shares

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 *(Class I)*

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

NATIONWIDE LIFE INSURANCE CO.

- ___ % Fixed Account
- ___ % Long Term Fixed Account *

OTHER AVAILABLE FUNDS

- ___ % _____
- ___ % _____
- ___ % _____

*The Long Term Fixed Account enforces stringent transfer restrictions. Please consult the prospectus for more details on these restrictions.

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)

Variable Life Fund Supplement for Use with Next Generation II FPVUL

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 <i>(please print)</i>	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
- N/A % VP International Fund - Class I
- ___ % VP Ultra Fund - Class I
- ___ % VP Value Fund - Class I

MFS® VIT (Initial Class)

- ___ % Investors Growth Stock Series
- ___ % Value Series

OPPENHEIMER (Initial Class)

- ___ % Capital Appreciation Fund/VA
- N/A % 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.
- N/A % 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)

- N/A % Foreign Securities Fund
- ___ % Rising Dividends Securities Fund
- ___ % Small Cap Value Securities Fund

GARTMORE GVIT (Class I)

- N/A % Emerging Markets Fund
- N/A % Global Health Sciences Fund
- N/A % Global Technology and Communications Fund
- ___ % Government Bond Fund
- ___ % Mid Cap Growth Fund
- ___ % Money Market Fund
- ___ % Nationwide® Fund
- ___ % U. S. Growth Leaders Fund

NEUBERGER BERMAN AMT

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

DREYFUS

- ___ % Small Cap Stock Index Port. - Service Shares
- ___ % Stock Index Fund - Initial Shares
- ___ % VIF Appreciation Port. - Initial Shares

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 (Class I)

- Fund Name (Subadviser)
- ___ % Comstock Value Fund (Van Kampen)
- N/A % High Income Bond Fund (Federated)
- N/A % International Value Fund (Dreyfus)
- ___ % Mid Cap Index Fund (Dreyfus)
- ___ % Multi Sector Bond Fund (Van Kampen)
- ___ % Small Cap Growth Fund (Multi Managers)
- ___ % Small Cap Value Fund (Multi Managers)
- ___ % Small Company Fund (Multi Managers)

NATIONWIDE LIFE INSURANCE CO.

- ___ % Fixed Account
- ___ % Long Term Fixed Account *

OTHER AVAILABLE FUNDS

- ___ % _____
- ___ % _____
- ___ % _____

*The Long Term Fixed Account enforces stringent transfer restrictions. Please consult the prospectus for more details on these restrictions.

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)