Nationwide Life Insurance Company
Home Office: Columbus, Ohio

Accelerated Death Benefit Claim Form

Employer Instructions

1. Check that the employee has completed dated and signed this claim form. Verify that all required documentation has been provided.
2. Be sure that the employee has retained a copy of this claim form and all required documentation for their records.
3. Complete all of Section 1 (Employer Statement) and attach a copy of the most recent beneficiary designation. Please confirm that the beneficiary name, SSN/TIN, address and relationship information is accurate prior to submission. A Change Request Form should be submitted in the event beneficiary information needs to be updated.
4. Send this claim form and all required documentation via one of these methods:
   a. Mail: Nationwide P.O. Box 1910, Covington, LA 70434
   b. Fax to: 985-898-1770
   c. E-mail to service@nebsupport.com

If you have any questions, please contact Customer Service at (877) 717-4455

Employee Instructions

1. Answer all of Section 2 (Employee Statement). All questions should be answered by the employee or his/her legally appointed guardian or representative. If applicable, proof of guardianship or representation should also be submitted.
2. Have your doctor complete the Attending Physician's Statement. Also, include lab results and x-rays, if applicable. The x-rays will be returned to the physician.
3. If applicable, provide the following documentation:
   a. If you are divorced, a copy of the court approved divorce settlement agreement.
   b. If you have assigned your rights under the group policy to an assignee or an irrevocable beneficiary, written consent from that assignee or irrevocable beneficiary for payment of an accelerated death benefit.
4. Be sure to keep a copy of this claim form and all additional documentation for your records. Give the employer this claim form and all additional documentation.

Section 1 – Employer Statement

Group Name & Address (Street Name/Number, City, State, Zip)	Group Number

Employee Information

Employee Name (First, MI, Last)	Gender ☐ M ☐ F	Marital Status ☐ Single ☐ Widowed ☐ Married ☐ Divorced/Separated

Residential Address – No P.O. Box (Street Name/Number, City, State, Zip)

Mailing Address, if different (Street Name/Number, City, State, Zip)

Class & Location	Rate of Pay (at date last worked) $ per	Date Employed

Amount of Basic Life Insurance $	Amount of Voluntary Life Insurance $

Date Employed	Date Last Worked	Reason for Leaving Work

Is premium currently being paid by or on behalf of the employee? ☐ Yes ☐ No	If 'No', What was the Date of Last Premium Payment? Explain:

I certify that the above information is correct and complete according to our records. I certify that I have read the applicable State Fraud Notice on page 4.

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

By signing below, I am providing consent to Nationwide Employee Benefits to receive claim documents and communications electronically. Please refer to the terms and conditions on page 5. If you do not consent to Electronic Delivery of Insurance Documents, please check here ☐.

Name of Employer's Authorized Representative	Title

Signature of Employer's Authorized Representative ▶	Date

Section 2 – Claim Payment Options

Please select one of the following benefit payment options:

☐ **I authorize Nationwide to deposit my benefit claim proceeds into my personal bank account.** As a convenience to me, I authorize Nationwide Insurance and its authorized representative, Gilsbar, L.L.C., Covington, LA (TIN #72-0519951), to deposit claim payments and, if necessary, make adjustments for any error to my account at the Bank (or other financial institution) I have indicated below.

Bank Name_____ Name on Bank Account_____

Checking ☐ Savings ☐

Please submit ***a voided blank check or a copy of a bank statement, direct deposit authorization form or other documentation showing the routing and account numbers.***

Authorized Signature_____ Date _____

☐ **Please send a lump sum check to me for all benefit claim proceeds.**

Section 3 – Employee Statement

Are you completing this claim form as the insured employee? ☐ Yes ☐ No
If No, Print Name and Indicate Relationship to Employee:

Insured Employee Name (First, MI, Last)	SSN	Date of Birth

Are you in the process of or have you converted your Group Life Coverage to an Individual Policy? ☐ Yes ☐ No
If yes, please discuss your options with your employer. You will not be eligible for the accelerated death benefit if you have converted.

Have divorce proceedings ever been instituted by or against you? ☐ Yes ☐ No
If so, when and where?

Have you assigned your rights under the group policy to an assignee or irrevocable beneficiary? ☐ Yes ☐ No

Claim Details – All questions should be answered by or on behalf of the insured. Nationwide reserves the right to request an Independent Medical Examination at the Company's expense.

State Nature of Qualifying Medical Condition	Indicate Amount of Benefit Being Claimed $

Indicate names, addresses and corresponding dates of treatment of physicians who have treated you for qualifying condition:

Physician Name & Address	Dates of Treatment
Physician Name & Address	Dates of Treatment
Physician Name & Address	Dates of Treatment

Certification

I certify that I have read the State Fraud Notices on page 4. I certify that the above information is complete, true and correctly recorded.

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

By signing below, I am providing consent to Nationwide Employee Benefits to receive claim documents and communications electronically. Please refer to the terms and conditions on page 5. If you do not consent to Electronic Delivery of Insurance Documents, please check here ☐.

Employee's Signature (or Signature of Employee's Legally Appointed Representative) ▶	**Date**
Witness' Signature ▶	**Date**

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Accelerated Death Benefit
Attending Physician's Statement

Patient's Name (First, MI, Last)	Date of Birth
Address (Street Name/Number, City, State, Zip)	SSN
Group Name	Group Number

The patient is responsible for completion of this form without expense to the Company. Space is available on the reverse side if you wish to add to your answers. If prognosis section is not completed in full, claim processing will be delayed.

History

When did symptoms first appear or accident happen? _____ - _____ - _____

Present Condition

Subjective symptoms

Objective findings (Include results of current x-rays, EKGs or any other special tests relevant to your judgment of prognosis.)

Is patient: ☐ Ambulatory? ☐ Bed confined? ☐ House confined? ☐ Hospital confined?

Diagnosis

Treatment

Date of first visit for above condition	Date of most recent visit
_____ - _____ - _____	_____ - _____ - _____

Prognosis

"In my best medical judgment, the above patient's life expectancy is _____ months or less, or not more than _____ months"

Mental Condition

Is the patient competent to endorse checks and direct the proceeds thereof? ☐ Yes ☐ No

Remarks

Physician Name (please print)	Specialty/Degree
Physician Address (Street Name/Number, City, State, Zip)	Telephone Number

I certify that the above information is correct and complete according to my records, knowledge and belief.

Attending Physician's Signature ►	Date

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State Fraud Notices

(Alabama) Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

(Alaska) A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

(Arizona) Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

(Arkansas) Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

(Colorado) It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

(Delaware) Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

(District of Columbia) Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

(Florida) Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

(Idaho) Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

(Indiana) Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

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

(**Louisiana**) Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

(Maryland) Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

(Minnesota) A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

(New Hampshire) Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

(New Jersey) Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

(New Mexico) Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

(New York) Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

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

(Oklahoma) WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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

(Rhode Island) Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

(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.

(Texas) Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

(Virginia) 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.

(Washington) 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.

(West Virginia) Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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Terms and Conditions of Electronic Delivery of Insurance Documents

In order for Nationwide Employee Benefits (hereinafter referred to as "we" or "us) to send you your insurance-related documents and communications electronically, to the extent permitted by law, you must first consent to us doing so. The insurance-related documents and communications you will receive in electronic format will have the same contractual force and effect as insurance-related documents and communications sent to you in paper format. We reserve the right, in our sole discretion, to provide any insurance-related documents and communications to you in paper form instead, and / or to discontinue this service or modify the terms of this agreement at our option. If we do, we will provide you with reasonable notice and you will have the option to withdraw your consent at that time.

YOUR CONSENT: By NOT checking the box in Section 1 Page 1 or Section 3 Page 2, you:

1. Consent to receive insurance-related documents and communications, including but not limited to, your policy documents, disclosures, notices, explanation of benefits (EOB), claims documentation, **as well as termination and cancellation or non-renewal notices**, electronically to the email address you provide to us on the claim form instead of receiving these records in a paper format from **Nationwide Employee Benefits.**
2. Agree and acknowledge that your consent is provided and/or obtained in connection with a transaction affecting interstate commerce subject to the Electronic Signatures in Global and National Commerce Act and the Uniform Electronic Transactions Act, or a similar electronic transactions law, as adopted by state law.
3. Agree that the document(s) delivered to you electronically shall have the same meaning and effect as if you were provided a paper document, whether or not you choose to view the document(s), unless you previously withdrew your consent to receive documents via electronic means as provided below. Electronic document(s) are considered received by you at the time the documents are sent, unless Nationwide receives notice that the email notification was not delivered to you at the email address you provided.

YOUR RIGHT TO WITHDRAW YOUR CONSENT: If you consented to receiving insurance-related documents and communications electronically, you may withdraw your consent at any time. After we process your withdrawal of consent, you will begin receiving your insurance documents and correspondence in paper form. To withdraw your consent, please send a written request to Nationwide Employee Benefits, PO Box 1910, Covington, LA 70434.

YOUR RIGHT TO RECEIVE PAPER COPIES: You have the right to obtain paper copies of your insurance-related documents and communications at any time. To obtain paper copies, please contact Nationwide Employee Benefits at 1-877-717-4455, service@nebsupport.com, or PO Box 1910, Covington, LA 70434.

YOUR OBLIGATIONS: If you consent to receive insurance documents and correspondence electronically, you are responsible for (i) providing Nationwide with an updated and active e-mail address through the contact listed below. You should be diligent in updating your email address with us in the event that your address changes; (ii) maintaining or having access to a computer capable of connecting to the internet; (iii) maintaining internet access; (iv) installing software on your personal computer to receive, access, store, and print in accordance with the Technical Requirements listed below; (v) an email service account that allows you to read, write, and send email; (vi) an active email address

UPDATING YOUR CONTACT INFORMATION: It is your responsibility to provide Nationwide Employee Benefits with a current, valid email address and to promptly update any changes to this information by contacting us at 1-877-717-4455, service@nebsupport.com, or PO Box 1910, Covington, LA 70434.

UNDELIVERABLE AND RETURN EMAILS: Any e-mails returned as undeliverable will result in a suspension of electronic document delivery and a return to paper copies sent via U.S. mail.

TECHNICAL REQUIREMENTS: The following minimal technical requirements are necessary to receive electronic records:

E-Mail – Access to an email account with a provider such as Gmail®, Outlook®, or Yahoo!®
PDF Reader – Acrobat® or similar software may be required to view and print PDF files