Nationwide Life Insurance Company
Home Office: Columbus, Ohio

Life Waiver of Premium or Continuation of Benefit Form

Employee Instructions

1. You will need to review the State Fraud Notices below and complete the Employee Statement.
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. Be sure to keep a copy of this form and all additional documentation for your records. Give the employer this claim form and all additional documentation.

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 the Employer Statement below and attach a copy of the most recent beneficiary designation.
4. Send this claim form and all required documentation to:

Nationwide Insurance
c/o Disability Insurance Specialists
PO Box 29
Bloomfield, CT 06002
Customer Service phone number: (800) 654-3826
Customer Service fax number (860) 769-6981
E-Mail: NWPW@dispec.com

Employer Statement

Group Name	Group Number
To whom should we direct all correspondence on this claim?	Telephone Number
Address (Street Name/Number, City, State, Zip)	E-mail Address

Employee Information

Employee Name (First, MI, Last)	Gender ☐ M ☐ F	Marital Status ☐ Single ☐ Widowed ☐ Married ☐ Divorced/Separated
Class & Location	Rate of Pay (at date last worked) $ per	Date Employed
Did the insured meet the definition of Actively at Work at date of disability? ☐ Yes ☐ No If No, Explain:		Date Last Worked

Date of Disability	Original Date Insured with Nationwide	Insurance Termed prior to disability? ☐ Yes ☐ No

Will insured be able to retire under this plan? ☐ Yes ☐ No	Normal Retirement Date ___/___/_____

Amount of Insurance at Time of Disability

Basic Life $	Voluntary Life $

Certification and Signature: 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 6.

(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 7. If you do not consent to Electronic Delivery of Insurance Documents, please check here ☐.

Name of Employer's Authorized Representative (printed)	Title
Signature of Employer's Authorized Representative ▶	Date

Nationwide Life Insurance Company

Life Waiver of Premium or Continuation of Benefit Employee Statement

Please type or print legibly.

Section 1: Group (Employer) Information

Group Name	Group Number

Section 2: Employee Information

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

Address (Street Name/Number, City, State, Zip)	Phone Number

Section 3: Disability Information

Describe the usual duties of your job:

Did your usual job involve:	Please explain all YES answers:
a) the use of machines, tools or equipment? ☐ Yes ☐ No b) technical knowledge or special skills? ☐ Yes ☐ No c) any supervisory responsibilities? ☐ Yes ☐ No d) travel? ☐ Yes ☐ No	
Please describe the kind and amount of physical activity involved in your job during a typical work day (circle the number of hours in a day). a) Walking 0 1 2 3 4 5 6 7 8 b) Standing 0 1 2 3 4 5 6 7 8 c) Sitting 0 1 2 3 4 5 6 7 8	Lifting and Carrying - Describe what was lifted, how heavy it was, how often it was lifted and how far it was carried:

How does your illness or injury now prevent you from performing your usual duties as described above?

List any skills you may have as a result of prior employment, training or education, or military service:

List last year of school completed (i.e. 6th grade, 12th grade, College Degree, etc):

Before you stopped working, did your illness or injury cause you to change:	Explain how your condition caused these changes:
Date of Change a) your job duties? ☐ Yes ☐ No ___/___/_____ b) your hours of work? ☐ Yes ☐ No ___/___/_____ c) your attendance? ☐ Yes ☐ No ___/___/_____	

Briefly describe your injury or illness that prevents, or has prevented, you from working:

If condition is due to injury, please indicate the date of the injury and where it occurred:
Date ___/___/_____ Location:

Describe how the accident occurred (if applicable):

When did you become unable to work because of your disability?	Date of first treatment for the illness or injury: _____ / _____ / _____	Are you still disabled? ☐ Yes ☐ No

List the name, address and phone number of the primary doctor who has your latest medical records related to this illness or injury:
Name: Telephone Number:
_____ _____
Address:
_____

How often do you see this doctor?	Date you first saw this doctor? ___/___/_____	Date you last saw this doctor? ___/___/_____

Reasons for visits:	Type of treatment received:

Continue on Next Page

Employee Statement Continued

Have you seen any other doctor since your illness or injury began? ☐ Yes ☐ No
If yes, Name & Address: Telephone Number:

How often do you see this doctor?	Date you first saw this doctor? ___/___/_____	Date you last saw this doctor? ___/___/_____

Reasons for visits:	Type of treatment received:

Has your doctor told you to restrict your activities? ☐ Yes ☐ No
If yes, list name of doctor and state what they told you about restricting your activities:

Check any of the following which apply to you:
- ☐ Confined in a hospital or other medical institution
- ☐ Confined to a house (not able to go outside)
- ☐ Able to go outside without help
- ☐ Confined to a bed or wheelchair at home
- ☐ Able to go outside only with the help of someone else or a device

Are your home duties, social activities or ability to care for your personal needs limited in any way? ☐ Yes ☐ No
If yes, describe how and why they are limited:

Do you expect to return to work? ☐ Yes ☐ No	Date expected to return: ___/___/_____	Date returned: ___/___/_____

Have you been seen by other agencies for your injury or illness (VA, Vocational, Rehabilitation, Welfare, etc.)? ☐ Yes ☐ No
If yes, Name & Address of Agency: _____

Your Claim Number:	Dates of Visits:	Types of treatment or examination received:

Are you receiving retirement benefits from an employer, federal, state, municipal or association retirement plan? ☐ Yes ☐ No
Are you in the process or have you converted your Group Life Coverage to an Individual policy? ☐ Yes ☐ No

If you answered yes to either of the above questions and you are applying for waiver of premium, please discuss the options with your employer. You may not be eligible for benefits under the waiver of premium provision.

Section 4: Certification

I certify that I have read the State Fraud Notices on page 6. I certify that the above information is complete, true and correctly recorded. I understand that I must notify Nationwide promptly if:

a. my medical condition improves so that I would be able to work, even if I have not yet returned to work.
b. I go to work whether as a employee or as a self employed person.

(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 7. If you do not consent to Electronic Delivery of Insurance Documents, please check here ☐.

Employee's Signature ▶	Date

Nationwide Life Insurance Company

Life Waiver of Premium or Continuation of Benefit Form – Attending Physician's Statement

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

Instructions

The purpose of this report is to assist us in making a disability determination. In filling out this report please include sufficient details of history, physical and diagnostic findings, clinical course, therapy and response to enable us to make this determination. Attach additional pages as needed. After signing this form, return it to patient.

History

When did symptoms first appear or accident happen? Mo_____ Day_____ Year_____

Date patient ceased work because of disability? Mo_____ Day_____ Year_____

Has patient ever had same or similar condition? ☐ Yes ☐ No If yes, state when and describe:

Diagnosis (including any complications)

Subjective symptoms:

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

Dates of Treatment (for above condition)

Date of first visit : ___/___/_____	Date of last visit: ___/___/_____	Frequency?

Nature of Treatment (including surgery, date and description, and medications prescribed, if any)

Progress

Patient has: ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

Patient is: ☐ Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospital Confined

Has patient been hospital confined? ☐ Yes ☐ No If yes, confined from ___/___/_____ to ___/___/_____

Facility name and address_____

Physical Impairment (as it relates to employment)

☐ Class 1: No limitation of functional capacity; capable of heavy physical activity. No restrictions. (0-10%)

☐ Class 2: Slight limitation of functional capacity; capable of light manual activity. (15-30%)

☐ Class 3: Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity. (35-55%)

☐ Class 4: Marked limitations. (60-70%)

☐ Class 5: Severe Limitation of functional capacity; incapable of minimal (sedentary) activity. (75-100%)

Remarks:

Continued on Next Page

Mental/Nervous Impairment (if applicable)

☐ Class 1: Able to function under stress and engage in interpersonal relations (no limitations)

☐ Class 2: Able to function in most stress situations and engage in most interpersonal relations (slight limitations)

☐ Class 3: Able to engage in only limited stress situations or engage in only limited interpersonal relations (moderate limitations)

☐ Class 4: Unable to engage in stress situations or engage in interpersonal relations (marked limitations)

☐ Class 5: Significant loss of psychological, physiological, personal and social adjustment (severe limitations)

Remarks:

Cardiac (if applicable)

Functional Capacity

☐ Class 1: No limitation ☐ Class 2: Slight limitation ☐ Class 3: Marked limitation ☐ Class 4: Complete limitation

Competency

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

Prognosis

Do you expect a fundamental or marked change in the future?	If improved, will patient recover sufficiently to perform duties of:	
	Own Job	Other Work
☐ No ☐ Yes – Improvement ☐ Yes – Deterioration	☐ No, Never ☐ Yes: ☐ 3-6 mos ☐ 6-12 mos ☐ over 1 yr	☐ No, Never ☐ Yes: ☐ 3-6 mos ☐ 6-12 mos ☐ over 1 yr

If no improvement expected, please explain:

Rehabilitation

Is patient a suitable candidate for trial employment or job training?		If yes, when could he/she commence trial employment?	
Own Job	Other Work	Own Job	Other Work
☐ No ☐ Yes	☐ No ☐ Yes	Date ___/___/_____ ☐ Full-time ☐ Part-time	Date ___/___/_____ ☐ Full-time ☐ Part-time

If no, please explain:

Additional Care

Have you referred your patient for other types of consultation? ☐ Yes ☐ No If yes, Specialty:_____

Physician name and address:_____

Additional Remarks

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

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

Attending Physician's Signature ▶	Date

Send this claim form and all required documentation to:
Nationwide c/o Disability Insurance Specialists
PO Box 29, Bloomfield, CT 06002
Customer Service fax number (860) 769-6981
E-Mail: NWPW@dispec.com

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.

Nationwide
is on your side

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 on the bottom of Page 1 or Section 4 Page 3, 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