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Nationwide Life Insurance Company
Home Office: Columbus, Ohio

Accidental Dismemberment or Specific Loss Claim Form

Employee/Claimant Instructions

1. You will need to review the State Fraud Notices on page 5 and complete Sections 2 of this form (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. 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. Complete Section 1 of this form (Employer Statement).
3. Submit your completed claim form, including any applicable supporting documentation listed above 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
4. If you have any questions, please contact Customer Service at (877) 717-4455.

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Accidental Dismemberment or Specific Loss Claim Form
Employer and Employee Statement

Please type or print legibly.

Section 1: Employer Statement – To be completed by employer's authorized representative

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

Employee Information

Employee Name (First, MI, Last)	Amount of Insurance at Time of Accident $	
Class & Location	Rate of Pay (at date last worked) $ per	Date Employed
Effective Date of Coverage:	Occupation:	
Is Employee Full- Time ☐ Yes ☐ No Part-Time ☐ Yes ☐ No	Hours worked per week:	
Did the insured meet the definition of Actively at Work when the accident occurred? ☐ Yes ☐ No If No, Explain:		Date Last Worked

Dependent Information - Complete only if this claim is for an insured dependent under Voluntary AD&D Benefits.

Insured Dependent Name (First, MI, Last)	Was Dependent Insured at the time of accident? ☐ Yes ☐ No – Explain:	Amount of Dependent's Insurance $

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 5.

(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 6. 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: Employee Statement

Are you completing this claim form as the insured employee? ☐ Yes ☐ No

If No, Print Name and Indicate Relationship to Employee:

Is the insured in a coma? ☐ Yes ☐ No If yes, to whom should we direct all correspondence on this claim? (Name, address, phone)

Employee Name (First, MI, Last)	SSN	Date of Birth
Address (Street Name/Number, City, State, Zip)	Phone Number	

Dependent Information - Complete only if this claim is for an insured dependent under Voluntary AD&D Benefits.

Insured Dependent Name (First, MI, Last)	SSN	Gender ☐ M ☐ F	Date of Birth
Address, if different than employee's (Street Name/Number, City, State, Zip)			

Accident/Incident Details

Date of Injury	Date of Loss	Did the injury arise out of and during the course of employment? ☐ Yes ☐ No
Place of Accident		
Name and Address of Physician		Date First Treated by Physician
Extent of Loss		
Describe in detail how the accident occurred:		

Please select one of the following benefit payment options:

☐ **I authorize Nationwide to deposit my life 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.**

I certify that I have read the State Fraud Notices on page 5. 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 6. 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**
Signature of Injured Spouse or Dependent (if over age 18) (if claiming benefits) ►	**Date**

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Nationwide Employee Benefits SM
Accidental Dismemberment or Specific Loss
Attending Physician's Statement

Patient's Name and Address	**SSN**	**Date of Birth**

1. When did the accident happen? (mm/dd/yyyy)

2. When did the patient first consult you for this condition? (mm/dd/yyyy)

3. Was there any disease or condition prior to the date of the accident which might have served as a contributory cause?
☐ Yes ☐ No If Yes, supply medical records.

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

5. If physician other than you treated insured for this injury or any contributory condition, please provide name and address of physician.
Name:_____ Telephone: (_____) _____
Address (Street Name/Number, City, State, Zip):_____

☐ **LOSS OF LIMB or LOSS OF USE** – Provide copies of medical records to support claim. Please mark all applicable loss(es).

Hand	☐ Right	☐ Left
Foot	☐ Right	☐ Left
Arm	☐ Right	☐ Left
Leg	☐ Right	☐ Left
Thumb & Index Finger	☐ Right Hand	☐ Left Hand
Fingers	☐ Right, #_____	☐ Left, #_____
Toes	☐ Right, #_____	☐ Left, #_____

☐ **Severance***
Provide date of amputation: _____-_____-_____

☐ **Total Paralysis (Arm/Leg Only)**
Provide date of loss of use: _____-_____-_____
Has paralysis been continuous for 12 months? ☐ Y ☐ N

*Severance of hand/foot must be at or above the wrist/ankle. Severance of fingers/toes must be at or above the metatarsophalangeal joint.

☐ **LOSS OF SIGHT** - Please use SNELLEN notation or its equivalent – Provide copies of medical records to support claim.

Record of Vision:
1. Date of first observation_____-_____-_____
2. Date of last observation_____-_____-_____

3a. Uncorrected:
R.E. _____ L.E. _____
R.E. _____ L.E. _____

3b. Corrected:
R.E. _____ L.E. _____
R.E. _____ L.E. _____

4. From what date was vision recorded in question 3b?
_____-_____-_____

5. If totally blind, provide date this occurred:
Right Eye _____-_____-_____ Left Eye _____-_____-_____

6. If eye has been enucleated, provide date.
Right Eye _____-_____-_____
Left Eye _____-_____-_____

7. In your opinion can vision be improved by treatment, surgery or lenses?
☐ Y ☐ N
State your recommendations.

8. In your medical opinion, has the patient sustained complete and irrecoverable loss of sight due to an accidental injury? ☐ Y ☐ N

☐ **LOSS OF HEARING** - Provide copies of auditory test results to support claim. ☐ **Right Ear** ☐ **Left Ear** ☐ **Both Ears**

In your medical opinion, has the patient sustained complete and irrecoverable hearing loss due to an accidental injury? ☐ Y ☐ N

☐ **LOSS OF SPEECH** - Provide copies of speech test results to support claim.

In your medical opinion, has the patient sustained complete and irrecoverable loss of speech due to an accidental injury? ☐ Y ☐ N

☐ **COMA** - Provide diagnosis and enclose medical records regarding the patient's comatose condition as a result of accidental injury.

What date did the coma first begin? ____-____-_____

Has the patient been in the coma continuously? ☐ Y ☐ N
If no, please provide details, e.g., date ranges, on a separate sheet.

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 2 or Section 2 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