

MAIL TO: NATIONWIDE LIFE INSURANCE COMPANY NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY

Life Underwriting P.O. Box 182835 Columbus, OH 43218-2835 Fax: 1-888-677-7393

EXAMINATION

(Part B of an application to Nationwide Insurance Companies for Life Insurance)

Nam	e of Proposed Insured (please print)	Social Security No. Date of Birth					
Phys	icians: Include both primary care and specialists and date last consulted.	(If more than two physicians, indicate	so under "details".)				
Nam	e	Name					
	ess	Address					
Telep	hone	Telephone					
Medi	cal specialty	Medical specialty					
Date	and reason last consulted	Date and reason last consulted					
	ent medications to include prescription, over-the-counter medication takes and frequency		tural" or herbal medications. Gi	ve			
	e best of your knowledge and belief, in the past 10 years, have you		diagnosed as having:	Yes No			
(Exp	ain all "yes" answers in DETAILS OF YES ANSWERS section below unle	ess otherwise instructed.)	11 - 1 - 1 - 1 1 1 1 1 1 1 1 1 1 1 1 1				
1.	AIDS (Acquired Immune Deficiency Syndrome), or any other AIDS-related Immune deficiency Virus) toot?	ed condition, or received a positive res	suit of an HIV (Human				
2	Immunodeficiency Virus) test?	diomyonathy, congestive heart failure	heart murmur, valvular heart				
۷.	disease, congenital heart defect, or other disorders of the heart?						
3.	Abnormal electrocardiogram, heart catheterization, coronary bypass sur						
	Irregular heart beat, palpitations, high blood pressure, high cholesterol, of						
5.	Aneurysm, carotid artery disease, deep venous thrombosis, phlebitis, pe	eripheral vascular disease, any other of	lisorder of the blood vessels				
	or pulmonary embolism?						
	Diabetes, abnormal blood sugar, thyroid, adrenal, parathyroid, pituitary,						
7.	Cancer, leukemia, lymphoma, any malignant or benign tumor, cyst, poly	p or any chronic disease of the skin or	lymph glands?				
	8. Any abnormal screening tests for cancer including PSA (prostate specific antigen), mammogram, or PAP smears?						
9.	9. Disorder of the blood including anemia, sickle cell disorders, thalassemia, hemophilia, or any other disorder of the red blood cells, or white						
10	blood cells, platelets, or clotting factors?	animuma fainting transpar Daukinaan'a	diagona mandal material tica				
10.	Headaches, Stroke, TIA (transient ischemic attack), paralysis, epilepsy, cerebral palsy, multiple sclerosis, Alzheimer's disease, dementia, ALS (L	seizures, fainting, tremor, Parkinson's	disease, mental retardation,				
11	nerves, spinal cord, or brain?						
11.	of the lungs or respiratory system?						
12	An abnormal chest X-ray, CT scan, MRI, Pet Scan, or Ultrasound?						
13.	Ulcer, intestinal bleeding, ulcerative colitis, Crohn's disease, diverticulitis	s, persistent diarrhea, rectal bleeding.	hernia, or any other disorder				
	or disease of the mouth, throat, esophagus, stomach, intestines or abdo						
14.	Jaundice, cirrhosis, hepatitis, or any disease of the liver, pancreas or ga	ll bladder?					
15.	Sugar, protein or blood in the urine, kidney stone, glomerulonephritis, his	story of nephrectomy, any other diseas	se or disorder of the kidneys,				
	bladder, or any part of the urinary system?						
16.	6. Uterine fibroids, endometriosis, abnormality or change in menstrual cycle, ovarian cyst/tumor, prostate enlargement, prostate cancer,						
	testicular mass, sexually transmitted diseases, or any other disorder of t	the reproductive system or breasts?					
17.	Depression, anxiety, bipolar disorder, obsessive compulsive disorder, ne						
40	affective disorders, eating disorder, hallucinations, or any other mental, l						
	Alcoholism or drug addiction?	undrama fibramyalaia barniatad diaa	or any disarder of the				
19.	muscles igints happy tendens ligaments ening or back?	marome, libromyaigia, nerniated disc,	or any disorder of the				
20	muscles, joints, bones, tendons, ligaments, spine, or back?						
20.	Any other disease, disorder or injury not disclosed?						
22	If female, are you aware if you are currently pregnant? (If yes, please pr	ovide due date)					
		· · · · · · · · · · · · · · · · · · ·					
	TAILS OF YES ANSWERS. Identify question number, the reason(s) and		name, address, and phone num	iber of			
the	physician(s) or other health care providers. (Use additional blank page if	additional space is needed.)					

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EXAMINATION

(Part B (continued) of an application to Nationwide Insurance Companies for Life Insurance)

23a Ha		in DETAILS OF YES ANSWERS					Yes No
		: 10 years, consulted, been refer ovider or by any hospital, clinic, n					st or
dis	sclosed? (If it was	for a "check up", annual physica	l, employment phys	sical, etc., so si	tate and give	findings and results.)	
		10 years, been advised to have					
24a. Ha	ave you in the past	: 10 years, used tobacco or nicot	ine in any form? (If	yes, specify d	ates and all fo	orms of tobacco or nicotine	🗀 🗀
pro	oducts used.)						
		: 10 years, used alcoholic bevera : 10 years, used any illegal, restr					
c. Have you in the past 10 years, used any illegal, restricted, or controlled substance except as prescribed by a physician?							
26. Ha	ive you ever had a	any application for Life or Health	Insurance (or any a	application for i	reinstatemen	t for Life or Health Insurance) de	eclined,
postponed, rated-up or limited?							
of	an automobile, mo	otorcycle, or any type of motor-po	owered vehicle; scu	ıba diving, moı	untain climbir	ig, hang gliding, parachuting, sk	с у
28. Ha	diving, bungee jumping, soaring, or ballooning?						
pa	st 3 years been co	onvicted of more than one moving	g violation?				
29. 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?							
30. Ha	ive you ever been	charged with a violation of any c s, do you plan to travel or reside	criminal law?				
31. In	the next 12 month	s, do you plan to travel or reside	outside of the Unit	ed States or C	anada?		
32. DC	ave vou had anv b	intend to join any active or reser ankruptcies in the past 7 years o	r do vou have anv	organization?. suits or iudame	ents pendina	against you at this time?	
DETAIL	S OF YES ANSW	ERS. Identify question number, t	he reason(s) and o	letails of yes ar	nswers. Also,	if applicable, provide the diagno	osis and name,
34.		Health Concerns or	Age or Age	Brother or		Health Concerns or	Age or Age at
34.	Living	Health Concerns or Cause of Death	Age or Age at Death	Brother or Sister	Living	Health Concerns or Cause of Death	Age or Age at Death
34.	Living Y N		Age or Age at Death		YN		
Father	YN		Age or Age at Death		Y N Y N		
			Age or Age at Death		YN		
Father Mother	Y N Y N		at Death	Sister	Y N Y N Y N Y N	Cause of Death	
Father Mother	Y N Y N	Cause of Death	at Death	Sister	Y N Y N Y N Y N	Cause of Death	
Father Mother Other fan All the state of the containing of the	Y N Y N atements and ans nat a copy of this g a false or decepted fraud.	diabetes, heart disease, cancer, wers on this form are complete examination form may be attactive statement, and does so with	kidney disease or and true to the behed to and form a	Sister other inheritab est of my know part of any po	Y N Y N Y N Y N Y N Vedge and be	Cause of Death Cause of Death Cause of Death	Death n hand or not; and olication or a claim
Father Mother Other fan All the state of the containing of the	Y N Y N atements and anset a copy of this g a false or deception	diabetes, heart disease, cancer, wers on this form are complete examination form may be attactive statement, and does so with	kidney disease or and true to the behed to and form a	Sister other inheritab est of my know part of any po	Y N Y N Y N Y N Y N Vedge and be	Cause of Death Cause of Death Cause of Death	Death n hand or not; and olication or a claim
Father Mother Other fan All the state of the containing of the	Y N Y N atements and ans nat a copy of this g a false or decepted fraud.	diabetes, heart disease, cancer, wers on this form are complete examination form may be attact tive statement, and does so with	kidney disease or and true to the behed to and form a	Sister other inheritab est of my know part of any po	Y N Y N Y N Y N He conditions'	Cause of Death Cause of Death Cause of Death	Death n hand or not; and olication or a claim
Father Mother Other fan All the state of the containing of the	Y N Y N atements and ans nat a copy of this g a false or decepted fraud.	diabetes, heart disease, cancer, wers on this form are complete examination form may be attact tive statement, and does so with	kidney disease or and true to the behed to and form a	Sister other inheritab est of my know part of any po	Y N Y N Y N Y N Ide conditions' Vledge and beolicy issued. A he/she is factory	Cause of Death Cause of Death Cause of Death	Death n hand or not; and olication or a claim

PARAMED EXAM

Proposed Insured (First, MI, Last)	SSN / Tax ID # Date of Birth (mi			n/dd/yyyyy)				
1. a. Height (in shoes) b. Weight (clothed) ftinlbs.	c. Did you weigh? ☐ Yes ☐ No		I you measure? Yes □ No	e. Chest (full inspiration)in.	f. Chest (forced expiration)in.	g. Abdomen (at umbilicus)in.		
2. BLOOD PRESSURE: Record two additional blood pressure readings if the initial blood pressure is greater than 145 systolic or 90 diastolic. Take measurements before blood draw and allow 5 minutes between readings. Was a large cuff used? Yes No 1st Reading/								
3. After Exercise PULSE At Rest (15 squats - equ			LSE gularities per mir	At Rest	After Exercise (15 squats - equiv.)	3 minu	utes later	
Complete the following questions: (explain of the following questions): (explain of the following questions)	d age?d age?d age?d age?d sexcessive use of all cal history?d during the examinated and answer all que wing questions and als below including example disorder (e.g. deminated per week? If no, why amental activities of during (e.g. deminated activities activities of during (e.g. deminated activities activi	ation? testions attests: ercise company not?) aily livir	ns 4-7 in Details nobacco, or drugs asked in connect (explain all 'yes rapacity, type and memory loss)?	section below) section below) section with this examination with the examination wit	nation?	Yes	No	
Details of answers: Identify question number, letter and detailed information.								
10. Timed get up and go test: Time the number of seconds it takes for the insured to sit and rise from a straight back and armless chair, walk 10 feet and return to the chair and sit back down. Timing should begin when the insured begins standing up from a chair and ends when sitting back downseconds								
Please check all that apply: a. Rising from chair: Rises easily with no assistance Requires more than one attempt Has balance issues, needs assistance of c. Walking: Unassisted at a normal pace With assistance or mild difficulty Stumbles, extremely slow pace, needs swalker or cane	·		☐ Need ☐ Stum d. Sitting do ☐ Smoo	othly with no hesitat s mild assistance o bles or needs suppown in chair: othly with no hesitat s on armrest for sup s assistance	r has mild difficulty ort	y into chai	r	

11. Clock Draw Test:						
Make sure that the insured understands your instructions, but not need to score this test.	you do					
Have the proposed insured draw a circle in the space to the rig put the numbers around the clock in the correct positions, then hands of the clock at 10 minutes past 11 (11:10).	ght and n set the					
12. Signature Section						
I have examined		this	Day	day of	Month	,Year
and have witnessed his/her signature on the front of this examina	tion			Signature of Ex	xaminer	
Please Print:						
Examiner's Name:		Phone Nu	ımber:			
Examination Company:		Time of ex	xaminatior	n:a.m.	p.	m.
Address:	Producer	requestinç	g examination:			
				ng did you use to ide with picture □		Insured?
The following are being forwarded to the authorized laboratory:	□ Exar			☐ Stress EKG		