Nationwide is on your side

Nationwide Life Insurance Company
Home Office: Columbus, Ohio

Employee Enrollment Form

Section I –Employer Information Please print or type

Group Number	Employer Name		
Employer Address	City	State	Zip Code

Section II – Employee Information Please print or type

Employee Last Name, Suffix (e.g., Sr, Jr)	First Name	M/I	Gender	E-mail Address	Home Phone
					( ) -
Residence Address	**City**	**County**	**State**	**Zip Code**	**Work Phone**
					( ) -
Employee Member #	**Occupation**	**Class**		**Location/Division**	

Marital Status	Date of Birth (MM-DD-YYYY)	Earnings Reported on
☐ Single ☐ Married ☐Divorced/Separated ☐ Widowed	Social Security #	☐ W2 ☐ 1099 ☐Other, Explain_____ Annual Earnings (Salary)_____

Enrollment Status

☐ Active Full Time Employee – List Date of Hire_____-_____-_____

☐ Active Part Time Employee (if applicable) – List Date of Hire_____-_____-_____

☐ Retired Employee – List Date of Retirement _____-_____-_____ *(Coverage available only if offered by your Employer)*

Section III – Election or Declination of Coverages Please print or type

Coverage Election Codes: EE = Employee Only, ES = Employee and Spouse, EC= Employee and Child(ren), EF = Employee and Family
Please check to indicate your coverage election/declination for you and your eligible dependents.
You must elect coverage for yourself for your dependents to be eligible.
Note: Some coverages may not be offered by your employer.
† Stand alone AD&D coverage. Includes Dependent AD&D, if Dependent coverage is offered by your employer.

Product	Coverage Elections *	Coverage Declinations *	Elected Benefit Amount
Basic Group Term Life (and AD&D if applicable)	☐		
Basic Dependent Life	☐	☐	
Voluntary Group Term Life (and AD&D if applicable)	☐	☐	$_____ or __X base salary ($_____ increments)
Voluntary Accidental Death and Dismemberment (AD&D) †	☐ EE ☐ EF	☐ EE ☐ EF	
Voluntary Spousal Life (and AD&D if applicable)	☐	☐	**Spouse:** $_____ ($_____ increments)
Voluntary Child(ren) Life (and AD&D if applicable)	☐	☐	**Children:** $_____ ($_____ increments)
Long Term Disability	☐	☐	
Short Term Disability	☐	☐	
Voluntary Long Term Disability	☐	☐	
Voluntary Short Term Disability	☐	☐	

WAIVER OF ALL COVERAGES

Please note, do not complete this waiver section if you are electing any type of coverage offered on this application.

☐ I DECLINE **ALL** coverages offered to me for which I am required to contribute all or a portion of the premium. I have read the Late Enrollee Important Notice in Section V of this enrollment form, and I understand what may be required of me to enroll at a later date.

_____ _____-_____-____
Employee Signature Date

Reason for declining employee and/or dependent coverage (i.e. benefits, elsewhere, cost, other):

_____

If you are waiving all coverages offered, you do not need to complete any additional sections of this application.

Section IV – Enrollment Information **Please print or type**

Beneficiaries (Complete this section only when Life or AD&D or Accidental Death benefits are selected)

Unless otherwise specified herein, if two or more beneficiaries are named as primary or as contingent, the proceeds shall be paid in equal shares to the named beneficiaries surviving the insured. If specifying a %, totals must equal 100%. To name additional beneficiaries, please attach a separate sheet.

	Last Name, First Name, MI	Relationship	Social Security Number XXX-XX-XXXX	%
Primary				
Primary				
Contingent				
Contingent				

Eligible Dependents to be Covered

Relation	Name Last, Suffix (e.g. Sr., Jr.) First, MI	Social Security Number (XXX-XX-XXXX)	Date of Birth (M-D-YYYY)	Gender (M/F)
Spouse*		- -	- -	
Child		- -	- -	
Child		- -	- -	
Child		- -	- -	
Child		- -	- -	

*For purposes of this Enrollment Form, Spouse includes a Domestic Partner, subject to state mandates.

Please check here if Spouse is a Domestic Partner ☐

Section V – Please Read the Following Important Notices

Late Enrollees If you refuse coverage for yourself and/or your dependents for any reason, you will be considered a late enrollee and will only be permitted to enroll during the group's next annual enrollment period or within 31 days of a change in family status.

Pre-existing The coverage for which you are enrolling may include a pre-existing condition limitation.

Health Information Practices I understand that under the Federal Regulations and state law, I have a right to see and correct personal information that Nationwide collects about me, and that I may obtain a description of my rights under these laws and of Nationwide's information practices by writing to Nationwide at the following address: Nationwide Life Insurance Company, Attention: Compliance Department, One Nationwide Plaza, Columbus, Ohio 43215.

Confirmation I agree that the information set forth on this enrollment form is correctly recorded, complete and true to the best of my knowledge and belief, and that it forms the basis of my insurance. I further agree that the Certificate together with this Enrollment Form, the Group Policy, and Policyholder's Application, and any amendments or riders will completely describe the benefits and conditions of the insurance agreement. Nationwide Life Insurance Company (hereafter referred to as "Company") will rely and act upon the answers and information I provide on this Enrollment Form. The Company reserves the right to retroactively adjust the premium rate for the group at any time in the event that material misrepresentation of information has occurred. My insurance coverage will not become effective until this Enrollment Form is received and approved by the Company, any applicable premium is paid, and in no event prior to the effective date of the Group Policy.

Section VI – Please Read, Sign and Date Below

(Alabama) Any person who knowingly presents a false or fraudulent claim for payment of a 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.

(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.

(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.

(Kentucky) Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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) 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.

(Maine) 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/or civil penalties.

(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.

(Missouri) An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether an insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question(s) appears in this application, you should not renew it.

(NAIC) 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.

(New Hampshire) The policy provides limited benefits. Review your policy carefully.

(New Jersey) Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

(New Mexico) 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/or civil penalties.

(Oklahoma) 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.

(Puerto Rico) Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a maximum of two (2) years.

(Washington) Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

(All Other States) 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/or civil 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 five thousand dollars and the stated value of the claim for each such violation.

Employee's Signature ▶	Date

Employer Certification and Authorization

I certify that the above information is correct and complete according to our records.

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