



Nationwide Life Insurance Company

Home Office: Columbus, Ohio

Group Life and Accidental Death Claim Form

On Your Side®

Please accept our deepest sympathies for your loss. Our objective is to provide fast and accurate claims service. Listed below are instructions on claim submissions that, when followed, will assist us in providing this service.

General Instructions: Please read this page before you fill out the Claim Form.

Written notice of the claim should be provided to us within 30 days after date of death. Written proof of loss (completed claim form and supporting documents) should be provided to us within 90 days after the date of death.

To complete processing of the claim, we must have:

1. An original certified Death Certificate bearing the seal of the appropriate local, state or federal agency issuing the certificate must accompany this form. Copies will not be accepted.
2. Autopsy report/coroner's report, if performed, including a toxicology report
3. Newspaper articles, if accidental death and if applicable
4. Police, Fire and/or Accident Report, if accidental death
5. A separate Beneficiary Statement (Section 2) for *each* beneficiary.
6. A fully completed copy of the Employer's Statement

Beneficiary/Claimant Instructions

1. You will need to complete all sections of the Beneficiary Statement. Each beneficiary must complete a separate Beneficiary Statement. Please attach a separate sheet listing all addresses at which you have lived in the past 2 years.
2. Obtain all supporting documentation listed above, as applicable.
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.

State Fraud Notices

(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 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.

(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.

(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.

Group Life and Accidental Death Claim Form Beneficiary Statement

Please type or print legibly.

Section 1: Information about the Insured (Deceased)

Name of Insured (First, MI, Last)	Insured Social Security Number
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Section 2: Claimant/Beneficiary Information

Are you making this claim as the Beneficiary? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what is your relationship to the deceased?		
Are you making this claim as the Administrator, Guardian or Executor? <input type="checkbox"/> Yes, please provide appropriate proof. <input type="checkbox"/> No		
Name (First, MI, Last)	SSN	Date of Birth
Residential Address – No P.O. Box (Street Name/Number, City, State, Zip)		
Mailing Address, if different (Street Name/Number, City, State, Zip)		
Driver's License or Additional ID #	State of Issue	<input type="checkbox"/> Driver's License <input type="checkbox"/> Government ID <input type="checkbox"/> Military ID
Daytime Telephone Number	E-mail address (optional)	
<i>Complete only if the beneficiary is a trust or estate:</i>	Trust or Estate Name	Trust or Estate TIN

Section 3: Important Information

Social Security Number: In general, life insurance benefits are NOT subject to income tax. However, because you may be earning taxable interest under the Nationwide Bank Secure Money Market Account program, the Federal government requires us, and all other financial institutions that pay interest, to ask for and obtain your Social Security Number (SSN) or other Taxpayer Identification Number (TIN). If you fail to supply us with your SSN or other TIN, the Federal government requires us to withhold a portion of any interest otherwise payable to you as a deposit against the taxes that may be due.

If you have been notified by the Internal Revenue Service (IRS) that you are subject to "backup withholding" for failure to report all your interest or dividend in the past, and if the IRS has not written to you stating that you are no longer subject to backup withholding, you must indicate your status on the Beneficiary Statement where applicable (below).

Claims by a Trust, Estate or Assignee: If you are filing this claim as a Trustee, Executor or Administrator, you must complete and sign this statement and submit certified copies of the appointment papers. Please be sure to indicate the Trust or Estate TIN above.

Assignment of Benefits: If any portion of the benefits has been assigned, please include a copy of the assignment.

Beneficiary Signature: Please sign the Beneficiary Statement below in the same manner as you would sign checks. Your signature may be used to verify Nationwide Bank Secure Money Market Account checks you write or instructions you give us in the future. You will also be certifying, under penalties of perjury, that your SSN or other TIN and backup withholding status are true.

Section 4: Certification and Signature

I certify that I have read the State Fraud Notices on the previous page. I certify that the above information is correct to the best of my knowledge and belief and that the person named above was Insured by the policy, and that his or her insurance was in effect on the date the death occurred.

Under penalties of perjury, I certify that:

- (1) The number shown on this form is my correct taxpayer identification number, and
- (2) I am not subject to backup withholding because (a) I have not been notified that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (b) the Internal Revenue Service has notified me that I am no longer subject to backup withholding, or that I am exempt from backup withholding, and
- (3) I am a United States citizen (including a U.S. resident alien).

You must cross out item (2) if you have been notified by the IRS that you are currently subject to backup withholding because of failure to report interest or dividends on your tax return.

If your proceeds are \$10,000 or more, you will be set up with a Secure Money Market Account and therefore the following applies: I understand and agree, by signing this form, that Nationwide Bank, an affiliate of Nationwide, will access and utilize consumer report information to open my account. I authorize my information to be shared with Nationwide Bank for purposes of establishing my Secure Money Market Account. To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify and record information that identifies each person who opens accounts. That this means for me: When I open an account, Nationwide Bank asks for my name, address, date of birth, and other information that will allow them to identify me. Nationwide Bank may ask to see my driver's license and/or other identifying documents.

(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.

Beneficiary's Signature ▶	Date
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Group Life and Accidental Death Claim Form Employer Statement

Not for use by beneficiaries. Please type or print legibly.

Employer Instructions

1. Check that each beneficiary/claimant has completed, dated and signed a Beneficiary Statement. Verify that all required documentation has been provided.
2. Complete the Employer Statement and attach a copy of the most recent beneficiary designation information. If a beneficiary who is entitled to a benefit is deceased, provide name, date of death and a copy of his/her certified death certificate. The insured employee is automatically the beneficiary for all dependent death claims.
3. Send this claim form and all required documentation to:
Nationwide, P.O. Box 1199, Newark, OH 43058-1199 or Fax (740) 788-1546

Section 1: Policy and Employer Information

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

Section 2: Employee Information – Complete only if this claim is for an insured employee

Employee Name (First, MI, Last)	SSN	Date of Birth
Class & Location	Rate of Pay (at date last worked) \$ _____ per	Date Employed
Did the insured meet the definition of Actively at Work at the time of death? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Explain:		Date Last Worked
Was claim for Waiver of Premium or continuation due to total disability benefits submitted prior to death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Date of Death	Original Date Insured with Nationwide	Insurance Termed prior to death? <input type="checkbox"/> Yes <input type="checkbox"/> No

Amount of Insurance at Time of Death

Basic Life \$ _____	Voluntary Life \$ _____	Basic AD&D \$ _____	Voluntary AD&D \$ _____
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Section 3: Dependent Information – Complete only if this claim is for an insured dependent

Insured Dependent Name (First, MI, Last)	Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F	SSN
Address (Street Name/Number, City, State, Zip)			
Relationship to Insured Employee	If spouse, was he/she divorced or legally separated from the employee? <input type="checkbox"/> Yes <input type="checkbox"/> No	If child, was he/she: Married? <input type="checkbox"/> Yes <input type="checkbox"/> No Full-time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was dependent insured at the time of death? <input type="checkbox"/> Yes <input type="checkbox"/> No – Explain:	Date of Death	Amount of Dependent's Insurance \$ _____	

Section 4: Accidental Death Claim Information – Complete only if death was due to an accident and the group plan provides and Accidental Death benefit. Refer to the Instructions for a list of necessary supporting documentation.

Date of Accident or Incident	Place of Accident
Time of Accident or Incident	Did the death arise out of and during the course of employment? <input type="checkbox"/> Yes <input type="checkbox"/> No
Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, by whom? (Physician name)

Information About Physician Attending the Deceased or Injured Following the Accident

Physician Name	Professional Designation	Telephone Number
Address (Street Name/Number, City, State, Zip)		

Section 5: Certification and Signature

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