

AUXILIARY POLICE, FIREFIGHTERS & RESERVE UNITS Insurance Policy Application

Print or
type only

which, upon acceptance and approval by **Nationwide Life Insurance Company**—Columbus, Ohio 43216, will become a part of Specified Hazard Insurance Policy Number 502- _____

Office Use Only

1. Name of Plan Sponsor Group's Name _____

Address Street _____ City _____ State _____ Zip _____ County _____

2. Policy Term: The policy term starts at **12:01 a.m.** on ____/____/____ which is the effective date, and ends at **12:01 a.m.** on ____/____/____ which is the first renewal date.

3. Covered Activities

On duty under the direction of the plan sponsor and/or the government or private unit for which the insured is serving; those activities sponsored and directly supervised by the plan sponsor; training courses, tests, drills, or trials of a piece of apparatus connected directly with such duties; and direct travel to and/or from such activities. (500)

4. Maximum Benefit Amounts—the word “None” means the benefit is not included

| Benefit Provisions | Maximum Benefit Amounts | | | |
|--|-------------------------|--------------|--------------------|--------------|
| | CLASS 1 | CLASS 2 | CLASS 3 | CLASS 4 |
| ACCIDENTAL DEATH & SPECIFIC LOSS with a \$250,000 overall maximum for any one accident. | | | | |
| Death | \$5,000 | \$12,500 | \$5,000 | \$12,500 |
| Specific Loss (Face Amount) | 10,000 | 25,000 | 10,000 | 25,000 |
| MEDICAL EXPENSE | | | | |
| Accident | Deductible | None | None | None |
| | Overall Maximum | 25,000 | 50,000 | 25,000 |
| WEEKLY ACCIDENT INCOME | | | | |
| Starting on the first day of disability for up to 52 weeks | None | None | 100 | 200 |
| OFFICE USE ONLY | 2220P 4220E | 5011E | 2220P 4220E | 5011E |

5. Premium Rates by Class(es) of Eligible Persons — check class and Medical Expense Plan desired

| Annual | | Premium Rates per Eligible Person | |
|---|---|---|--|
| Class | Eligible Persons | <input type="checkbox"/> Medical Expense PRIMARY Plan | <input type="checkbox"/> Medical Expense EXCESS Plan |
| All auxiliary and all volunteer members of the plan sponsor (check only one box): | | | |
| 1 | <input type="checkbox"/> Class 1 Benefits (C13) | \$4.75 | \$3.10 |
| 2 | <input type="checkbox"/> Class 2 Benefits (C13) | Not Available | 6.25 |
| 3 | <input type="checkbox"/> Class 3 Benefits (C13) | 10.75 | 9.50 |
| 4 | <input type="checkbox"/> Class 4 Benefits (C13) | Not Available | 18.75 |

The minimum premium per policy term is \$225 if the medical expense PRIMARY plan has been elected and \$175 if the medical expense EXCESS plan has been elected.

6. The Policy is to cover all eligible persons (05)

7. It is understood and agreed that: (a) the premium will be paid entirely by the plan sponsor with no contribution made by the eligible persons toward the cost of the insurance; and (b) **premium will be paid annually in advance based on the total number of eligible persons anticipated to be insured during the policy term (BF50).**

(NY) 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 sending your check to Nationwide Life Insurance Company (“Nationwide”), you give your consent to Nationwide to authorize our financial institution to convert your check into an electronic fund transfer. Please be aware that your bank account may be debited as soon as the same day we receive your payment and you will not receive a canceled check. For authorized checking account withdrawal (also called Automated Clearing House or “ACH”) call 844-203-2691.

By signing below, you agree that you have read all of the Fraud Warnings provided with this application.

Previous Policy Number _____
 Date _____
 Appointed Agent's Signature and Number _____
 Appointed Agent's Phone Number _____
 Appointed Agent's E-mail Address _____
 GR-9050 (Office Use) _____

Signature of Applicant _____
 Printed Name and Title of Applicant _____
 Address of Applicant _____
 Applicant's Phone Number _____
 Applicant's E-mail Address _____
 Check box if no agent was used.

Volunteer fire departments and ambulance companies are not eligible under this brochure—Please visit our website at nationwide.com/groupprotector or contact us at 844-203-2691.

Medical Expense Benefit

If, as a result of injury, an insured incurs covered expenses starting within 90 days from the date of the accident causing the injury, we will pay, less the deductible (if any) shown in the application and not to exceed the overall maximum benefit amount, all covered expenses incurred within 3 years from such date.

Covered expenses means the reasonable and customary charges for local ("local" not applicable in a CT contract) professional ambulance service to or from a hospital and/or surgical center as well as the following reasonable and customary charges for treatment, services and supplies provided or prescribed by a doctor:

- (1) hospital or surgical center care;
- (2) medical treatment;
- (3) nursing care provided by a licensed nurse;
- (4) X-rays and lab exams;
- (5) prescription drugs and therapeutic services and supplies;
- (6) dental treatment as a result of injury to sound, natural teeth (natural teeth in SC);
- (7) the following licensed home health care agency services and supplies provided instead of an otherwise required hospital or skilled nursing home confinement:
 - (a) physical, occupational, respiratory and speech therapy,
 - (b) the services of a home health aide and
 - (c) medical supplies.

If excess medical has been elected, we will not pay benefits for, nor can this plan's deductible (if any) be satisfied by, covered expenses to the extent that they are collectible under certain other policies and/or health plans as stated in the policy.

Coverage is provided under policy form No. GR-9051-2.

Certain provisions of the policy are summarized in this folder. All benefits are subject to the policy, which alone constitutes the agreement under which payments are made.

Death Benefit

If, as a result of injury, an insured dies within one year from the date of the accident causing the injury, we will pay the death benefit less any specific loss benefit paid because of the same accident. The one year limit does not apply in a PA or WV contract.

Specific Loss Benefit

If, as a result of injury, an insured suffers a specific loss within one year from the date of the accident causing the injury, we will pay:

| Specific Loss | % of Face Amount |
|-------------------------------------|------------------|
| Each Arm | 75% |
| Each Leg | 75% |
| Each Hand | 50% |
| Each Foot | 50% |
| Sight of Each Eye | 50% |
| Speech | 50% |
| Hearing of Each Ear | 25% |
| Thumb and Index Finger of Same Hand | 25% |

The total payment for all of the specific losses of an insured because of any one accident will not be more than the face amount. No specific loss benefit will be paid if the death benefit applies. The loss of the thumb and index finger of the same hand benefit will not be paid if the loss of the hand or arm benefit applies. The loss of the hand or foot benefit will not be paid if the loss of the arm or leg benefit applies.

Policy Exclusions & Limitations

We will not pay benefits for expenses incurred for:

- (1) the examination, prescription, purchase or fitting of eye-glasses, contact lenses or hearing aids; or
- (2) treatment by a person employed or retained by the plan sponsor or its subsidiaries or affiliates and for which no charge is normally made; or
- (3) care or treatment by a person who ordinarily lives in the insured's home or is a parent, grandparent, spouse, brother, sister or child of either the insured or the insured's spouse (if a NJ contract, care or treatment furnished by a member of the insured's immediate family).

Nor will we pay benefits for loss or expenses resulting from:

- (4) intentional self-destruction or an attempt at it or intentional self-inflicted injury (if MO contract, while sane);
- (5) war or an act of war, declared or undeclared; or
- (6) air travel unless the insured is a passenger on a regularly scheduled flight of a properly licensed commercial airline.

PREMIUM REPORT (Must be completed for Application to be accepted)

Type of Group: _____

Group Activities Include: _____

Age Range of Members: _____ to _____ years of age

| Anticipated Number of Eligible Persons to be Insured During the Policy Term | | | Annual Premium Rate per Eligible Memberships | Premium Due |
|---|-------------------|---------------|--|-------------|
| Auxiliary Members | Volunteer Members | Total Members | | |
| + | | = | X | = \$ |

***The annual minimum premium per policy term is \$225 for PRIMARY medical coverage and \$175 for EXCESS medical coverage.**

I certify that to the best of my knowledge and belief: (1) the preceding information is correct and complete; (2) premium is being paid for the total number of eligible persons who are anticipated to be insured during the policy term; and (3) **the premium is being paid entirely by the plan sponsor with no contribution made by the eligible persons toward the cost of the insurance.**

Date

by _____
Signature of Applicant

Day Telephone Number

Fax Number

E-mail Address

Note: For authorized checking account withdrawal (also called Automated Clearing House "ACH") download and complete the Authorization Form found at www.nationwide.com/ach or for credit card payment call, 844-203-2691.

How do you apply and pay for coverage?

Complete ALL fields on the application. Be sure to sign and date where indicated. **We need to receive the completed application and premium payment BEFORE the desired policy effective date.**

APPLICATION OPTIONS

Online at nationwide.com/groupprotector

Mail the application and Premium Report, if applicable, to GrouProtector / K&K Insurance Group, Inc., PO Box 2338, Fort Wayne IN 46801

E-mail: Scan the application and Premium Report, if applicable and email them to grouprotector@kandkinsurance.com. Include payment by filling out, scanning and emailing the ACH form or submit payment with a credit or debit card. If you prefer, you may mail a check (see below).

Fax: the application and Premium Report, if applicable, to 260-459-5903. Submit payment by credit or debit card, ACH, or if you prefer you may mail a check (see below).


PAYMENT OPTIONS

Pay by mail: Mail payment to GrouProtector c/o K&K Insurance Group, Inc., PO Box 2338, Fort Wayne, IN 46801


Pay by credit or debit card: Call (844) 203-2691

Pay by electronic check (ACH): Download and complete the Automated Clearing House (ACH) Authorization Form found at nationwide.com/ach and mail, fax or e-mail the ACH form with your application.

How do you contact us?

 1-844-203-2691
(8:00 a.m. - 5:00 p.m. ET, M-F)

 1-260-459-5903

 GrouProtector / K&K Insurance Group
PO Box 2338
Fort Wayne, IN 46801

 grouprotector@kandkinsurance.com

 nationwide.com/groupprotector



Nationwide®

Underwritten by Nationwide Life Insurance Company.

Administered by K&K Insurance Group, Inc.

Nationwide, the Nationwide N and Eagle, Nationwide is on your side and GrouProtector are service marks of Nationwide Mutual Insurance Company.

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Fraud Warnings

(CA) 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.

(FL) 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.

(KY) 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.

(LA) 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.

(MD) 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.

(MO) 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.

(PA) 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.

(PR) 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 aggregated 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.

(WA) 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. This policy provides limited business activities accidental death and specific loss benefits only.

Please read these important notices and warnings

All cases are subject to the acceptance of the risk and may be subject to review of prior claims experience.

Unless otherwise specified in the Benefit Provisions, this policy does not provide coverage for sickness or for legal liability.

This policy does not provide basic hospital, basic medical or major medical insurance. (In NY: as defined by the New York State Insurance Department)

(NY) The insurance offered in this brochure is (1) not a deposit; (2) not insured by the Federal Deposit Insurance Corporation; and (3) not guaranteed by the bank, trust company, savings bank, savings and loan associations, federal savings association or national bank.