# Nationwide<sup>®</sup>

### 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)

Name of Proposed Insured (please print)	Social Security No.	Date of Birth							
Physicians: Include both primary care and specialists and date last consulted. (	If more than two physicians, indicate :	so under "details".)							
	• •	•							
NameAddress	NameAddress								
Telephone	Telephone								
Medical specialty									
Date and reason last consulted	Medical specialty Medical specialty Date and reason last consulted Date and reason last consulted								
Current medications to include prescription, over-the-counter medication taken regularly, dietary supplements, "natural" or herbal medications. Give details of dosage and frequency.									
To the best of your knowledge and belief, have you ever consulted a licens diagnosed as having:	sed health care provider for, been t	reated for, or been	Yes No						
(Explain all "yes" answers in DETAILS OF YES ANSWERS section below unless	s otherwise instructed.)								
1. AIDS (Acquired Immune Deficiency Syndrome), or any other AIDS-related									
Immunodeficiency Virus) test?									
2. Heart disease, heart attack, angina, chest pain, shortness of breath, cardi	omyopathy, congestive heart failure,	heart murmur, valvular heart							
disease, congenital heart defect, or other disorders of the heart?									
3. Abnormal electrocardiogram, heart catheterization, coronary bypass surge 4. Irregular heart beat, palpitations, high blood pressure, high cholesterol, or	ery, angiopiasty, or other cardiac test	or procedure?							
<ol> <li>Irregular heart beat, palphations, riigh blood pressure, riigh cholesterol, or</li> <li>Aneurysm, carotid artery disease, deep venous thrombosis, phlebitis, peri</li> </ol>	hboral vascular disease, any other di	corder of the blood vessels							
or pulmonary embolism?	prierai vasculai disease, ariy otilei di								
6. Diabetes, abnormal blood sugar, thyroid, adrenal, parathyroid, pituitary, or	other glandular disorder?		ΠП						
7. Cancer, leukemia, lymphoma, any malignant or benign tumor, cyst, polyp 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. Disorder of the blood including anemia, sickle cell disorders, thalassemia,	hemophilia, or any other disorder of	the red blood cells, or white							
blood cells, platelets, or clotting factors?									
10. Headaches, Stroke, TIA (transient ischemic attack), paralysis, epilepsy, se	eizures, fainting, tremor, Parkinson's c	disease, mental retardation,							
cerebral palsy, multiple sclerosis, Alzheimer's disease, dementia, ALS (Lo									
nerves, spinal cord, or brain?	and ar actual place appear or parcels	nov or any other diagons							
11. Asthma, emphysema, chronic bronchitis, tuberculosis, persistent hoarsen									
	of the lungs or respiratory system?								
13. Ulcer, intestinal bleeding, ulcerative colitis, Crohn's disease, diverticulitis,	persistent diarrhea, rectal bleeding, h	ernia, or any other disorder							
or disease of the mouth, throat, esophagus, stomach, intestines or abdom	nen?	orma, or any carer decrees							
14. Jaundice, cirrhosis, hepatitis, or any disease of the liver, pancreas or gall	bladder?								
15. Sugar, protein or blood in the urine, kidney stone, glomerulonephritis, history	ory of nephrectomy, any other disease	e or disorder of the kidneys,							
bladder, or any part of the urinary system?	bladder, or any part of the urinary system?								
16. Uterine fibroids, endometriosis, abnormality or change in menstrual cycle,									
testicular mass, sexually transmitted diseases, or any other disorder of the									
17. Depression, anxiety, bipolar disorder, obsessive compulsive disorder, neu									
affective disorders, eating disorder, hallucinations, or any other mental, be	eriaviorai, psychological or psychiatric	disorders?							
<ul><li>18. Alcoholism or drug addiction?</li><li>19. Arthritis, rheumatoid arthritis, osteoporosis, chronic pain, chronic pain syn</li></ul>	drome fibromyalgia herniated disc o	or any disorder of the							
muscles, joints, bones, tendons, ligaments, spine, or back?	aromo, noromyaigia, normatoa aloo, e								
20. Any disease of eyes, ears, nose, or throat?									
21. Any other disease, disorder or injury not disclosed?									
22. If female, are you aware if you are currently pregnant? (If yes, please prov	vide due date.)								
DETAILS OF YES ANSWERS. Identify question number, the reason(s) and dethe physician(s) or other health care providers. (Use additional blank page if an example of the physician	etails of yes answers, diagnosis and r dditional space is needed.)	name, address, and phone num	ber of						

## NATIONWIDE LIFE INSURANCE COMPANY NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY

#### **EXAMINATION**

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

23a. Have	you in the past	in DETAILS OF YES ANSWERS 10 years, consulted, been refere	ed to, or been exa	mined or treate	ed by any ph	nysician, chiropractor, psychologist or	Yes No
disclo	sed? (If it was i	vider or by any hospital, clinic, m for a "check up", annual physical,	, employment phys	sical, etc., so st	ate and give	r health care facility not already e findings and results.)excluding HIV or AIDS) that was not	. 🗆 🗆
comp	leted or results	that you have not received?  10 years, used tobacco or nicoti				·	. 🗆 🗆
b. Have c. Have 25. Have 26. Have postpe 27. In the of an diving 28. Have	cts used.) you in the past you in the past you In the past you ever had a oned, rated-up past 3 years, r automobile, mo , bungee jumpi you ever had y	10 years, used alcoholic beveraed 10 years, used any illegal, restrict 10 years, requested, applied, or ny application for Life or Health I or limited?	ges? (If yes, how rected, or controlled received a pension nsurance (or any antend to engage in owered vehicle; scurrevoked; or ever	much, what kind substance exc n, benefits, or papplication for r 	d (beer, wind ept as preso payment be reinstatemen lot, student untain climb	e, liquor), how often?) cribed by a physician? cause of injury, sickness or disability? nt for Life or Health Insurance) declined, pilot, or crew member; organized racing ing, hang gliding, parachuting, sky while impaired or intoxicated; or in the	
29. Excep	ot as prescribed	l by a physician, have you ever u	ised, or been conv	icted for sale o	r possessio	n of cocaine or any other narcotic or	
illegal drug?							
34.	Living	Health Concerns or	Age or Age	Brother or	Living		e or Age at
Father		Cause of Death	at Death	Sister	ΥN	Cause of Death	Death
	YN				Y N Y N		
Mother	YN	dishertes has at disease services	Lida a dia a a a a a a	- 4l :l::4l-	ΥN	-0	
All the staten	nents and answ	on form may be attached to and t	d true to the best o	f my knowledg	e and belief	, whether written by my own hand or not; who, with the intent to defraud or knowing tive statement is guilty of insurance frauc	that he/she
Signed this o	lay of						
•	-	Month/Day			Year		
Signed		Signature of Examiner				Signature of Proposed Insured	

PARAMED EXAM

Proposed Insured (First, MI, Last)			SSN / Tax ID # Date of Bir			(mm/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. Abdo (at ui	men <i>mbilicus)</i> 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/ Srd Reading/ Srd Reading/								
3. After Exercise PULSE At Rest (15 squats - equ			LSE	At Rest	After Exercise (15 squats - equiv.)	3 minutes later		
Pulse Rate							<b>≥</b>	
Details of answers: Identify question number,	letter and detailed in	formatio	on.					
10. <b>Timed get up and go test:</b> 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 examination.  Signature of Examiner								
Please Print:								
Examiner's Name:		Phone Nu	ımber:					
Examination Company:		Time of ex	xaminatior	n:a.m.	p.	m.		
Address:			Producer requesting examination:					
				ng did you use to ide with picture □		Insured?		
The following are being forwarded to the authorized laboratory:	□ Exar			☐ Stress EKG				