NATIONWIDE LIFE INSURANCE COMPANY
NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY
NATIONWIDE LIFE INSURANCE COMPANY OF AMERICA
NATIONWIDE LIFE AND ANNUITY COMPANY OF AMERICA
MEDICAL EXAM FORM

This form is approved for use in the following state(s):

MN

Please use correct form for state where application is signed.

INSTRUCTIONS:

1. All questions are to be completed by the examiner.
2. Print legibly and use black ink. Any changes must be initialed by the Proposed Insured.
3. Answer questions fully. Obtain the name and address of any treating medical provider.
4. This form becomes part of the contract of insurance, therefore, the signature of the Proposed Insured and witness are necessary.
5. Do not provide comments regarding the insurability of the Proposed Insured.
6. On the Paramed or Physician's Exam section, provide your comments if appearance is unhealthy.
7. Note question 35 must be completed if applicant is disabled or over age 70.
8. Mailing Instructions:

   ☐ **Life Underwriting**
   Refer to your company's order instructions for exam handling and appropriate lab information

   ☐ **COLI/BOLI, 1-11-08**
   One Nationwide Plaza
   Columbus, OH 43215-2220

   ☐ **Nationwide Health Plans**
   P.O. Box 8026
   Dublin, OH 43016-9902

Mail To: ☐ **Nationwide Life Insurance Company**
☐ **Nationwide Life and Annuity Insurance Company**
☐ **Nationwide Life Insurance Company of America**
☐ **Nationwide Life and Annuity Company of America**

☐ Life Underwriting P.O. Box 182835 Columbus, OH 43218-2835	☐ Corporate Insurance Market One Nationwide Plaza Columbus, OH 43215-2220	☐ Nationwide Health Plans P.O. Box 8026 Dublin, OH 43016-9902 Fax: 1-614-854-3872

MEDICAL EXAMINATION

(Part B of an application to Nationwide Insurance for Life or Health 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".)*

Name__________	Name__________
Address__________	Address__________
Telephone__________	Telephone__________
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.__________

The applicant does not have to disclose an HIV (AIDS Virus) test which was administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. Please refer to the authorization section for a detailed definition of "Emergency Medical Personnel".

To the best of your knowledge and belief, have you ever been treated for, taken medication for, or been diagnosed as having:

	Yes	No
1. Any immune disorder?	☐	☐
2. Heart disease, including heart attack, angina, or other chest pain, shortness of breath, cardiomyopathy, congestive heart failure, heart murmur, or valvular heart disease, congenital heart defect, or other disorders of the heart?	☐	☐
3. Heart catheterization, abnormal electrocardiogram, or other cardiac test, coronary bypass surgery, or angioplasty?	☐	☐
4. Irregular heart beat, palpitations, high blood pressure, high cholesterol, or high triglycerides?	☐	☐
5. Aneurysm, carotid artery disease, deep venous thrombosis, phlebitis, peripheral vascular disease, any other disorder of the blood vessels, or pulmonary embolism?	☐	☐
6. Diabetes or abnormal blood sugar?	☐	☐
7. Thyroid, adrenal, parathyroid, pituitary, or other glandular disorder?	☐	☐
8. Cancer, leukemia, lymphoma or any malignant or benign tumor, cyst, or polyp?	☐	☐
9. Any abnormal screening tests for cancer including PSA (prostate specific antigen), mammogram, or PAP smears?	☐	☐
10. 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?	☐	☐
11. Headaches, Stroke, TIA (transient ischemic attack), paralysis, epilepsy, seizures, fainting, tremor, Parkinson's disease, mental retardation, cerebral palsy, multiple sclerosis, Alzheimer's disease, ALS (Lou Gehrig's disease), or any other symptoms or disorders of the nerves, spinal cord, or brain?	☐	☐
12. Asthma, emphysema, chronic bronchitis, tuberculosis, persistent hoarseness or cough, sleep apnea or narcolepsy, or any other disease of the lungs or respiratory system?	☐	☐
13. An abnormal chest X-ray or CT scan?	☐	☐
14. Ulcer, intestinal bleeding, ulcerative colitis, Crohn's disease, diverticulitis, persistent diarrhea, rectal bleeding, hernia, or any other disorder of the mouth, throat, esophagus, stomach, intestines or abdomen?	☐	☐
15. Jaundice, cirrhosis, hepatitis, or any disease of the liver, pancreas or gall bladder?	☐	☐
16. Sugar, protein or blood in the urine, kidney stone, glomerulonephritis, history of nephrectomy, any other disease or disorder of the kidneys, bladder, or any part of the urinary system?	☐	☐
17. 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 the reproductive system or breasts?	☐	☐
18. Psychological or psychiatric disorders including depression, bipolar disorder, obsessive compulsive disorder, schizophrenia, attention deficit disorders, affective disorders, eating disorder, hallucinations, or any other mental or behavioral disorder or disease?	☐	☐
19. Arthritis, osteoporosis, chronic pain, chronic pain syndrome, fibromyalgia, herniated disc, or any disorder of the muscles, joints, bones, tendons, ligaments, spine, or back?	☐	☐
20. Any disease of eyes, ears, nose, or throat?	☐	☐
21. If female, are you aware if you are currently pregnant? *(If yes, please provide due date.)*	☐	☐

DETAILS of *yes* answers. Identify question number. Circle applicable items. Include diagnosis and name and address of medical provider(s) consulted. (Use page 2 if additional space is needed.)

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MEDICAL EXAMINATION

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

Have you in the past 5 years:	**Yes**	**No**
22. Been treated for, taken medication for, or been diagnosed as having alcoholism or a drug addiction?	☐	☐
23a. Been a patient (including outpatient) in a hospital, clinic, mental health facility, or other medical facility?	☐	☐
b. Consulted or been referred to any physician not listed above?	☐	☐
c. Been medically advised to have surgery, hospitalization, testing, or treatment that was not completed?	☐	☐
24a. Used tobacco? *(If yes, specify dates and form of tobacco used.)*	☐	☐
b. Used alcoholic beverages? *(If yes, how much, what kind (beer, wine, liquor), how often?)*	☐	☐
c. Except as prescribed by a physician, have you, other than on a one–time or experimental basis, used drugs within the past five years, or ever been convicted for sale or possession of cocaine or any other narcotic or illegal drug? *(If yes, provide details.)*	☐	☐
25. Requested or received a pension, benefits, or payment because of injury, sickness or disability?	☐	☐

ADDITIONAL SPACE FOR DETAILS OF *YES* ANSWERS. *(Identify question number.)*

26.	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
Father	Y N				Y N		
					Y N		
Mother	Y N				Y N		
					Y N		

Other family members with diabetes, heart disease, cancer, kidney disease or other inheritable conditions?

All the statements and answers on this form are representations not warranties that are complete and true to the best of my knowledge and belief, whether written by my own hand or not; and I agree that a copy of this medical examination form may be attached to and form a part of any policy issued. The term "Emergency Medical Personnel" includes individuals employed to provide pre–hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, included security guards at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is transported to receive medical care and who would qualify for immunity under the good Samaritan law.

Signed this day of ______________________, ________.
Month/Day Year

Signed______________________ ______________________
Signature of Medical Examiner Signature of Proposed Insured

PARAMED OR PHYSICIAN'S EXAM

27a. Height (in shoes) _______ft. ______in. Weight (clothed) _______lbs. b. Did you weigh? ☐ Yes ☐ No c. Did you measure? ☐ Yes ☐ No

d. Chest (full inspiration) ________in. e. Chest (forced expiration) ______in. f. Abdomen (at umbilicus) _______in. **Yes No**

28. Is appearance unhealthy or older than stated age? *(If yes, please explain below.)* .... ☐ ☐
29. Do you suspect anything unfavorable such as excessive use of alcohol, tobacco, or drugs? *(If yes, please explain below.)* .... ☐ ☐
30. Are you aware of additional significant medical history? .... ☐ ☐
31. Did anyone accompany the Proposed Insured during the examination? .... ☐ ☐
32. Was the Proposed Insured able to understand and to answer all questions asked in connection with this examination? .... ☐ ☐

33. BLOOD PRESSURE: Record two additional blood pressure readings if the initial blood pressure is greater than 145 systolic or 90 diastolic. Take measurement before blood draw and allow 5 minutes between readings. If arm is overly large, was a large cuff used? ☐ Yes ☐ No

1st Reading	2nd Reading	3rd Reading
/	/	/

34.

PULSE	At Rest	After Exercise (15 squats - equiv.)	3 Minutes Later	PULSE	At Rest	After Exercise (15 squats - equiv.)	3 Minutes Later
Pulse Rate				Irregularities per min.			

If applicant is disabled, or over age 70, answer the following questions: **Yes No**

35a. Does he/she exercise? *(If yes, provide details including exercise capacity, type, frequency.)* .... ☐ ☐
b. Does he/she do any volunteer work or have any hobbies? *(If yes, please provide details.)* .... ☐ ☐
c. Does he/she have any gait or mobility problems? *(If yes, describe.)* .... ☐ ☐
d. Does he/she have any evidence of a cognitive disorder (e.g. dementia, memory loss)? *(If yes, provide details.)* .... ☐ ☐
e. Does he/she drive? *(If yes, how many miles per week? If no, why not?)* .... ☐ ☐

Do not ask the following questions if applicant works, volunteers or participates in an exercise program outside of the home.

f. Does he/she need assistance with any instrumental activities of daily living (e.g. banking, shopping)? *(If yes, provide details.)* .... ☐ ☐
g. Does he/she need assistance with any activities of daily living (e.g. feeding, bathing, dressing)? .... ☐ ☐

PHYSICIAN'S EXAM

Are there any abnormalities: **Yes No**

36. of the eyes, ears, or nose (including funduscopic examination)? .... ☐ ☐
37. of the neck including carotid upstroke and bruits, JVD, scars, or thyroid abnormality or enlarged lymph nodes? .... ☐ ☐
38. of the chest including wheezes or rales, axillary nodes, increased AP diameter, evidence of COPD? Any disorders of the breasts? .... ☐ ☐
39. of the heart including heart sounds, gallops, thrills, or murmurs, displaced PMI, etc.? .... ☐ ☐
40. of the abdomen including liver or spleen enlargement, masses, bruits, hernia, scars, tenderness, or inguinal nodes? .... ☐ ☐
41. of the extremities including clubbing, cyanosis, edema, varicose veins, ulcers, deformities or amputations? .... ☐ ☐
42. of the skin including pigmentation, lesions, tattoos, scars, or other abnormalities? .... ☐ ☐
43. of the neurological exam including orientation, memory, weakness, paralysis, or abnormal reflexes? .... ☐ ☐

A confidential report may be sent to: Medical Director, Nationwide Life Insurance Company, 5100 Rings Road, Dublin, Ohio 43017-1522.

DETAILS OF *YES* ANSWERS. *(Identify question number.)*

I have examined ______________________ *(Applicant)* this ________ Day day of ______________ Month, ________ Year
and have witnessed his/her signature on the front of this examination.

PLEASE PRINT OR TYPE:

Examiner's Name:______________________

Phone Number:______________________

Examination Company:______________________

Address:______________________

Taxpayer Identification No.______________________

____
Medical Examiner's Signature

Time of examination: ________ a.m. ________ p.m.

Producer requesting examination: ______________________

Which of the following did you use to identify the Proposed Insured?

☐ Driver's License with picture ☐ Other picture ID____________

Purpose of examination: ☐ Life ☐ Group ☐ Disability

Reference No./Policy No. (if known) ______________________

The following are being forwarded to the authorized laboratory: ☐ Exam form ☐ EKG ☐ HIV Consent ☐ Blood ☐ Urine ☐ Other________