



**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):

CA

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 36 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**
1651 Exposition Blvd.
Suite 100
Sacramento, CA 95815



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
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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 include prescription, over-the-counter medication taken regularly, dietary supplements, "natural" or herbal medications. Give details of dosage and frequency. _____

Have you ever consulted or been treated by a member of the medical profession, taken medication for, undergone any test or procedure listed below, or been diagnosed as having:

- | | | Yes | No |
|---|--|--------------------------|--------------------------|
| 1. AIDS (Acquired Immune Deficiency Syndrome)? (If applying for Health Insurance, please do not complete question #1.) | | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Heart catheterization, abnormal electrocardiogram, or other cardiac test, coronary bypass surgery, or angioplasty? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Irregular heart beat, palpitations, high blood pressure, high cholesterol, or high triglycerides? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Aneurysm, carotid artery disease, deep venous thrombosis, phlebitis, peripheral vascular disease, any other disorder of the blood vessels, or pulmonary embolism? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Diabetes or abnormal blood sugar? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Thyroid, adrenal, parathyroid, pituitary, or other glandular disorder? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Cancer, leukemia, lymphoma or any malignant or benign tumor, cyst, or polyp? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Any abnormal screening tests for cancer including PSA (prostate specific antigen), mammogram, or PAP smears? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Asthma, emphysema, chronic bronchitis, tuberculosis, persistent hoarseness or cough, sleep apnea or narcolepsy, or any other disease of the lungs or respiratory system? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. An abnormal chest X-ray or CT scan? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Jaundice, cirrhosis, hepatitis, or any disease of the liver, pancreas or gall bladder? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Alcoholism or drug addiction? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Arthritis, osteoporosis, chronic pain, chronic pain syndrome, fibromyalgia, herniated disc, or any disorder of the muscles, joints, bones, tendons, ligaments, spine, or back? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Any disease of eyes, ears, nose, or throat? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Any other mental or physical disease or disorder not listed above? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. If female, are you aware if you are currently pregnant? (If yes, please provide due date.) | | <input type="checkbox"/> | <input type="checkbox"/> |

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.)

PARAMED OR PHYSICIAN'S EXAM

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

34. 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

Table with 8 columns: 35. PULSE, At Rest, After Exercise (15 squats - equiv.), 3 Minutes Later, PULSE, At Rest, After Exercise (15 squats - equiv.), 3 Minutes Later. Sub-headers: Pulse Rate, Irregularities per min.

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

- 36a. 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

- 37. of the eyes, ears, or nose (including funduscopic examination)? [] []
38. of the neck including carotid upstroke and bruits, JVD, scars, or thyroid abnormality or enlarged lymph nodes? [] []
39. of the chest including wheezes or rales, axillary nodes, increased AP diameter, evidence of COPD? Any disorders of the breasts? [] []
40. of the heart including heart sounds, gallops, thrills, or murmurs, displaced PMI, etc.? [] []
41. of the abdomen including liver or spleen enlargement, masses, bruits, hernia, scars, tenderness, or inguinal nodes? [] []
42. of the extremities including clubbing, cyanosis, edema, varicose veins, ulcers, deformities or amputations? [] []
43. of the skin including pigmentation, lesions, tattoos, scars, or other abnormalities? [] []
44. 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.)

Blank lines for providing details of yes answers.

I have examined _____ this _____ day of _____, _____ Year
(Applicant) Day 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 _____

- Nationwide Life Insurance Company of America
Service and Technology Center, P.O. Box 15750, Wilmington, DE 19850-5750, (800) 688-5177
- Nationwide Life and Annuity Company of America
Service and Technology Center, P.O. Box 15750, Wilmington, DE 19850-5750, (800) 688-5177



NOTICE AND CONSENT FORM FOR AIDS VIRUS (HIV) TESTING

The HIV Antibody Test

To evaluate your insurability, the Insurer named above (the Insurer) has requested that you consent to be tested to determine the presence of human immunodeficiency virus (HIV) antibodies. The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of tests will be performed by a certified laboratory through a medically accepted procedure which is extremely reliable.

Meaning of Test Results

While positive HIV antibody test results would not mean that you have AIDS, they would mean that you would be at significantly increased risk of developing AIDS or AIDS-related conditions. The presence of antibodies means that the tested person has been infected with the HIV virus. It is still possible that the person will not develop AIDS or AIDS-related conditions. Positive HIV antibody results will adversely affect your application for insurance.

A negative test result means no antibodies to the HIV virus were found. Because of varying incubation periods, absence of HIV antibodies does not mean that you have not been infected with the virus. Absence of HIV antibodies does not mean that you are immune to the virus.

Counseling

Many public health organizations have recommended that before taking an AIDS-related test, a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

Public health officials recommend that persons who test positive for the HIV antibodies should seek counseling to become informed about the implications of the test results.

Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions or concerns, you should consult your own physician or own health care provider.

A Counseling Resources List is provided on Page 2 for your information.

Notification of Test Results

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you are entitled to that information if you so desire. Because a trained person should deliver that information so that you can understand clearly what the test results mean, you are asked to list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting possible positive test results: _____

Address: _____

Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

Consent

I have read and I understand this Notice and Consent for AIDS Virus (HIV) Testing. I voluntarily consent to testing and disclosure of the test results as described above. I have been given written information about AIDS.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Name of Proposed Insured (please print):	Address:
Signature of Proposed Insured or Parent/Guardian:	Date Signed:

COUNSELING RESOURCES LIST

As required by California law, the following list of counseling resources is being provided to you. It was compiled from publicly available information, which is subject to change without notice to the Insurer. Therefore, the Insurer makes no representations or warranties about the accuracy of this information as of the date you receive this list, or about the quality or nature of any services these resources may provide.

This is not a complete list of all resources that may be available to you. We suggest you contact your own physician or health care provider, your county health department, or your local chapter of the American Red Cross, for further information.

AIDS HOTLINE - U.S. PUBLIC HEALTH SERVICE
(800) 342-AIDS

SPANISH AIDS HOTLINE
(800) 222-SIDA

TTY INFORMATION
Information and Referral for Hearing Impaired
(213) 464-0029

KERN COUNTY AIDS TEAM - Bakersfield
(805) 861-3631

CENTRAL VALLEY AIDS TEAM - Fresno
(209) 264-2436

AIDS PROJECT - EAST BAY - Oakland
(415) 420-8181

SACRAMENTO AIDS FOUNDATION - Sacramento
(916) 448-2437

SAN FRANCISCO AIDS FOUNDATION - San Francisco
(415) 864-5855

SONOMA COUNTY AIDS INFORMATION HOTLINE
(707) 579-AIDS

AIDS HOTLINE - Southern California
(800) 922-AIDS

HEMOPHILIA FOUNDATION OF SOUTHERN CALIFORNIA
Social Services - Southern California
Hemophilia AIDS Information
(818) 793-6192
(714) 740-2222

CALIFORNIA DEPARTMENT OF HEALTH SERVICES - Statewide Services
Office of AIDS, Sacramento
(916) 323-7415

AIDS SERVICES FOUNDATION OF ORANGE COUNTY - Costa Mesa
(714) 646-0411

AIDS PROJECT - LOS ANGELES
West Hollywood
(213) 876-8951

INLAND AIDS PROJECT
Riverside/San Bernardino Counties
(714) 784-2437

SAN DIEGO AIDS PROJECT
(619) 543-0300 - City of San Diego
(619) 945-6000 - City of Vista

SANTA BARBARA COUNTY AIDS INFORMATION HOTLINE
(805) 965-2925

SHASTA COUNTY HELPLINE
(916) 225-5252