



**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 (<i>please print</i>)	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 to 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)? (<i>If applying for Health Insurance, please do not complete question #1.</i>)..... | <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? (<i>If yes, please provide due date.</i>) | <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.)

