Nationwide Life Insurance Company

One Nationwide Plaza
Columbus, Ohio 43215

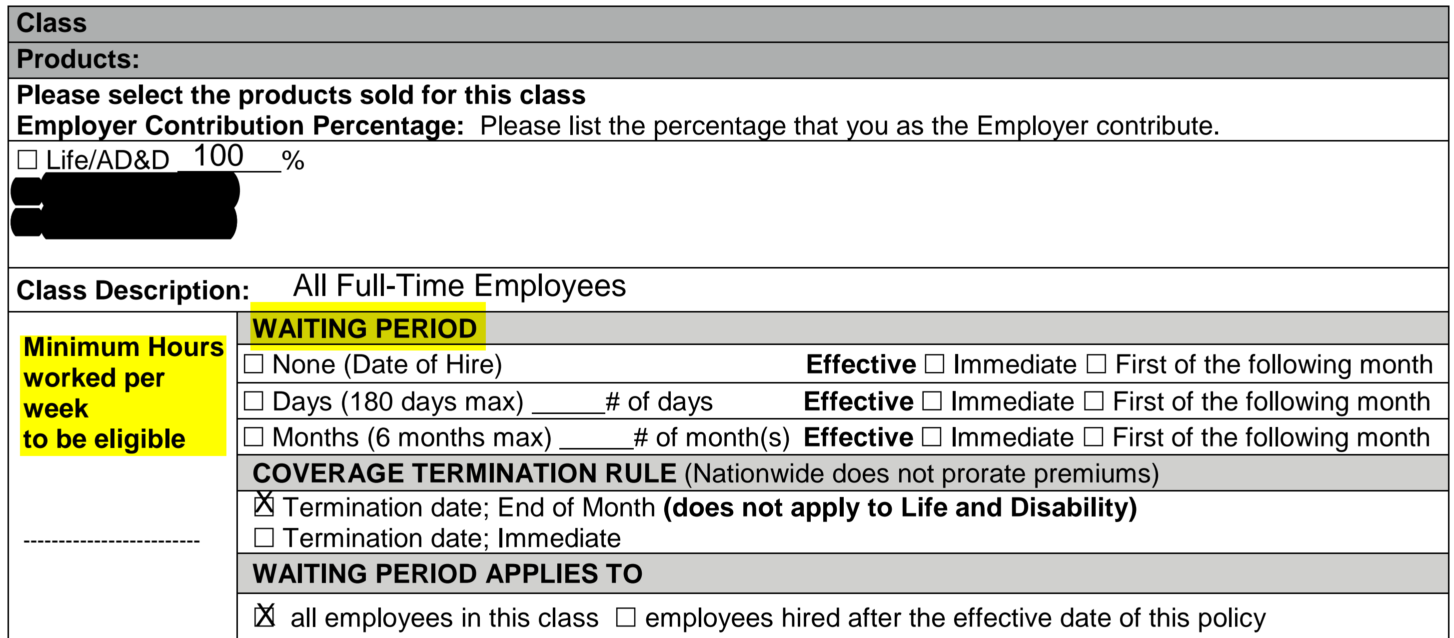
Nationwide Employee Benefits
POLICYHOLDER APPLICATION FOR GROUP INSURANCE

Application is hereby made for the Benefits set forth herein. The information given below shall be the basis of the agreement with the Plan Sponsor.

Section I - Administrative Information

Company Name				
DBA Name				
Policyholder Street Address (No P.O. Box)	City	State	Zip	County
Mailing Address (if different from above)	City	State	Zip	County
Phone (xxx-xxx-xxxx)	Administrative Contact			
Fax (xxx-xxx-xxxx)	Title			
Employer's Tax Identification Number	Email Address			
Requested Effective (MM/DD/YYYY)	Business Start Date (MM/DD/YYYY)			
Describe the Nature of Business			SIC Code	

Section II – Product and Class Selection



Class	
Products:	
Please select the products sold for this class **Employer Contribution Percentage:** Please list the percentage that you as the Employer contribute.	
☐ Life/AD&D 100 %	
Class Description: All Full-Time Employees	
Minimum Hours worked per week to be eligible ------------------------	**WAITING PERIOD**
	☐ None (Date of Hire) **Effective** ☐ Immediate ☐ First of the following month
	☐ Days (180 days max) _____# of days **Effective** ☐ Immediate ☐ First of the following month
	☐ Months (6 months max) _____# of month(s) **Effective** ☐ Immediate ☐ First of the following month
	COVERAGE TERMINATION RULE (Nationwide does not prorate premiums)
	☒ Termination date; End of Month **(does not apply to Life and Disability)** ☐ Termination date; Immediate
	WAITING PERIOD APPLIES TO
	☒ all employees in this class ☐ employees hired after the effective date of this policy

Section III - General Conditions

In applying for the Benefits set forth herein, the undersigned understands and agrees that:

1. Payment of the first Premium by the Policyholder after delivery of the Policy by Nationwide Life Insurance Company shall constitute acceptance of the terms and conditions contained in the Policy so issued, including riders, endorsements or amendments, if any.
2. All necessary administrative information concerning all Covered Persons shall be subject to the provisions of the Policy and shall be furnished to Nationwide Life Insurance Company by the Policyholder.
3. This Application is subject to the approval of Nationwide Life Insurance Company at its Home Office and that nothing contained herein shall be binding upon said Company until this Application has been so approved.
4. All benefits will be in accordance with the benefits proposed and agreed upon between Nationwide Life Insurance Company and the Policyholder as set forth in the Policy, subject to the Policyholder's approval.
5. Benefits are not provided unless otherwise provided in the Policy; (a) in case of bodily injury or sickness arising out of or in the course of any employment for wage or profit; or (b) for any bodily injury or sickness for which the person on whom the claim is presented has or had a right to compensation under Workers' Compensation or similar occupational disease law. (Not applicable to Long Term Disability.)
6. The Policy is delivered in and is governed by the laws of the state of ___________________________.

By the signature below of its duly authorized representative, the proposed Policyholder hereby applies for the Nationwide Life Insurance Company Policy and the proposed Policyholder understands and agrees that it shall be subject to the provisions set forth herein.

It is understood that all of the answers provided in this application are representations and not warranties.

BEFORE SIGNING THE APPLICATION, PLEASE READ THE FRAUD WARNING(S) APPLICABLE TO YOUR STATE(S) AND COVERAGE(S) BELOW:

FRAUD WARNING FOR LONG TERM DISABILITY COVERAGE: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

FRAUD WARNING FOR ALL COVERAGES: 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.

Please see the page(s) below for state-specific variations of this fraud notice.

(Alabama) Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in prison, or any combination thereof.

(Kansas) 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, may be guilty of insurance fraud as determined by a court of law.

(Kentucky) 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.

(**Arkansas/Louisiana**) Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

(NAIC) Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

(Ohio) Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

(Oklahoma) Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

(Oregon) 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 may be guilty of a fraudulent insurance act, which may result in a conviction of crime.

(Pennsylvania) 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.

Please Sign and Date

Signature of Employer	Printed name of Employer	Job Title	Month / Day / Year

Signature of Agent/Producer:

Signature of Agent/Producer	Printed name of Agent/Producer	Date

Section IV - Producer Information

Name of Agency		
Agency Address		
Name of Agent Representing this Group (First Name/MI/Last Name)		
Phone (xxx-xxx-xxxx)	Fax (xxx-xxx-xxxx)	Email Address
Producer Number (if assigned)		

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ACH payment authorization form

You authorize a single or regularly scheduled charge to the designated bank account. With recurring ACH payments, the amount debited from your account may change if your group size or member benefits change. An invoice will be emailed to the billing contact around the 15th of each month. This will provide you a minimum of 10 days to review the invoice and total dollar amount due, and contact us if there are any changes to be made prior to the ACH debit being pulled from your account. The only exception to this time frame is on your first invoice, which may provide you with less than 10 days.

Bank information:

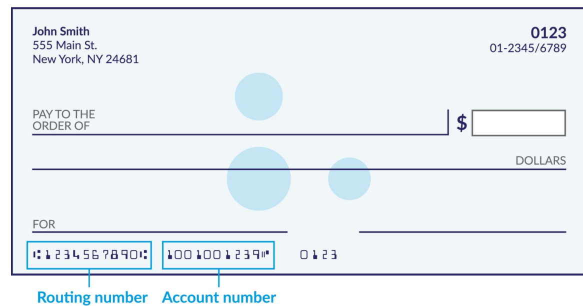
Select one: ☐ Checking account ☐ Savings account

Account name: ______________________________

Bank name: ______________________________

Routing number: ______________________________

Account number: ______________________________



Please select which ACH method you are authorizing:

☐ **Single ACH (Gives us permission to debit your account one time only for the amount indicated on the date indicated)**

I ____________________________ (Group representative) on behalf of ________________________________ (Group's name) ________________ (Group's number) authorize Beam Benefits to initiate a single ACH/electronic debit from the selected account for $_________________. I authorize Beam Benefits to initiate the single ACH/electronic debit on _____/_____/_____ (Date). I agree that ACH transactions I authorize comply with all applicable laws.

☐ **Recurring ACH (Authorizes regularly scheduled payment of your monthly invoice total due)**

I ____________________________ (Group representative) on behalf of ________________________________ (Group's name) ________________ (Group's number) authorize Beam Benefits to initiate a monthly recurring ACH/electronic debit from the selected account. I agree that ACH transactions I authorize comply with all applicable laws.

With recurring ACH payments, if your account balance is currently past due, the initial payment will occur upon receipt of this authorization for the remaining balance owed to bring the account current. Subsequent recurring debits will be initiated and will occur on the first business day following the 1st of each month.

☐ **Please check this box to authorize Beam Benefits to credit the account listed on page 1.**

Any credit to your account will appear on your bank statement and will include a combination of the terms Beam, premium, and the year.

I understand that this authorization will remain in full force and effect until I notify Beam Benefits that I wish to revoke this authorization by emailing adminsupport@beambenefits.com. I understand that Beam Benefits requires written notice at least 5 days prior to the first business day following the 1st of each month in order to cancel this authorization.

Signature: ________________________________ Date: _______________

In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) or if the entry was returned for reasons of insufficient or uncollected funds, I understand that Beam Benefits may reinitiate a returned entry up to two times. Payment will continue to process for up to, but not greater than 30 days after a payment has been declined, until approved.

It is recommended that you print a copy of this authorization and maintain it for your records. It is also recommended that you provide a voided check with this authorization form so that Beam Benefits can confirm your routing and account number and make this process as seamless as possible.