Nationwide Life Insurance Company
Home Office: Columbus, Ohio

Group Life and Accidental Death Claim Form

Please accept our deepest sympathies for your loss. At this difficult time, our goal is to service your claim quickly and accurately. Thank you, in advance, for providing us with the information we need by following the instructions below.

General Instructions: Please Read this Page Before You Fill Out the Claim Form

Please provide us with written notice of the claim within 30 days after the date of death followed by written proof of loss (this completed claim form and all supporting documents) within 90 days after the date of death.

To complete processing of the claim, we must have:

1. An original certified Death Certificate bearing the seal of the appropriate local, state or federal agency issuing the certificate along with this form. A copy is acceptable.
2. Autopsy report/coroner's report, if performed, including a toxicology report.
3. Newspaper articles, if the death was accidental and articles are available.
4. Police, Fire and/or Accident Report, if the death was accidental.
5. A separate Beneficiary Statement (Section 2) for *each* beneficiary.
6. A fully completed copy of the Employer's Statement (page 3 below).

Beneficiary/Claimant Instructions

1. Please complete all sections of the Beneficiary Statement. If there are multiple beneficiaries, each individual must complete a separate Beneficiary Statement. If necessary, please include a separate sheet listing all addresses at which you have lived in the past two years.
2. Submit your completed claim form, including any applicable supporting documentation listed above via one of these methods.
    a. Mail: Nationwide P.O. Box 1910, Covington, LA 70434
    b. Fax to: 985-898-1770
    c. E-mail to service@nebsupport.com
3. If you have any questions, please contact Customer Service at (877) 717-4455

Be sure to keep a copy of all the documents for your records

State Fraud Notices: Please Read

(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.

(California) For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

(District of Columbia) 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.

(Florida) Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

(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.

(Louisiana) It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

(Maine) 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.

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

(Missouri) An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether an insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question(s) appears in this application, you should not renew it.

(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.

(New Hampshire) The policy provides limited benefits. Review your policy carefully.

(New Jersey) Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

(New Mexico) 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.

(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.

(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 civil penalties.

(Puerto Rico) Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a maximum of two (2) years.

(Washington) Any person who knowingly provides false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

(All Other States) 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.

(New York) 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Please type or print legibly.

Section 1: Information about the Insured (Deceased)

Name of Insured (First, MI, Last)	Insured's Social Security Number

Section 2: Claim Payment Options

Please select one of the following benefit payment options:

☐ **I authorize Nationwide to deposit my life proceeds into my personal bank account.** As a convenience to me, I authorize Nationwide Insurance and its authorized representative, Gilsbar, L.L.C., Covington, LA (TIN #72-0519951), to deposit claim payments and, if necessary, make adjustments for any error to my account at the Bank (or other financial institution) I have indicated below.

Bank Name_____ Name on Bank Account_____
Bank Account # _____Bank Account Routing/Transit # _____
Checking ☐ Savings ☐

Authorized Signature_____ Date _____

If selecting Checking Account, please submit ***a voided blank check from the account into which proceeds will be deposited.***

☐ **Please send a lump sum check to me for all life insurance proceeds.**

☐ **Nationwide Secure Money Market Account.** I authorize my information to be shared with Nationwide Bank. I understand and agree, by signing this form, that Nationwide Bank, an affiliate of Nationwide, will access and utilize consumer report information to open my account. I authorize my information to be shared with Nationwide Bank for purposes of establishing my Secure Money Market Account. To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify and record information that identifies each person who opens an account. For me this means that when I open an account, Nationwide Bank asks for my name, address, date of birth, and other information that will allow them to identify me. Nationwide Bank may also ask to see my driver's license and or other identifying documents.

(If you wish the proceeds to be paid to a funeral, please obtain an Absolute Assignment from your funeral director. By law this form can only be used to authorize payment to you as the beneficiary.)

Section 3: Claimant/Beneficiary Information – Please Complete this Section with Your Information)

Are you making this claim as the Beneficiary? ☐ No ☐ Yes. My relationship to the deceased is:

Are you making this claim as the Administrator, Guardian or Executor? ☐ No ☐ Yes. Please provide appropriate proof.

Name (First, MI, Last)	Social Security Number	Date of Birth

Residential Address – No P.O. Box (Street Name/Number, City, State, Zip)

Mailing Address, if Different (Street Name/Number or P.O. Box, City, State, Zip)

Driver's License or Other ID Number	State of Issue	☐ Driver's License ☐ Government ID ☐ Military ID

Daytime Telephone Number	E-mail address (optional)

Complete only if the beneficiary is a trust or estate:	Trust or Estate Name	Trust or Estate TIN

Section 4: Important Information

Social Security Number: In general, life insurance benefits are NOT subject to income tax. However, because you may be earning taxable interest under the Nationwide Bank Secure Money Market Account program, the Federal government requires us, and all other financial institutions that pay interest, to ask for and obtain your Social Security Number (SSN) or other Taxpayer Identification Number (TIN). If you fail to supply us with your SSN or other TIN, the Federal government requires us to withhold a portion of any interest otherwise payable to you as a deposit against the taxes that may be due.

If you have been notified by the Internal Revenue Service (IRS) that you are subject to "backup withholding" for failure to report all your interest or dividend in the past, and if the IRS has not written to you stating that you are no longer subject to backup withholding, you must indicate your status on the Beneficiary Statement where applicable (below).

Claims by a Trust, Estate or Assignee: If you are filing this claim as a Trustee, Executor or Administrator, you must complete and sign this statement and submit certified copies of the appointment papers. Please be sure to indicate the Trust or Estate TIN above.

Assignment of Benefits: If any portion of the benefits has been assigned, please include a copy of the assignment.

Beneficiary Signature: Please sign the Beneficiary Statement below in the same manner as you would sign checks. Your signature may be used to verify Nationwide Bank Secure Money Market Account checks you write or instructions you give us in the future. You will also be certifying, under penalties of perjury, that your SSN or other TIN and backup withholding status are true.

Section 5: Certification and Signature

I certify that I have read the State Fraud Notices on the previous page. I certify that the above information is correct to the best of my knowledge and belief and that the person named above was Insured by the policy, and that his or her insurance was in effect on the date the death occurred. Under penalties of perjury, I certify that:

(1) The number shown on this form is my correct taxpayer identification number, and
(2) I am not subject to backup withholding because (a) I have not been notified that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (b) the Internal Revenue Service has notified me that I am no longer subject to backup withholding, or that I am exempt from backup withholding, and
(3) I am a United States citizen (including a U.S. resident alien).

You must cross out item (2) if you have been notified by the IRS that you are currently subject to backup withholding because of failure to report interest or dividends on your tax return.

(New York) 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Beneficiary's Signature ►	Date

Not for use by beneficiaries. Please type or print legibly.

Employer Instructions

1. Provide each beneficiary with a Claim Form, a Beneficiary Statement and a completed Employer Statement (including any attachments).
2. Complete the Employer Statement and attach a copy of the most recent beneficiary designation information. If a beneficiary entitled to a benefit is deceased, please provide name, date of death and a copy of his/her certified death certificate. (Please note that the insured employee is automatically the beneficiary for all dependent death claims.)
3. Once completed, either you or the beneficiary(ies) should send this claim form and all required documentation to Nationwide.

Section 1: Policy and Employer Information

Group Name	Group Number
Direct All Correspondence on this Claim to:	Telephone Number
Address (Street Name/Number, City, State, Zip)	E-mail Address

Section 2: Employee Information

Employee Name (First, MI, Last)		SSN	Date of Birth
Work location/Division:	Occupation/Job Title:	Rate of Pay (at date last worked) $ per	Date Employed
Did the insured meet the definition of Actively at Work at the time of death? ☐ Yes ☐ No If No, Explain:			Date Last Worked

Was a claim for Waiver of Premium or Continuation due to total disability benefits submitted prior to death? ☐ Yes ☐ No

Date of Death	Original Date Insured with Nationwide	Insurance Termed prior to death? ☐ Yes ☐ No

Is/Was Employee Full Time ☐ Yes ☐ No Part-Time ☐ Yes ☐ No Hours Worked Per Week _____

Reason for Employee Leaving Work:

If more than thirty one days elapsed between date last worked and date of death, do you consider death occurred while he/she was
☐ Retired Employee ☐ Absent on Sick Leave ☐ Totally Disabled ☐ Absent due to Temporary Lay-Off ☐ No Longer Employed

Amount of Insurance at Time of Death

Basic Life $	Voluntary Life $	Basic AD&D $	Voluntary AD&D $

Section 3: Dependent Information – Complete Only if this Claim is for an Insured Dependent

Insured Dependent Name (First, MI, Last)	Date of Birth	Gender ☐ M ☐ F	SSN
Address (Street Name/Number, City, State, Zip)			
Relationship to Insured Employee:	If spouse, was he/she divorced or legally separated from the employee? ☐ Yes ☐ No		
If child was he/she: Married? ☐ Yes ☐ No Full-time Student? ☐ Yes ☐ No Employed? ☐ Yes ☐ No			
Was dependent insured at the time of death? ☐ Yes ☐ No – Explain:	Date of Death	Amount of Dependent's Insurance $	

Section 4: Accidental Death Claim Information – Complete Only if Death was Due to an Accident and Your Group Plan Provides an Accidental Death Benefit. Refer to the Instructions Above for a List of Necessary Supporting Documentation.

Date of Accident	Describe in detail how the accident occurred:
Place of Accident	Did the death arise out of and during the course of employment? ☐ No ☐ Yes
Was an autopsy performed? ☐ Yes ☐ No	Was the employee in a coma prior to death? ☐ Yes ☐ No Does the employee have a child who is a full-time college student? ☐ Yes ☐ No

Information About Physician Attending the Deceased or Injured Following the Accident

Physician Name	Professional Designation	Telephone Number
Address (Street Name/Number, City, State, Zip)		

VERY IMPORTANT: ERISA

Is Employer subject to ERISA compliance? ☐ No ☐ Yes

Section 5: Certification and Signature

I certify that the above information is correct and complete according to our records.

Name of Employer's Authorized Representative (printed)	Title
Signature of Employer's Authorized Representative ▶	Date