Nationwide®
is on your side

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

(A photocopy or facsimile copy of this authorization is as valid as the original)

☐ **Nationwide Life Insurance Company** ☐ **Nationwide Life and Annuity Insurance Company**

Please return completed authorization to: P.O. Box 182928, Columbus, Ohio 43218-2928 • Phone: 1-800-445-1717 • Fax: 1-888-677-7393

SECTION 1: GENERAL INFORMATION – Please Print.

Proposed Insured's Name First/Last:_____

Proposed Insured's Social Security Number: _____Date of Birth:_____

Proposed Insured's Address:_____

City: _____State: _____Zip:_____

SECTION 2: AUTHORIZATION

TO: Nationwide Life Insurance Company and Nationwide Life and Annuity Insurance Company (collectively the "Nationwide")

I authorize Nationwide to disclose information about me, including health information, to the person named below for the purpose of providing me with additional information regarding the underwriting decisions made in connection with my life insurance application(s) submitted to Nationwide.

Authorized Person's Name First/Last:_____

Authorized Person's Address:_____

City: _____State: _____Zip:_____

Telephone Number:_____E-mail Address:_____

The information that may be disclosed by Nationwide pursuant to this Authorization is (check all that apply):

☐ Medical Exam
☐ Urinalysis
☐ Blood Profile
☐ Other: _____
☐ Medical Records received from any healthcare provider
☐ Electrocardiogram
☐ All results performed in connection with the underwriting file

SECTION 3: ACKNOWLEDGEMENT

I understand and acknowledge that:

- I am not required to sign this Authorization as a condition of my application for insurance from Nationwide.
- Signing, not signing or revoking this Authorization will not affect my eligibility for Nationwide insurance.
- Information disclosed pursuant to the Authorization may no longer be subject to Nationwide's privacy policy.
- Information that may have been subject to federal privacy rules, once disclosed, may no longer be covered by those rules and my be subject to re-disclosure by the recipient.
- The Company may charge a reasonable fee to apply to its copying and mailing costs.
- This information is being supplied to me in regards to my life insurance application and in no way represents any medical advice nor recommendations about my medical condition or options for care and treatment. I recognize that those are issues to be discussed with my health care provider.

I further understand and acknowledge that: (i) this Authorization will be valid for 12 months following the date signed and will cover applications for life insurance submitted to Nationwide during the next 12 months, beginning on the date the Authorization is signed; (ii) I have the right to revoke this Authorization at any time and may do so by writing to Nationwide at the address above; however, action taken by Nationwide in reliance on this Authorization prior to receipt of my revocation by Nationwide will remain valid; and (iii) I can receive a copy of this authorization upon request to Nationwide.

SECTION 4: SIGNATURE(S)

If Proposed Insured is under 18, the ☐ **Parent** or ☐ **Guardian** is to sign below for such child.

➢_____ _____
Signature of Proposed Insured Date

As witness, I attest to having observed the party named above sign in my presence.

➢_____ _____
Witness to Signature Date