Effective Date:_____

❑ Initial Enrollment
❑ Newly Eligible Plan Participant*
❑ Special Enrollment*

Plan Participant Enrollment Application

(Do not use this form for COBRA)

Group Life and Limited Benefit Medical

Nationwide® On Your Side℠

Please Print or Type

Name (Last) (First) (MI)	Gender	Date of Birth MM/DD/YY	Social Security No.
	❑ M ❑ F	/ /	- -

Address City State Zip County	Home Phone
	( ) -

Policyholder	Eligibility Status Date of Hire/Retirement	Business Phone
Quality Business Solutions	❑ Active ❑ Retiree / /	( ) -

Avg Weekly Hours	Earnings	Job Title	**Dept. or Branch**
	$ ❑ Hourly ❑ Annual		

❑ YES, I want Coverage(s) offered by my Policyholder.

Select Type of Coverage:

Standard Plan
❑ Plan Participant
❑ Plan Participant + 1 Dependent
❑ Plan Participant + Family

Select Plan
❑ Plan Participant
❑ Plan Participant + Spouse
❑ Plan Participant + Child(ren)
❑ Plan Participant + Family

❑ No, I do not want any coverage. *I understand that if I want coverage, at a later date, I must provide evidence of insurability to the Nationwide Life Insurance Company.*

Is the reason you are declining coverage because you currently have health coverage?
❑ Yes ❑ No

_____ _____
Signature Date

LIST ALL MEMBERS TO BE COVERED. DOCUMENTATION IS NEEDED FOR ADOPTED/FOSTER/STEP CHILDREN OR SPOUSES WITHOUT THE SAME SURNAME

Name (Last, First, MI)	Date of Birth MM/DD/YY	Gender	Social Security No.	Relationship
	/ /		- -	Spouse
	/ /		- -	Child
	/ /		- -	Child
	/ /		- -	Child
	/ /		- -	Child

Are any of the children age 18 or over a full-time student? ❑ No ❑ Yes If Yes, ❑ proof of enrollment attached ❑ proof to be provided

Beneficiary – This section applies only when Group Life or Accidental Death benefits are offered.

Any amount of insurance for which there is no Beneficiary designated will be payable to Your survivors in order of precedence (1) your spouse, (2) children born to or legally adopted by you, share and share alike, (3) parents, or (4) your estate. The proceeds will be paid to your designated Beneficiary, if there is a Beneficiary designated. You may designate or change Your Beneficiary at any time by filing a Change of Beneficiary Form. This designation or change must be made on forms we provide and must be received by the Policyholder.

I hereby declare that I am an active contract worker of the Policyholder indicated above and that I work at or from the location indicated. All information given by me on this form at Nationwide Life Insurance Company's request is true and complete and is offered to Nationwide Life Insurance Company as inducement to grant insurance.

_____ _____
Signed Date