NATIONWIDE LIFE INSURANCE COMPANY
NATIONAL CASUALTY COMPANY

LIFE / ACCIDENTAL DEATH AND DISMEMBERMENT CLAIM FORM

CLAIM FILING INSTRUCTIONS

NOTE TO ORGANIZATION AND MEMBER/INSURED/BENEFICIARY: Our objective is to provide fast and accurate claims service. Listed below are instructions on claim submissions that, when followed, will assist us in providing this service. For Life benefits, you may want to consult with your investment professional for assistance in determining the claim option (see page 6) that is best suited for your individual financial situation.

WHEN TO FILE A CLAIM

1. Written notice of the claim should be provided to us within 30 days after the loss begins or date of death.
2. Written proof of loss (completed claim form and supporting documents) should be provided to us within 90 days after the loss starts or date of death.

HOW TO FILE A CLAIM

Section I. The Plan Sponsor along with the member/insured or beneficiary must complete this section by answering all applicable questions.
Section II. Complete this section if the claim is related to a death, not due to an accident.
Section III. Complete this section if the claim is related to an accidental death or dismemberment.
Section IV. If the claim is related to a loss of use of a limb, loss of sight or loss of hearing, the attending physician must complete this section. It must also be signed by the member/insured.
Section V. and VI. Complete these sections if claim is related to death or accidental death.
Section VII. If the claim is related to a Ohio County Farm Bureau member tractor accident, the County Farm Bureau Sponsor must complete this section.

WHAT TO FILE WITH A CLAIM

All applicable questions on the claim form must be completed in full. Mail this form and any of the following to us at the address below:

a. Certified copy of death certificate, required if applicable
b. Autopsy report/coroner's report, if performed
c. Newspaper clippings, if applicable
d. Fire report, if applicable
e. Copy of membership form, if available
f. Copy of Beneficiary Designation form, if available

WHERE TO FILE A CLAIM or HOW TO CONTACT US

Nationwide Specialty Health
PO BOX 420
Springfield, MA 01101
Phone: 1-800-538-8272
Web Address: www.GrouProtector.com

SECTION I. COMPLETE IN FULL (Plan Sponsor Signature required at the end of Section VII)

1. Policy Number ___________________

2. Name of Plan Sponsor Organization (Group Name)____

3. Name of Member/Insured____ 4. Gender ☐ M ☐ F

5. Address of Member/Insured____

Street City State Zip

6. Member/Insured Social Security Number

7. If claim is for dependent, provide name | 8. Dependent Date of Birth - -

9. Relationship to member/insured

SECTION II. COMPLETE FOLLOWING QUESTIONS IF CLAIM IS RELATED TO A DEATH (NOT DUE TO AN ACCIDENT)

1. Date and Time of Death. Date ___-_____-_____ Time _____________ ☐ AM ☐ PM

2. **Where** did the death take place?

3. **How** did the death take place? (Be specific, explain exactly what happened. Use additional paper if necessary.)

4. Name and Address of physician attending deceased following the death

____ __________________ (____) ______________________

Physician Name Professional Designation Telephone Number

____

Street City State Zip

________-______-___________ ____

Date Physician Signature

5. Was an autopsy performed? ☐ Yes ☐ No If Yes, by whom? Physician name ____

Answer questions 6 and 7 below if the claim is related to a Volunteer Group Policy. If unsure, please contact us.

6. If deceased member/insured was covered under a Volunteer Group Insurance Policy, did he/she have any chronic disease, physical defects or deformities? ☐ Yes ☐ No If Yes, please describe.

7. If deceased member/insured was covered under a Volunteer Group Insurance Policy, did he/she receive any medical treatment in the last five years? ☐ Yes ☐ No If Yes, please provide dates and diagnosis.

SECTION III. COMPLETE THE FOLLOWING QUESTIONS IF CLAIM IS RELATED TO AN ACCIDENTAL DEATH OR DISMEMBERMENT

1. If accidental death, date and time of death. Date ___-_____-_____ Time _____________ ☐ AM ☐ PM

2. If accidental death, was an autopsy performed? ☐ Yes ☐ No If Yes, by whom?

Physician Name ____

3. **What** injuries occurred?

4. **Where** did the accident/death take place?

5. **How** did the accident/death take place? (Be specific, explain exactly what happened. Use additional paper if necessary.)

6. Name and Address of physician attending deceased or injured following the accident.

_______________________________________ ____________________ (_____) ____________________

Physician Name | Professional Designation | Telephone Number

____

Street | City | State | Zip

_______-______-__________ ____

Date | Physician Signature

Answer questions 9 through 10 below if the claim is related to a Sports Accident, Travel Accident or Specified Hazard Policy. If unsure, please contact us.

7. If member/insured is/was covered under a Sports Accident, Travel Accident or Specified Hazard policy, did the accident/death occur while taking part in an activity sponsored and directly supervised by the plan sponsor?

☐ Yes ☐ No If Yes, Describe type of activity involved. ____

8. If member/insured is/was covered under a Sports Accident, Travel Accident or Specified Hazard policy, did the accident/death occur during direct travel to or from the meeting place to take part in a member/insured activity?
☐ Yes ☐ No

9. If deceased member/insured was covered under a Volunteer Group Insurance Policy, did he/she have any chronic disease, physical defects or deformities?
☐ Yes ☐ No If Yes, please describe.

10. If deceased member/insured was covered under a Volunteer Group Insurance Policy, did he/she receive any medical treatment in the last five years?
☐ Yes ☐ No If Yes, please provide dates and diagnosis.

SECTION IV: TO BE COMPLETED BY ATTENDING PHYSICIAN IF DISMEMBERMENT OR LOSS OCCURRED

IV. A. LOSS OF LIMB – You must submit medical records to support claim

Loss of Limb ☐ No ☐ Yes If Yes, please answer the following:

1. Did insured lose limb as a result of an accident? ☐ Yes ☐ No
2. If Yes, please mark applicable loss(es).

Right Wrist ☐ Above ☐ Below
Right Arm ☐ Above Elbow ☐ Below Elbow

Left Wrist ☐ Above ☐ Below
Left Arm ☐ Above Elbow ☐ Below Elbow

Right Foot ☐ Above ☐ Below
Right Leg ☐ Above Knee ☐ Below Knee

Left Foot ☐ Above ☐ Below
Left Leg ☐ Above Knee ☐ Below Knee

Right Thumb and Forefinger ☐
Left Thumb and Forefinger ☐

3. Date of amputation/loss of use _______-_______-__________

Physician Name ____

Physician Signature ____ Date ____-____-______

____

Street | City | State | Zip

IV. B. LOSS OF SIGHT

Please use Snellen notation or its equivalent – You must provide diagnosis and enclose medical records regarding existing eye condition.

Loss of Sight ☐ Yes ☐ No If Yes, please answer the following:

1. Did insured lose sight as a result of said accident? ☐ Yes ☐ No

2. Record of Vision	Uncorrected	Corrected
a. Date of first observation - -	R.E. _________ L.E. _________	R.E. _________ L.E. _________
b. Date of last observation - -	R.E. _________ L.E. _________	R.E. _________ L.E. _________

3. From what date was vision recorded in question 2b?
- -

4. If totally blind, provide date this occurred
Right Eye - - Left Eye - -

5. If eye has been enucleated, provide date
Right Eye ___-____-_____ Left Eye ___-____-_____

6. In your opinion can vision be improved by treatment, operation or lenses?
☐ Yes ☐ No
State your recommendations.

7. Is loss of sight irrecoverable? ☐ Yes ☐ No

8. Was there any disease or condition prior to the date of the accident, which might have served as a contributory cause?
☐ Yes ☐ No If Yes, supply medical records.

9. If physician other than yourself treated insured for this contributory condition, please provide the name and address of physician attending following the accident.

Physician Name ____ Professional Designation_______________

Telephone Number (____)________________

Physician Signature ____ Date ____-____-____

____
Street City State Zip

10. If treated at a hospital provide name of institution with dates of admission and dates of discharge for this loss

_______________________________ _______-_______-___________ _______-____-________
Institution Name Date Admitted Date Discharged

____
Street City State Zip

IV. C. LOSS OF HEARING

You must provide a copy of the following: Measurement of pure tone air-conduction & bone-conduction thresholds, speech reception threshold, discrimination score, tympanometry, acoustic reflexes, acoustic reflex decay, and any medical records pertaining to this condition.

Attending Physician Name____

Physician Signature ____ Date ____-____-_______

____
Street City State Zip

I certify that the above information is true and correct. I AUTHORIZE any doctor, medical practitioner, hospital, clinic, other medical or medically related facility or insurance company, the Medical Information Bureau, Inc. consumer reporting agency or employer, having information available regarding either: (a) benefits for which either I, or the minor child for whom I am either parent or guardian, may be entitled to for this claim, or (b) the diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or the minor child for whom I am the parent or guardian; to provide Nationwide Specialty Health, Columbus Ohio, or it legal representatives, any and all such information. I AGREE that a photographic copy of this Authorization will be valid as the original. This authorization will remain valid for the term of coverage of the policy.

Date ___-____-____ **Signature of Insured** _________________________________ Phone (____) _________________
(parent or guardian, if minor)

SECTION V. TO BE COMPLETED BY OHIO COUNTY FARM BUREAU CLAIM REPRESENTATIVE

<table>
<tr><td colspan="3">1. Indicate whether the member has one or more years of membership.
☐ One year or less ☐ Over one year</td></tr>
<tr><td colspan="3">2. If related to a tractor accident: Ohio Farm Bureau Tractor Safety Sticker ☐ was ☐ was not in place on the tractor at the time of accident. Attach a copy of the motor vehicle accident report indicating the insured ☐ was ☐ was not wearing an approved seat belt or child restraint system at the time of accident.</td></tr>
<tr><td>3. Current dues/premium paid on:
- -</td><td>4. Effective date of membership:
- -</td><td>5. Did the member designate a beneficiary?
☐ Yes ☐ No If Yes, please provide designation form.</td></tr>
<tr><td colspan="3">6. I certify that the above information is correct to the best of my knowledge and belief, that the person named above is/was insured by the policy, and that his or her insurance was in effect on the date the accident or death occurred.
Name of County Farm Bureau Sponsor ____________________
Signature of County Farm Bureau Sponsor____________________ Date ____-____-______
Title ____________________ Phone (____)____________________</td></tr>
</table>

STATE FRAUD NOTICES

(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.

(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.

(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.

(**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.

(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.

(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 aggregated 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 presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law."

(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.

SECTION V. HANDLING OF BENEFICIARY INFORMATION

1. Benefit amount

2. Are you making this claim as the **Beneficiary**? If so, what is your relationship to deceased.________________________

3. Beneficiary Name____

4. Beneficiary Address ____

Street City State Zip

5. Beneficiary Date of Birth _______-_______-________

6. Beneficiary Social Security Number __________________________

7. Check one: ☐ Beneficiary Drivers License, ☐ Government ID Number or ☐ Military ID Number ___________________

State of Issue ______________________ (Required only for life benefit distribution Option 1[see page 6])

8. Beneficiary E-mail address (optional) ____

I certify that the above information is correct to the best of my knowledge and belief, that the person named above was Insured by the policy, and that his or her insurance was in effect on the date the accident or sickness occurred.

Beneficiary Signature ____ Date _______-_______-________

Phone (_____)___________________________

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

I certify that the above information is correct to the best of my knowledge and belief, that the person named above was insured by the policy, and that his/her insurance was in effect on the date the accident or death occurred.

Signature of Plan Sponsor____ Date _______-_______-________

(You may submit proof of membership or certificate of Coverage in place of Plan Sponsor signature)

Title ____ Phone ( )___________________________

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SECTION VI. BENEFIT DISTRIBUTION

Full Distribution Election

Customers tell us that following a loss, they felt more "in control" by taking the appropriate amount of time to make prudent long-term financial decisions. By opening a Nationwide Bank Secure Money Market Account, you can take time to properly consider your choices. Having a separate account simplifies record keeping. You will have the peace of mind FDIC coverage provides. Nationwide Bank member FDIC.

☐ **Option 1**

I would like to receive a full distribution of my benefits via a lump-sum payment. Please deposit my benefit lump-sum payment into Nationwide Bank's Secure Money Market. The death claim benefit must be at least $5,000 to qualify for this option. By choosing this option, I authorize my information to be shared with a Nationwide affiliate, Nationwide Bank.

Benefits Of This Option?

- You provide yourself with time to make important decisions.
- Your funds are protected by FDIC insurance up to the Federal limits.
- You have immediate access to your funds with personalized checks, while earning an attractive interest rate on all funds in the account.
- You may request an ATM card honored across America at more than 400,000 ATMs in the Visa Plus network after your account has been established at the Bank.
- Simply call 877-I-Bank-NW (877-422-6569) for interest rate information.
- No monthly service fees.
- Personalized checks provided at no charge. Check order are free too.
- You have the support of a specialized dedicated account service team. They are ready to help, just by calling 1-877-I-Bank-NW (1-877-422-6569).
- For your protection, all new accounts are subject to routine account approval, using bank industry standards to confirm eligibility.
- The Nationwide Secure Money Market offers you the security of FDIC insurance as well as the ability to partition these funds from other household funds. You may add other funds to this account as you wish.
- You may keep the account open indefinitely as long as you maintain the minimum balance of $250.

☐ **Option 2**

I would like to receive a full distribution of my benefits via a lump-sum payment by check.

Please check the option you prefer and sign below if you are choosing either payment Option 1 or Option 2.
Thank you. This will aid us in meeting your needs.

____ ____-____-____

Name (please print) Date

Signature ____

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