FRAUD WARNINGS

(CA) **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.

(LA) 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.

(NY) Please read statement located at bottom of application (reverse side) above signature section.

(PA) 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.

(WA) 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.

NOTE: These plans are available in DC, PR, VI, and all 50 states, EXCEPT for Classes 1 and 2 in VT. Excess medical is not available in NJ and to schools in AL and PA. Horseback riding groups and sports groups are not eligible under this brochure — for these groups please contact Special Risks Health at our Office at 1-800-525-8669 (options 5).

PREMIUM REPORT

Must be completed for application to be accepted

Specific Name of Youth Group*: _____

_____

Type of Youth Group: _____

_____

Activities Include: _____

_____

Age Range of Participants (not staff):
_____ to _____ years of age

*Example: "ABC Church - Youth Fellowship Only"

	Anticipated Number of Eligible Memberships		Annual Premium Rate per Eligible Membership		Premium Due
Members under age 12	_____	× $	_____	= $	_____
Members age 12 and over	_____	× $	_____	= $	_____
Counselors	_____	× $	_____	= $	_____
Total premium due (subject to annual minimum*)				$	_____

***The annual minimum premium per policy term is $225 for primary medical coverage and $175 for excess medical coverage.**

I certify that to the best of my knowledge and belief: (1) the preceding information is correct and complete; (2) premium is being paid for the total number of eligible persons who are anticipated to be insured; and (3) the premium is being paid entirely by the plan sponsor with no contribution made by the eligible persons toward the cost of the insurance.

_____ by _____
Date Applicant Signature and Title

_____ _____
Day Telephone Number Fax Number

_____
E-mail Address

Note: If additional space is required, use a separate sheet. For authorized checking account withdrawal (also called Automated Clearing House "ACH") call 1-800-525-8669, option 5.

HERE ARE THE ACCIDENT BENEFITS

DEATH BENEFIT - If, as a result of injury, an insured dies within one year from the date of the accident causing the injury, we will pay the death benefit less any specific loss benefit paid because of the same accident. The one year limit does not apply in a PA or WV contract.

SPECIFIC LOSS BENEFIT - If, as a result of injury, an insured suffers a specific loss within one year from the date of the accident causing the injury, we will pay:

75% of the face amount for loss of:
Each Arm
Each Leg

50% of the face amount for loss of:
Each Hand or Foot
Sight of Each Eye
Speech

25% of the face amount for loss of:
Hearing of Each Ear
Thumb and Index Finger of the Same Hand

The total payment for all of the specific losses of an insured because of any one accident will not be more than the face amount. No specific loss benefit will be paid if the death benefit applies. The loss of the thumb and index finger of the same hand benefit will not be paid if the loss of the hand or arm benefit applies. The loss of the hand or foot benefit will not be paid if the loss of the arm or leg benefit applies.

POLICY APPLICATION (please print or type)

which, upon acceptance and approval by **NATIONWIDE LIFE INSURANCE COMPANY—Columbus, Ohio 43216,** will become a part of **SPECIFIED HAZARD INSURANCE POLICY NUMBER 502–95–**_____

Office Use Only

1. **Name of Plan Sponsor** _____
   Group's Name

   Permanent Mailing Address _____
   Number Street City State Zip County

2. **Policy Term**: The policy term starts at **12:01** A.M. on _____ which is the effective date, and ends at **12:01** A.M. on _____ which is the first renewal date.

3. **Covered Activities**

   Supervised activities **(excluding snow skiing and league sports)** sponsored and/or endorsed by the plan sponsor and direct travel to and/or from such activities. (710)

4. **Maximum Benefit Amounts**—the word "None" means the benefit is not included.

Benefit Provisions	**Maximum Benefit Amounts**			
	Class 1	Class 2	Class 3	Class 4
ACCIDENTAL DEATH AND SPECIFIC LOSS with a $250,000 overall maximum for any one accident.				
Death - - - - - - - - - - - - - - -	$1,500	$2,500	$5,000	$7,500
Specific Loss (Face Amount) - -	3,000	5,000	10,000	15,000
MEDICAL EXPENSE				
Accident				
Deductible - - - - - - - - - -	None	None	None	None
Overall Maximum - - - - -	5,000	10,000	25,000	50,000
OFFICE USE ONLY	1596P 3596E	1820P 3820E	2220P 4220E	5011E

5. **Premium Rates by Class of Eligible Persons** – check class and Medical Expense Plan desired.

Annual Premium rates per Eligible Person			
Class	**Eligible Persons**	☐ Medical Expense Primary Plan	☐ Medical Expense Excess Plan
	All members or all members and counselors of the youth group which is sponsored and/or endorsed by the plan sponsor (check only one box):		
1	☐ **Class 1 Benefits** — Members under age 12 (C97) - - - - - -	**$1.60**	**$0.95**
	Members age 12 and over and counselors (C98)	**2.10**	**1.20**
2	☐ **Class 2 Benefits** — Members under age 12 (C97) - - - - - -	**1.90**	**1.15**
	Members age 12 and over and counselors (C98)	**2.50**	**1.60**
3	☐ **Class 3 Benefits** — Members under age 12 (C97) - - - - - -	**2.50**	**1.75**
	Members age 12 and over and counselors (C98)	**3.25**	**2.30**
4	☐ **Class 4 Benefits** — Members under age 12 (C97) - - - - - -	**Not Available**	**2.40**
	Members age 12 and over and counselors (C98)	**Not Available**	**3.10**
	Guests who attend meetings for the purpose of being encouraged to become members are automatically insured at no additional cost.		
The minimum premium per policy term is $225 if the medical expense primary plan has been elected and $175 if the medical expense excess plan has been elected.			

6. **The Policy is to cover all eligible persons** which include: ☐ members only (13), or ☐ members and counselors (14).

7. **It is understood and agreed that**: (a) the premium will be paid entirely by the plan sponsor with no contribution made by the eligible persons toward the cost of the insurance; and (b) **premium will be paid annually in advance based on the total number of eligible persons anticipated to be insured during the policy term** (BF50).

(NY) 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.

By signing below, you agree that you have read all of the Fraud Warnings on both sides of this application.

_____ Previous Policy Number

_____ Date

_____ Agent's Signature and Number

_____ Agent's Phone Number

_____ Agent's E-mail Address

_____ Signature of Applicant

_____ Printed Name and Title of Applicant

_____ Address of Applicant

_____ Applicant's E-mail Address

_____ Applicant's Phone Number