

**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 that excess medical is not available: in NJ; to schools in AL or PA; and under Classes 2, 4 and 6 (overnight programs) in KS or NY. Upward bound programs as well as contact football, ice hockey, martial arts, scuba/skin diving, snowboarding, snow skiing and wrestling are not eligible under this brochure – please contact Special Risks Health in our Home Office for these groups as well as for overnight excess medical programs in KS or NY.

<p><b>SHORT-TERM COVERAGE PREMIUM REPORT</b></p> <p>(Must be completed for Application to be accepted)</p> <p>Group Activities include: _____ _____ _____</p> <p>Age range of participants (not staff): _____ to _____ years of age</p>	<p>Dates at camp or conference including travel time</p>	<p>Number of eligible persons anticipated to be insured.</p>			<p>Daily premium per eligible person</p>	<p>Premium per day</p>	<p>Total number of days</p>	<p>Premium Due</p>		
	_____ thru _____	Participant	+	Staff	=	Total	× \$ _____	= \$ _____	× _____	= \$ _____
	_____ thru _____		+		=		× \$ _____	= \$ _____	× _____	= \$ _____
	_____ thru _____		+		=		× \$ _____	= \$ _____	× _____	= \$ _____
	_____ thru _____		+		=		× \$ _____	= \$ _____	× _____	= \$ _____
	_____ thru _____		+		=		× \$ _____	= \$ _____	× _____	= \$ _____
	_____ thru _____		+		=		× \$ _____	= \$ _____	× _____	= \$ _____
<p><b>Total premium due (subject to policy minimum*) ..... \$ _____</b></p>										
<p><small>*The annual minimum premium per policy term is \$225 for primary medical coverage and \$175 for excess medical coverage.</small></p>										
<p>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 during the policy term; 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.</p>										
					Date	by		Signature of Applicant		
					Day Telephone Number		Fax Number			
E-mail Address _____										
<p>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.</p>										

**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  termination date (short-term).  first renewal date.

3. **Covered Activities**

Supervised camp or conference activities (excluding snow skiing) sponsored and/or endorsed by the plan sponsor and direct travel to and/or from such activities. (501)

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	Class 5	Class 6
ACCIDENTAL DEATH AND SPECIFIC LOSS with a \$250,000 overall maximum for any one accident.						
Death - - - - -	\$10,000	\$17,500	\$7,500	\$10,000	\$7,500	\$10,000
Specific Loss (Face Amount) - -	20,000	35,000	15,000	20,000	15,000	20,000
MEDICAL EXPENSE Accident						
Deductible- - - - -	None	None	None	None	None	None
Overall Maximum- - - - -	25,000	25,000	25,000	25,000	25,000	25,000
Sickness (Overall Maximum) - -	None	5,000	None	5,000	None	5,000
<b>OFFICE USE ONLY</b>	2220P 4220E	7913P 6913E	2220P 4220E	7913P 6913E	2220P 4220E	7913P 6913E

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

Daily (calendar exposure day or portion thereof) Premium Rates per Eligible Person			
Class	Eligible Persons	<input type="checkbox"/> Medical Expense Primary Plan	<input type="checkbox"/> Medical Expense Excess Plan
	All participants or all participants and staff of:		
	<b>A SPORTS*</b>		
1	<input type="checkbox"/> Day Camp or Conference (PHI507/509 - C95) - - - - -	<b>\$0.35</b>	<b>\$0.30</b>
2	<input type="checkbox"/> Overnight Camp or Conference (PHI508/509 - C96) - -	<b>0.60</b>	<b>0.50</b>
	<b>ANY OTHER PRIVATE*</b>		
3	<input type="checkbox"/> Day Camp or Conference (PHI510/512 - C14) - - - - -	<b>0.18</b>	<b>0.14</b>
4	<input type="checkbox"/> Overnight Camp or Conference (PHI511/512 - C15) - -	<b>0.45</b>	<b>0.35</b>
	<b>ANY OTHER ORGANIZATIONAL* OR CHURCH*</b>		
5	<input type="checkbox"/> Day Camp or Conference (PHI513/515 - C14) - - - - -	<b>0.18</b>	<b>0.14</b>
6	<input type="checkbox"/> Overnight Camp or Conference (PHI514/515 - C15) - -	<b>0.30</b>	<b>0.21</b>
	*Excluding contact football, ice hockey, martial arts, scuba/skin diving, snowboarding, snow skiing, and wrestling.		
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:  participants only (06), or  participants and staff (09).

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 as follows: for short-term coverage –  in advance as shown in the Premium Report, or  in advance based on the total estimated premium due as shown in the Premium Report with an audit at the end of the policy term (BF51); or, for renewable coverage –  the minimum premium with this application with the remainder due quarterly in arrears (BF52).**

(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  
 \_\_\_\_\_