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-**____________________ (Home 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).

3. **Covered Activities**

Summer camp staff activities sponsored and/or endorsed by the plan sponsor and direct travel to and/or from such activities, excluding claims occurring while the Insured is intoxicated and/or under the influence of a drug or narcotic unless prescribed by a Physician.

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

Benefit Provisions	Silver Plan	Gold Plan	Platinum Plan
ACCIDENTAL DEATH AND SPECIFIC LOSS with a $250,000.00 overall maximum for any one accident.			
Death	$10,000	$17,500	$25,000
Specific Loss (Face Amount)	20,000	35,000	50,000
ACCIDENT AND SICKNESS MEDICAL EXPENSE			
Deductible	None	None	None
Overall Maximum per Accident	10,000	25,000	50,000
Overall Maximum per Sickness	2,500	5,000	7,500
Office Use Only		7913P	

5. **Premium Rates by Class(es) of Eligible Persons**

Class	Eligible Persons	**Daily** (calendar exposure day or portion thereof) **Premium Rates Per Eligible Person** — Medical Expense Primary Plan
1	**Silver Plan** ☐ Day or Overnight Camp or Conference	$ 0.50
2	**Gold Plan** ☐ Day or Overnight Camp or Conference	0.60
3	**Platinum Plan** ☐ Day or Overnight Camp or Conference	0.75

6. **The policy is to cover all eligible persons** which include: ☐ staff only.

7. **It is understood and agreed that**: the premium will be paid entirely by the plan sponsor; and ☐ **premium will be paid in advance as shown in the Premium Report** or ☐ **estimated premium will be paid in advance as shown in the Premium Report with an audit at the end of the policy term** (only available to groups exceeding $500 in total premium) (BF51).

____
Previous Policy Number

By ____________________
Signature of Applicant

____
Date

____
Printed Name and Title of Applicant

____
Agent's Signature and Number

____
Applicant's Address

____
Agent's Phone Number

____
Applicant's E-mail Address

____
Agent's E-mail Address

____
Applicant's Phone Number

Short-Term Coverage Premium Report - Daily

(If short-term coverage is needed, this section must be completed and sent in with the Application.)

Group Activities include:

Summer camp staff activities sponsored and/or endorsed by the plan sponsor and direct travel to and/or from such activities, excluding claims occurring while the Insured is intoxicated and/or under the influence of a drug or narcotic unless prescribed by a Physician.

Instructions: click and tab through the yellow boxes replacing the displayed dates, numbers of eligible persons, daily premium per person, and total number of days. The white boxes showing the total number of eligible persons, premium per day, and Premium Due will calculate automatically. You may also print the form and complete it manually if you wish. If you need assistance, please call 877-794-3113.

Dates at camp or conference including travel time			Number of eligible persons anticipated to be insured					Daily premium per eligible person		Premium per day		Total number of days		Premium Due
			Participant		Staff		Total							
	thru			+		=	0	x $		= $	0.00	x		= $	0.00
	thru			+		=	0	x $		= $	0.00	x		= $	0.00
	thru			+		=	0	x $		= $	0.00	x		= $	0.00
	thru			+		=	0	x $		= $	0.00	x		= $	0.00
	thru			+		=	0	x $		= $	0.00	x		= $	0.00
	thru			+		=	0	x $		= $	0.00	x		= $	0.00
	thru			+		=	0	x $		= $	0.00	x		= $	0.00
	thru			+		=	0	x $		= $	0.00	x		= $	0.00
	thru			+		=	0	x $		= $	0.00	x		= $	0.00
	thru			+		=	0	x $		= $	0.00	x		= $	0.00
	thru			+		=	0	x $		= $	0.00	x		= $	0.00
	thru			+		=	0	x $		= $	0.00	x		= $	0.00
								Total Premium Due (Subject to policy minimum*)						**$**	**0.00**

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

I certify 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.

_______________________ by _______________________

Date | Signature of Applicant

Day Telephone Number | Fax Number

E-Mail Address

Note: If additional space is required, use a separate sheet.