Nationwide®

Nationwide Secure Growth℠ Fixed Annuity

Application for

Individual Single Purchase Payment Deferred Fixed Annuity

Minimum Purchase Payment of $10,000

Nationwide Life Insurance Company

PO Box 182021, Columbus, OH 43218-2021 • Phone: 800-321-6064

Express Mail: 3400 Southpark Place Ste A, DSPF-F4, Grove City, OH 43123-4856

Please submit all pages of the application.

The IRS has declared that civil union partners and domestic partners are not considered spouses for purposes of federal tax law. Therefore the tax treatment provided by federal tax law to a surviving spouse is NOT currently available to a surviving civil union partner or surviving domestic partner. For information regarding federal tax laws, please consult a tax advisor.

1. Parties to the Contract (Please print)

1a. Contract Owner

Name (First, MI, Last): _____

Employer/Trust Name (if applicable): _____

(Additional forms required. See the New Business Enrollment Packet.)

Birth Date: _____ Sex: ☐ M ☐ F SSN/Tax ID: _____

Street: _____

City: _____ State: _____ ZIP: _____

Email: _____ Phone Number: _____

1b. Joint/Contingent Owner

Check **one** box only: ☐ Joint Owner *(Joint Owner is limited to spouses unless such limitation is prohibited by the state. Available only with Non-Qualified Contracts.)*

☐ Contingent Owner *(Available only with Non-Qualified Contracts.)*

Name (First, MI, Last): _____

Birth Date: _____ Sex: ☐ M ☐ F SSN/Tax ID: _____

Address: ☐ Same address as Contract Owner **or** fill out address below

Street: _____

City: _____ State: _____ ZIP: _____

Email: _____ Phone Number: _____

1. Parties to the Contract (continued)

1c. Annuitant Complete only if different from Contract Owner or if Contract Owner is a non-natural owner or a Trust. *(Annuitant must be age 90 or younger.)*

Name (First, MI, Last): _____

Relationship to Contract Owner: _____

Birth Date: _____ Sex: ☐ M ☐ F SSN/Tax ID: _____

Address: ☐ Same address as Contract Owner **or** fill out address below

Street: _____

City: _____ State: _____ ZIP: _____

Email: _____ Phone Number: _____

1d. Contingent Annuitant *(Must be age 90 or younger.)*

Name (First, MI, Last): _____

Birth Date: _____ Sex: ☐ M ☐ F SSN/Tax ID: _____

Address: ☐ Same address as Contract Owner **or** fill out address below

Street: _____

City: _____ State: _____ ZIP: _____

Email: _____ Phone Number: _____

1. Parties to the Contract (continued)

1e. Beneficiaries Allocation to all Primary Beneficiaries must equal 100%. Contingent Beneficiaries must also equal 100%. Providing your Beneficiaries social security numbers (SSN) will help expedite Beneficiary claims and will ensure that Nationwide can properly identify your Beneficiaries.

Primary Beneficiaries *Allocations must equal 100%.* ☐ Pay all Primary Beneficiaries equally

Legal Name (First, MI, Last): _____

Relationship to Annuitant: _____ Allocation (whole % only): _____%

Birth Date: _____ Sex: ☐ M ☐ F SSN/Tax ID: _____

Address: ☐ Same address as Contract Owner **or** fill out address below

Street: _____

City: _____ State: _____ ZIP: _____

Email: _____ Phone Number: _____

Legal Name (First, MI, Last): _____

Relationship to Annuitant: _____ Allocation (whole % only): _____%

Birth Date: _____ Sex: ☐ M ☐ F SSN/Tax ID: _____

Address: ☐ Same address as Contract Owner **or** fill out address below

Street: _____

City: _____ State: _____ ZIP: _____

Email: _____ Phone Number: _____

If more than two Beneficiaries, list additional names on the Additional Beneficiaries form (in New Business Enrollment Packet).

Contingent Beneficiaries *Allocations must equal 100%.* ☐ Pay all Contingent Beneficiaries equally

Legal Name (First, MI, Last): _____

Relationship to Annuitant: _____ Allocation (whole % only): _____%

Birth Date: _____ Sex: ☐ M ☐ F SSN/Tax ID: _____

Address: ☐ Same address as Contract Owner **or** fill out address below

Street: _____

City: _____ State: _____ ZIP: _____

Email: _____ Phone Number: _____

Legal Name (First, MI, Last): _____

Relationship to Annuitant: _____ Allocation (whole % only): _____%

Birth Date: _____ Sex: ☐ M ☐ F SSN/Tax ID: _____

Address: ☐ Same address as Contract Owner **or** fill out address below

Street: _____

City: _____ State: _____ ZIP: _____

Email: _____ Phone Number: _____

If more than two Beneficiaries, list additional names on the Additional Beneficiaries form (in New Business Enrollment Packet).

2. Contract Information

2a. Contract Type Must specify by checking a box.

☐ Non-Qualified
☐ Non Naturally Owned Non-Qualified*
☐ Traditional IRA – Tax Year: _____
☐ SEP IRA*
☐ SIMPLE IRA*
☐ Roth IRA – Tax Year: _____ Tax Year Roth IRA started: _____
☐ CRT* (Charitable Remainder Trust) **Not available in New Jersey.**
☐ Custodial Owned IRA
☐ 401(a)* (Investment Only)
☐ Beneficially Owned Non-Qualified*
☐ Beneficially Owned/Inherited Roth IRA*
☐ Beneficially Owned/Inherited IRA*

**Additional forms required.*

2b. Purchase Payment

Approximate Amount: $_____ $10,000 minimum.

Payment Submitted Via: ☐ Check ☐ Wire ☐ 1035(a) Exchange* ☐ Transfer/Rollover*

Source of Funds: _____

**Additional forms required. Please see the New Business Enrollment Packet.*

2c. Initial Interest Rate Guarantee Period(s)

You may elect from one or more Interest Rate Guarantee Periods, total allocations must be in whole numbers and equal 100%.

1 Year:_____% 3 Year:_____% 5 Year:_____% 7 Year*:_____%

Interest Rate Guarantee Period(s) are subject to availability.

All subsequent Interest Rate Guarantee Periods are one year in duration.

*The 7 Year Interest Rate Guarantee Period cannot be elected in combination with the 5 Year CDSC.

3. Options

Be aware, if the Contract Owner wants 5 Year CDSC, Return of Purchase Payment Guarantee, or MVA options(s) they must be selected below.

I elect:

☐ 5 Year Contingent Deferred Sales Charge Option (If this option is elected, then the surrender charge period will be 5 years. **This option cannot be elected in combination with the 7 Year Interest Rate Guarantee Period**.)

☐ Return of Purchase Payment Guarantee Option (If the Return of Purchase Payment Guarantee Option is not elected, Contingent Deferred Sales Charge will be applied to full Surrenders as described in the Contract. **This option cannot be elected in combination with the Market Value Adjustment**.)

☐ Market Value Adjustment (MVA calculation is only applied during the CDSC period and only applies to withdrawals greater than the Free Withdrawal amount. **This cannot be elected in combination with the Return of Purchase Payment Guarantee Option.**)

4. Fraud Warning

Interstate Insurance Product Regulation Commission State Fraud Language: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

5. Contract Owner Signatures and Authorizations

5a. Replacement Information

☐ Yes ☐ No **Do you have existing life insurance or annuity Contracts?**

☐ Yes ☐ No **Will the applied for Contract replace, discontinue or change any existing life insurance or annuity Contracts?**

If you answered "yes" to EITHER question above, ***your state may require NAIC or state specific replacement forms.*** *Please look in the New Business Enrollment Packet to see if your state requires additional NAIC or state specific replacement forms.*

5b. Acknowledgements, Disclosure and Signatures

I understand and acknowledge the following:

A copy of this application properly signed by the Representative will constitute receipt for such amount. If this application is declined by Nationwide, there will be no liability on the part of Nationwide, and any payments submitted with this application will be refunded.

- The Contract limits Purchase Payments to $1 million for all Contracts issued by Nationwide with the same Contract Owner, Joint Owner, Contingent Owner, Annuitant or Contingent Annuitant (if applicable), unless Nationwide agrees in writing to accept Purchase Payments exceeding $1 million.
- That I do not represent a corporate entity or institutional investor.
- I understand the purpose of the Contract for which I am applying is to provide long-term benefits to the Contract Owner and/or Annuitant and that, if I plan to change the Contract Owner or assign benefits under the Contract, the Contract will not meet this objective.
- I understand the purpose of the Contract for which I am applying is to provide long-term benefits to the Contract Owner and/or Annuitant and that, if the Annuitant I am naming has been diagnosed with or had any indication of an illness expected to result in death within 12 months, the Contract will not meet this objective.

When you sign this application, you are agreeing to the elections you have made and acknowledging your understanding of the terms and conditions described in this application. If you have any questions, ask your Representative BEFORE you sign this application.

Contract Owner Signature: _____

Joint Contract Owner Signature (if any): _____

State In Which Application Was Signed: _____ Date: _____

6. Primary Representative Information

6a. Primary Representative Replacement Information

☐ Yes ☐ No **Are you aware of any existing annuities or insurance owned by the applicant?**

☐ Yes ☐ No **Will the applied for Contract replace, discontinue or change any existing life insurance or annuity Contracts?**

6b. Primary Representative Information (Please print)

Name (First, MI, Last): _____

Office Street Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____ Percentage: _____%

Email: _____

Firm Name: _____

SSN: _____ *(Not required if Representative and Firm name are printed clearly above.)*

When the Representative signs this application, he/she is agreeing to all the terms and conditions applicable to him/her as the licensed Representative.

Signature: _____ Date: _____

Principal's Signature: _____ Date: _____
(If required)

7. Additional Representative Information

7a. Additional Representative Replacement Information

☐ Yes ☐ No **Are you aware of any existing annuities or insurance owned by the applicant?**

☐ Yes ☐ No **Will the applied for Contract replace, discontinue or change any existing life insurance or annuity Contracts?**

7b. Additional Representative Information (Please print)

Name (First, MI, Last): _____

Office Street Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____ Percentage: _____%

Email: _____

Firm Name: _____

SSN: _____ *(Not required if Representative and Firm name are printed clearly above.)*

When the Representative signs this application, he/she is agreeing to all the terms and conditions applicable to him/her as the licensed Representative.

Signature: _____ Date: _____

Principal's Signature: _____ Date: _____
(If required)