Nationwide
Health Plans®

Underwritten By Nationwide Life Insurance Company

AUTHORIZATION FORM FOR ENROLLMENT

Nationwide Life Insurance Company, DBA Nationwide Health Plans ("NHP") is required by law to maintain the privacy of our members' health information. A copy of this form is as valid as the original.

NHP REQUIRES THIS AUTHORIZATION FORM TO BE COMPLETED IN ORDER TO UNDERWRITE YOUR COVERAGE. THE ENROLLMENT PROCESS CANNOT BE COMPLETED WITHOUT THIS SIGNED FORM. REFER TO PARAGRAPH #5 BELOW. ***THIS FORM MUST BE SIGNED BY EACH ADULT FAMILY APPLICANT/ENROLLEE*** *(including dependents age 18 and over).*

I, ______________________________, ______________________________,
(applicant/enrollee print name) (spouse/registered domestic partner/print name)

______________________________, ______________________________,
(adult dependent print name) (adult dependent print name)

hereby authorize the use or disclosure of health information as described below. Additional adult dependents may be listed below.

(Applicant/Enrollee)

As the parent, I ______________________________ also authorize the use or disclosure of health
(applicant/enrollee)

information about my minor dependent(s), age 17 and under as described below:

____________________, ____________________, ____________________,
(print dependent'(s) name)

____________________, ____________________, ____________________.

1. Person(s) or group of persons authorized to disclose the information to NHP:
   - Any medical professional, hospital, or other healthcare facility, clinic, pharmacy, health benefit plan administrator, Medicare or Medicaid or any other health care provider or health plan that has medical information about me or my dependent(s);
   - Healthcare providers or health plans indicated in my application for insurance or on my dependents' application for insurance, or identified by me during a medical examination in connection with an application for insurance coverage, or identified by me during a health history interview in regard to myself or my dependent(s), or identified by me or by my dependent(s) to my insurance agent, or any other healthcare provider or health plan referred to in my medical records or my dependent(s) medical records.
2. I authorize the following person(s) or group of persons to receive the information disclosed by one of the persons or organizations listed in paragraph 1 above, and to use that information and the information included on my application for coverage as follows:

Hand-write initials beside coverage applying for/enrolling in:

HEALTH

a. Nationwide Life Insurance Company and it's affiliates including, but not limited to, its agents, underwriting operations, claims operations, legal representatives, its Medical Director or his/her designees, its sales and marketing operations to underwrite and rate the health plan coverage for which I applied. I understand that Nationwide Life Insurance Company may condition my or my dependents enrollment in the health plan on the signing of this authorization and checking this paragraph 2(a) authorizing the information to be used to underwrite and rate the health plan coverage for which I have applied.

________ applicant

________ spouse/RDP*

________ adult child

________ adult child

*registered domestic partner

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LIFE

________ applicant
________ spouse/RDP*
________ adult child
________ adult child

b. Nationwide Life Insurance Company or their affiliates including, but not limited to, their agents, underwriting operations, claims operations, legal, representatives, its Medical Director or his/her esignees, its sales and marketing operations, to underwrite and rate the life policy for which I applied. I understand that if I have applied for life coverage, Nationwide Life Insurance Company may condition the issuance of the life policy on the signing of this authorization and checking this paragraph 2(b) authorizing the information to be used to underwrite and rate the life coverage.

3. Description of the information that may be used or disclosed:
   All health information pertaining to me or my minor dependent(s), if applicable, related to the diagnosis, treatment or prognosis with respect to any physical, accident, illness, medical or mental condition, except psychotherapy notes, and any other related information, including but not limited to the information provided on my application.
4. I understand that if the person or entity that receives the information described herein is not a health care provider or health plan covered by federal privacy regulations, the information described here may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
5. I understand that my enrollment in the health plan may be conditioned on my signing this authorization and initialing paragraph 2(a). I understand that I may refuse to initial paragraph 2(b) of this authorization, and such refusal will not affect my enrollment in the health plan or the payment of benefits under the health plan. I understand that the issuance of a life policy may, however, be conditioned on my signing this authorization and checking paragraph 2(b).
6. If the person completing this authorization is the personal representative of the applicant/enrollee or dependent, describe your authority to act on this person's behalf.

   ____

   ____

7. As described in the Notice of Privacy Practices, I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Nationwide and its subsidiaries and affiliates in reliance on this authorization by sending a written signed and dated revocation to Nationwide Health Plans, 1651 Exposition Boulevard, Ste. 100 HM-20, Sacramento, CA 95815. The Notice of Privacy Practices of Nationwide is available on the Nationwide Health Plans web site at www.nationwidehealthplans.com.
8. I understand that either I or my personal representative, may receive a copy of this authorization upon request and that I may inspect or copy the information to be used or disclosed.
9. This authorization will expire when the coverage I have applied for is either approved or denied.

____ Date: __________
Applicant/Enrollee Signature

____ Date: __________
Spouse/Registered Domestic Partner Signature

____ Date: __________
Adult Child Signature

____ Date: __________
Adult Child Signature

____
Personal Representative Name, if applicable

____ Date: __________
Personal Representative Signature

*registered domestic partner