On Your Side®

Nationwide Life Insurance Company
Home Office: Columbus, Ohio

Nationwide Employee Benefits SM
Employee Change Request Form

Please read carefully and complete in ink to prevent your coverage changes from being delayed.
The Employee Information section is required for all changes. You must be enrolled to add a dependent. Please sign and date on the reverse.

Section 1: Employee Information

Group Number	Employer Name			
Employee Last Name, Suffix (e.g., Sr, Jr)	First Name	M/I	Social Security #	Telephone ( ) -

Section 2: Add Spouse

Spouse Last Name, Suffix (e.g., Sr, Jr)	First Name	Social Security #	Date of Birth	Date of Marriage	Spouse Employed? ☐ No ☐ Yes

Employed By (Company Name, City and State)	Spouse Insured Elsewhere for Dental? ☐ No ☐ Yes If yes, insured by_________________	Policy Number __________________
Indicate the coverages to which the spouse should be added: ☐ Ca$hBack ☐ Dependent Life ☐ Dental	Event Causing Eligibility?	Date of Event

Section 3: Add Children

Child Last Name, Suffix, First, M/I	Date of Birth	Gender (M/F)	Social Security #	Relationship (Check One)				Full-Time Student? (Y / N)	You &/or your spouse provide 50% support?
				Natural Child	Adoped Child	Step-Child	Legal Guard.		

* Please attach to this form copies of the court orders or legal documents creating this relationship

Indicate the coverages to which the child(ren) should be added: ☐ Ca$hBack ☐ Dependent Life ☐ Dental	Event Causing Eligibility?	Date of Event
Child Insured Elsewhere for Dental? ☐ No ☐ Yes If yes, insured by_______________________________________		Policy Number

Are any of the other Dependents listed above in the legal custody of another Person? ☐ No ☐ Yes If yes, complete the following:

Dependent	*Person with Legal Custody*	*Relationship to Dependent*	*Address of Custodian*

Section 4: Change in Marital Status

From ☐ Single ☐ Divorced ☐ Separated ☐ Married ☐ Widowed

To ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Section 5: Name Change

☐ Employee Name ☐ Due to Marriage
☐ Dependent's Name (indicate former name)____________________________
☐ Other, describe____

Change Name to:
____

Section 6: Change of Address

New Address____
Street City State Zip

Section 7: Delete Coverage

☐ Delete Spouse	Name____	As of________________
☐ Delete Child(ren)	Name____	As of ________________
☐ Employee	Name____	As of ________________

Reason

Indicate Reason for Coverage Deletion:____

Type of Coverage to be Deleted

☐ Delete All Coverage	As of (indicate last day of work)__________________________________
☐ Delete Ca$hBack	As of____
☐ Delete Dental	As of____
☐ Delete Life/Dependent Life	As of____

Section 8: Employee Retiring

☐ Electing Retiree Coverage (as applicable)	As of (indicate date of retirement)__________________________________

WAIVER OF COVERAGE

For Dental: If you are declining dental coverage for any of your eligible dependents (including your spouse) because he or she has other dental insurance coverage, you may in the future be able to enroll your dependents in this plan, provided that you request enrollment within 31 days after his or her other coverage ends.

For Voluntary Life: If you are declining coverage for any of your eligible dependents (including your spouse), you may be able to enroll your dependents in this plan during your group's next annual enrollment period, subject to proof of insurability.

For All Coverages: If you fail to enroll your dependents in all available coverages at this time, you may not be eligible to add your dependents later or your dependents may be subject to certain restrictions which are described in your plan.

(Alabama) Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

(California) 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.

(District of Columbia) 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.

(Florida) Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

(Kentucky) Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

(Louisiana) It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

(Maine) 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.

(Maryland) Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

(Missouri) An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether an insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question(s) appears in this application, you should not renew it.

(NAIC) 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.

(New Hampshire) The policy provides limited benefits. Review your policy carefully.

(New Jersey) Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

(New Mexico) 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.

(Oklahoma) Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

(Pennsylvania) 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.

(Puerto Rico) Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a maximum of two (2) years.

(Washington) Any person who knowingly provides false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

(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.

(New York) 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.

Employee Certification and Authorization I certify that I have read, or have had read to me, the completed change form and that all information is true and complete to the best of my knowledge. If adding spouse or dependent coverage, I certify that my dependent is eligible for coverage and authorize that any applicable contribution for the coverage selected be deducted from my earnings.	
Employee's Signature ►	Date
Employer Certification and Authorization I certify that the above information is correct and complete according to our records.	
Name of Employer's Authorized Representative (printed)	Title
Signature of Employer's Authorized Representative	Date

Submit your completed form to:
Nationwide, P.O. Box 4670, Springfield, MA 01101
or Fax to (413) 452-5334
Member Service phone number: (877) 657-5028
Email: nebenrollment@nebadmin.com