Nationwide® On Your Side

Nationwide Specialty Health®

License/Appointment Request Form

❑New Appointment ❑ Change Name ❑ Change Address

COMMISSIONS PAID TO: ❑ Individual ❑ Agency

General Agent _____

SECTION I – INDIVIDUAL AGENT INFORMATION

First Name	Middle	Last Name	Social Security Number -- --	Date of Birth	Gender M❑ F❑

Home Address	Street	City	State	ZIP	County

Home Phone Number	Home Fax Number	Email Address
( ) -	( ) -	

SECTION II – AGENCY INFORMATION

The Agency is a: ❑ Individual/Sole Proprietorship ❑ Partnership or LLC ❑ Corporation ❑ Other

Business/Agency Name	EIN Number (For Agency Pay)

Agency Street Address	City	State	ZIP	County

Agency Mailing Address	City	State	ZIP	County

Agency Phone Number	Agency Fax Number	Agency Email Address
( ) -	( ) -	

State(s) in which to be appointed:

License Number(s). Please attach a copy(ies) of the current health license(s)
Agent: Broker:

Is your Agency a wholesaler? ❑ Yes ❑ No. If "Yes" how many names are on its mailing list(s)? _____
How many are considered active producers for the Agency? _____

SECTION III – BROKER/AGENCY QUESTIONNAIRE

A letter of explanation must be attached on any "Yes" answer to the following questions.

1. Have you ever been convicted of any criminal activity involving dishonesty or a breach of trust? ❑ Yes ❑ No
2. Have you ever been convicted or are currently under indictment for any criminal felony? ❑ Yes ❑ No
3. Have you ever had a license or an appointment cancelled by an insurer for reasons other than low production? ❑ Yes ❑ No
4. Have you ever been suspended, disqualified or disciplined as a member of any profession? ❑ Yes ❑ No

I hereby authorize Nationwide and its representatives to make an independent investigation of my background, references, character, past employment, education, and criminal or police record, including those mandated by both public and private organizations and all public records for the purpose of confirming the information contained on this form and all other obtained information which may be material to my qualifications for licensing and/or appointment.

I release Nationwide, its representatives, and any other person or entity, which provides information pursuant to this authorization, from any and all liabilities, claims or lawsuits in regards to the information obtained from any and all of the above referenced sources used.

SECTION IV – SIGNATURE

I certify that to the best of my knowledge and belief, the above information is correct and complete.

Signature _____ Date _____

Print Name _____

Return with copies of all current health licenses for applicable states, current Errors and Omissions Declaration Page showing dates and amounts of coverage, Direct Deposit Form, signed Agreement(s) and HIPAA Authorization to:
Nationwide Specialty Health, Licensing Dept, 5525 Parkcenter Circle, CO-01-24, Dublin, Ohio 43017 or fax to (614) 854-3810.
Phone: 1-888-674-0385, ext 43741