

Wait!

**Please call before
attempting to complete your application!**

Avoid headaches and delays by allowing our office to assist you. We can help you complete your application and answer any questions you may have. You'll be surprised at how simple completing an application can be.

1 800 721-2618

(6:30 a.m. to 6:30 p.m. PST. Monday through Friday)

Please mail your application to:

Health One Insurance Agency
1344 Disc Dr. #210
Sparks, NV 89436
Attn: APDT

Or you may fax your application to:

800 905-6750



Nationwide[®] Health Plans

Underwritten by Nationwide Life Insurance Company

Individual and Family Enrollment Application

for the California Farm Bureau[®] Members' Health and Life Insurance Program underwritten by Nationwide Life Insurance Company

Instructions for Completing Your Application

You may use this application to apply for any of Nationwide Health Plans PPO Choice Plans, Individual Term Life Insurance, CashBack Plan, MedPerks, or Delta Dental and Vision products.

Membership in the California Farm Bureau is required for coverage under any of our products. If you are not a current Farm Bureau member, please fill out the Farm Bureau application on page 2.

Section A must be completed by all applicants regardless of the product for which you are applying.

Please print clearly using black or blue ink.

If you have any questions or are not sure how to answer a question, call your agent or Nationwide Health Plans, toll-free at 1-877-234-2727.

Health and Life Insurance

If you are applying for Health Insurance or Health Insurance and Individual Term Life Insurance coverage, please **complete Sections A, B, C, and D, and pages 8 and 10**. Life applicants must also **complete Section E**.

- Fully complete this application to avoid a return of the application and delay in processing. If any information is misstated, incorrectly recorded, or not true, this insurance may be considered void from the effective date.
- Give complete name, address, and phone number of all doctors indicated on page 5.
- If approved, this application will become part of your health Certificate of Insurance. Coverage will become effective on the first day of the month following Nationwide's approval of the application and with payment of the first full premium.

Please read and complete the required Authorization Form for Enrollment (GPH 11535) when applying for Health Insurance. A copy of this form is located in the back for your convenience.

Child(ren) Only Health Applications

If this is a Child(ren) Only health application, please enter Parent or Guardian's information **in Section A, boxes 1, 3, 9, 10, 11, and 12**.

- **In Section B**, check "Child(ren) Only Medical Coverage" box and enter information for all Dependent Child applicants (ages 0-17 years).
- **In Section C**, questions 4, 5 and 6, enter information for all Dependent Child applicants.
- Parent or Legal Guardian's signature is required on page 10.

A separate application must be completed if Parent(s) or Legal Guardian(s) are also applying for health insurance.

CashBack Plan

If you are applying for the optional CashBack Plan, please **complete Sections A and F**. This plan is only available to members who maintain a Nationwide Health Plans Health Insurance plan. Please ask your Nationwide agent for monthly premium rates.

MedPerks

If you are applying for the optional MedPerks Discount Program, please **complete Sections A and G**. This program is only available to members who maintain a Nationwide Health Plans Health Insurance plan. Please ask your Nationwide agent for monthly premium rates.

DeltaDental

If you are applying for one of the Delta Dental plans, please **complete sections A and H**. If you are applying for DeltaCare, you must select a dental office from the DeltaCare directory.

DeltaVision

If you are applying for DeltaVision, please **complete sections A and I**. Please select an Optometric office from the DeltaVision directory.

Premium Payment

Ask your Nationwide agent for monthly rates. You may use the Premium Calculation section on page 8 to help you calculate your monthly premium.

Nationwide Health Plans offers five payment modes: Monthly by check (\$5 monthly service fee applies); Monthly by EFT; Monthly by Repetitive Credit Card; Quarterly; and Semiannual. If you prefer to pay by EFT, please complete the EFT authorization form on page 9. If you are paying with a Business check, please complete the "Disclosure Notice to Business Owners" form on page 9.

Additionally, you may use a credit card for initial premium payment only. You must select a payment mode for premiums made after the initial premium payment.

Checks should be made payable to Nationwide Health Plans.

Do not terminate any existing coverage until you have been notified that your Nationwide coverage is in effect.



*Service mark used under license by the California Farm Bureau Federation.



Nationwide
Health Plans



This Application Is For (Check All That Apply):

- Preferred Eff. Date _____
- Health _____ Dental _____
- Individual Term Life _____ Vision _____
- CashBack Plan _____
- MedPerks _____

Home Office Use: Date Received _____

Underwritten by Nationwide Life Insurance Company

*Service mark used under license by the California Farm Bureau Federation.

Individual and Family Enrollment Application

A GENERAL INFORMATION (This section must always be completed regardless of type of coverage you are applying for.)

1 Primary Applicant's Name			2 Sex		3 Social Security/Tax I.D. No.		
Last		First		M.I.			
4 Birthdate (M/D/Y)		5 Place of Birth		6 Height		7 Weight	8 Marital Status
9 Home Address				10 <input type="checkbox"/> Billing Address <input type="checkbox"/> Mailing Address <input type="checkbox"/> Both (if other than home address)			
Street		City		State		Zip	
11 County of Residence		12 Home Ph. No. ()		13 Driver's Lic. No.		14 Farm Bureau Member No./County	
		Work Ph. No. ()					

B Please Check All of the Appropriate Boxes if Applying for Health Insurance

- | | | | | |
|---|---|---|--|---|
| <input type="checkbox"/> New Coverage | <input type="checkbox"/> Change of Plan | <input type="checkbox"/> Single Medical Coverage | <input type="checkbox"/> Family w/ 1 Child Medical Coverage | <input type="checkbox"/> Child(ren) Only Medical Coverage |
| <input type="checkbox"/> Addition to Plan | <input type="checkbox"/> Conversion to Separate Certificate | <input type="checkbox"/> Couple Medical Coverage | <input type="checkbox"/> Single w/ Children Medical Coverage | |
| <input type="checkbox"/> Reinstatement | | <input type="checkbox"/> Single w/ 1 Child Medical Coverage | <input type="checkbox"/> Family w/ Children Medical Coverage | |

Please Select One Health Plan for All Applicants (If you would like to apply for different plans, a separate application must be submitted.)

- | | | |
|---|--|---|
| <input type="checkbox"/> PPO Choice Advantage \$1,500 Deductible (Plan Y) | <input type="checkbox"/> PPO Choice Select \$500 Deductible (Plan AHL-G) | <input type="checkbox"/> PPO Choice Saver Plus \$1,750 Single Deductible (Plan V) |
| <input type="checkbox"/> PPO Choice Advantage \$2,500 Deductible (Plan Y) | <input type="checkbox"/> PPO Choice Select \$1,000 Deductible (Plan AHL-G) | <input type="checkbox"/> PPO Choice Saver Plus \$2,400 Single Deductible (Plan V) |
| <input type="checkbox"/> PPO Choice Advantage \$5,000 Deductible (Plan Y) | <input type="checkbox"/> PPO Choice 25 \$750 Deductible (Plan W) | <input type="checkbox"/> PPO Choice Saver Plus \$4,800 Single Deductible (Plan V) |
| <input type="checkbox"/> PPO Choice Classic \$2,500 Deductible (Plan CX) | <input type="checkbox"/> PPO Choice Value \$3,500 Deductible (Plan U) | <input type="checkbox"/> PPO Choice Saver Plus \$3,500 Family Deductible (Plan V) |
| <input type="checkbox"/> PPO Choice Classic \$5,000 Deductible (Plan CX) | <input type="checkbox"/> PPO Choice Value \$3,500 Deductible w/ Opt. Rx (Plan U) | <input type="checkbox"/> PPO Choice Saver Plus \$4,800 Family Deductible (Plan V) |
| | | <input type="checkbox"/> PPO Choice Saver Plus \$9,600 Family Deductible (Plan V) |

Additional Applicant's (Dependents) Full Name	Relationship To Primary Applicant	Birthdate (M/D/Y)	Place of Birth	Age	Sex	Social Security Number	Height	Weight
	Spouse	/ /						
	Child	/ /						
	Child	/ /						
	Child	/ /						
	Child	/ /						

C Health Insurance Information

1 a. What is Primary Applicant's occupation(s) and duties? _____

b. Is occupation covered under Workers' Compensation? Yes No

c. Are you involved in any sports for pay? Yes No

2 a. What is Spouse's occupation and duties (if applying)? _____

b. Is occupation covered under Workers' Compensation? Yes No

c. Is your spouse involved in any sports for pay? Yes No

3 Primary Applicant's Beneficiary - Full Name and Relationship.
(Life Insurance and AD&D program is underwritten by Nationwide Life Insurance Company, Columbus, Ohio.)

4 Has any Applicant previously applied for insurance under this program? If "Yes", give name(s), Application/Certificate No(s), and date(s) last insured. Yes No

5 Is any Applicant currently (or within the last 63 days) insured under any group or individual health insurance plan? Yes No

If "Yes",

a. Give name, address, and telephone number of insurance company(s) and specify policy number(s), name of insured(s), and how long insured.

b. Will that insurance be replaced by coverage applied for with Nationwide?

c. Is that prior coverage COBRA or continuation coverage provided by a former employer?

6 Do all additional Applicants listed on this page meet the following definition for dependent eligibility?

Primary Applicant's (a) spouse; (b) unmarried natural or adopted children from birth to 18 years of age; or (c) unmarried stepchildren, or legal wards from birth to 18 years of age, if Primary Insured contributes at least 50% to their support and claims them as an exemption for Federal and/or State Income Tax purposes. A child under age 24 who is a full-time student at an accredited school or college (12 units or more) is also eligible.

FOR HOME OFFICE USE ONLY

Agent No. 0J842 Trans. No. _____ Date Rec'd. _____ Amt. Rec'd. with App. \$ _____

Underwriter _____ Date Approved _____ Eff. Date _____

Health Plan _____ Health Cert. No. _____

D MEDICAL INFORMATION

To the best of your knowledge and belief, circle the condition(s) for which each "yes" answer applies and provide full details in the space provided.

<p>1. Within the past 10 years, has any applicant:</p> <p>a) been treated for, diagnosed with alcoholism, advised to seek treatment for, sought help for or advised to reduce alcohol or drug use? (If YES, include frequency of use and amount consumed.) Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>b) used marijuana, cocaine, heroin, methamphetamines, LSD, or any other non-prescription drugs? (If YES, identify drug and frequency of use.) Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>c) had any moving violations, a driver's license revoked or suspended, or been charged with driving under the influence? (If YES, provide name of applicant(s), driver's license number and details.) Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>3. Within the past 10 years has any applicant:</p> <p>a) been advised to have consultations or referrals to another physician, diagnostic tests, treatment, surgery or hospitalization (whether completed or not)? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>b) had an abnormal laboratory test, diagnostic test, physical exam, including but not limited to MRI, CT Scan, EKG, PET, EEG or X-ray? Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>2. Within the past 10 years, has any applicant sought or been advised to have treatment for, had follow-up visits for, or been diagnosed with:</p> <p>a) high blood pressure, chest pain, heart murmur, heart valve disorder, heart attack, heart surgery, irregular heart beat, stroke, TIA, aneurysm, vein or artery disease or disorder; or any other disease, disorder or injury of the heart or circulatory system? (Not including HIV.) Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>b) headaches, migraines, dizziness, fainting, Down's syndrome, multiple sclerosis, myasthenia gravis, cerebral palsy, muscular dystrophy, tremors, convulsions or seizures, paralysis, brain disorder or disease? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>c) diabetes or sugar intolerance, adrenal gland disorder, parathyroid gland disorder, thyroid gland disorder, pituitary gland disorder, hemochromatosis, high cholesterol or high triglycerides? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>d) any disease, disorder or injury of the kidney, bladder, prostate, ureter, or urinary tract? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>e) any disease, disorder or injury of the breasts or had breast implants? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>f) any disease, disorder or injury of the male/female reproductive organ system, impotence, infertility, sexually transmitted diseases (Not including HIV), irregular menstruation, uterine fibroids, endometriosis, complications of pregnancy, premature birth, pelvic inflammatory disease or abnormal pap smear? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>g) any disease, disorder or injury of the liver, stomach, intestine, colon, rectum, spleen, esophagus, gall bladder, pancreas, acid reflux/gastroesophageal reflux (GERD), hernia, colitis, ulcer, hepatitis, cirrhosis, hemorrhoids, surgery for weight control, or any other disease or disorder of the digestive tract? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>h) asthma, hay fever, allergies (including desensitization), COPD (chronic obstructive pulmonary disease), cystic fibrosis, emphysema, sarcoidosis, shortness of breath, tuberculosis, pneumonia, sleep apnea, or any disease, disorder or injury of the lungs or respiratory system? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>i) osteoarthritis, rheumatoid arthritis, back or neck pain, disease or disorder of the spine or spinal surgery, gout, osteoporosis, connective tissue disease, fibromyalgia, lupus, scleroderma, psoriasis or other disease, disorder or injury of the bones, joints, or muscles? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>j) eye (including cataracts), ear, nose, throat, tongue, or skin disease, disorder or injury? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>k) cancer, tumor, polyp or cysts? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>l) depression, panic attacks, anxiety, bipolar disorder, obsessive-compulsive disorder, schizophrenia, attention deficit disorder, attention deficit hyperactivity disorder or eating disorder? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>m) AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS-Related Complex)? (Not including HIV.) Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>n) Chronic fatigue syndrome, Lyme disease, Marfan syndrome, anemia, lymph node enlargement or any other disease or disorder of the blood? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>4. Does any applicant have any illness, injury, or physical symptoms for which he/she has not yet consulted or plans to consult a doctor? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>5. Has any applicant been prescribed or recommended medication, herbal or nutritional supplements within the past 2 years? If yes, provide details including frequency and dosage. Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>6. In the past 2 years, has any applicant been prescribed or used any medical device such as a CPAP machine or TENS Unit? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>7. Does any applicant have any physical abnormality, deformity or disfigurement? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>8. Has any applicant had an exam, consultation, checkup, been hospitalized or been treated by a doctor, acupuncturist, chiropractor, physical therapist, psychiatrist, psychologist, nurse practitioner, physician's assistant or licensed mental health counselor for any reason within the past 5 years? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>9. a) Are you, your spouse, or any of your dependents currently pregnant or had a positive home pregnancy test within the last 6 months? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, name of person expecting. _____</p> <p>b) Are you, your spouse, or any of your dependents expecting a child with anyone, including a surrogate? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, name of person expecting. _____</p> <p>c) Do any of the female applicants listed on this application menstruate? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please list their name(s). _____</p> <p>d) During the past 6 months, has each of the females listed in (c) above had a menstrual period every month, including within the last 30 days? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, please explain. _____</p> <p>10. If you are a male listed on the application, are you expecting a child with anyone, even if the mother is not listed on the application? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>11. Are you, your spouse, or any of your dependents planning to adopt a child or becoming a legal guardian of a child? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, expected date of adoption, guardianship or placement for adoption. _____</p> <p>12. Within the past 10 years has any applicant been refused, waived or offered a health policy at other than standard rate? If YES, provide name of applicant(s) and details. Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>13. Is any applicant currently receiving insurance or government benefits due to a disability? Yes <input type="checkbox"/> No <input type="checkbox"/></p>

Note: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

E Individual Term Life Insurance

Applicants and/or any dependents that are approved for a Nationwide Health Plans certificate will also qualify for Individual Term Life coverage at an additional charge. Applicants under the age of one year are not eligible for Life insurance. This coverage does not replace the \$5,000* Life & AD&D coverage you purchase for \$3.00 per month. You must maintain a qualifying health coverage with Nationwide Health Plans in order to keep the additional Individual Term Life Insurance. The Individual Term Life Insurance premium will be included with your Health Insurance billing. Will this insurance replace any existing Life Insurance? Yes No

Please list the family members applying for Individual Term Life Insurance Coverage. (Available for ages 1 - 64.)

Name of Family Member Full Name	Relationship To Primary Applicant	Birthdate (M/D/Y)	Amount	Beneficiary	Beneficiary's Address
	Self	/ /	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$30,000 <input type="checkbox"/> \$40,000		
	Spouse	/ /	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$30,000 <input type="checkbox"/> \$40,000		
	Child	/ /	<input type="checkbox"/> \$10,000		
	Child	/ /	<input type="checkbox"/> \$10,000		
	Child	/ /	<input type="checkbox"/> \$10,000		
	Child	/ /	<input type="checkbox"/> \$10,000		

*The \$5,000 coverage applies to the member only. If the spouse has coverage, a \$2,500 benefit amount applies. There is no child(ren) coverage under this benefit.

 APPLICANT'S NAME **X** APPLICANT'S SIGNATURE DATE

 SPOUSE'S NAME **X** SPOUSE'S SIGNATURE DATE

F CashBack Plan

Persons without comprehensive health insurance coverage are not eligible for this product.

This product is a supplement to qualified NHP PPO Choice Health Plans and is not a substitute for hospital or medical expense insurance. All applicants listed in Section A and B must apply if you are interested in coverage.

Available only with PPO Choice Plans listed on page 3 that have a \$1,000 deductible or higher.

Yes, I/We would like to apply for the CashBack Plan.

G OPTIONAL MedPerks Enrollment

This OPTIONAL MedPerks Program is not insurance. Only those applicants that are approved for health insurance coverage through the California Farm Bureau Members' Health and Life Insurance Program are eligible for the MedPerks Program. Participation in the California Farm Bureau Members' Health and Life Insurance Program is required to maintain the MedPerks Program.

The MedPerks Program will become effective on the same date as your coverage under the California Farm Bureau Members' Health and Life Insurance program.

The MedPerks Program premium will be included with your Health Insurance Program billing.

Applying for:

MedPerks A (without pharmacy):
 This product is issued to individuals approved for a health coverage plan through the California Farm Bureau Members' Health and Life Insurance Program that includes prescription drug coverage.

MedPerks B (with pharmacy):
 This product is issued to individuals approved for a health coverage plan through the California Farm Bureau Members' Health and Life Insurance program that does not include prescription drug coverage.

X _____
 APPLICANT'S SIGNATURE DATE



H DeltaDental Coverage Delta Dental is a standalone product.

Applying for **Delta Dental** - please **select one** of the following plans.

Delta Premier/AdapTable Dental Plan **OR**

Delta Care Dental Plan (**You must choose** a dental office from the Delta directory.) Dental Office # _____

Please make dental coverage effective ____ / 01 / ____ **OR** **upon approval of my health insurance (if applicable).**

If you are also applying for Health Insurance, please check the appropriate box:

Yes, I/we would like dental coverage even if my/our health insurance is **not** approved. **OR**

No, I/we do not want dental coverage if my/our health insurance is **not** approved.

Please list names applying for Delta Dental coverage.

Applicant's Full Name	Relationship	Birthdate (M/D/Y)	Sex	Social Security Number
	Self	/ /		
	Spouse	/ /		
	Child	/ /		
	Child	/ /		
	Child	/ /		
	Child	/ /		

X _____
APPLICANT'S SIGNATURE DATE

X _____
AGENT'S SIGNATURE DATE



I DeltaVision Coverage DeltaVision is a standalone product.

Applying for **Delta Vision** - please select a vision office from the Delta directory. Enter office name and office # in the space provided.

Optometric Office Choice _____ Vision Office # _____

Please make vision coverage effective ____ / 01 / ____ **OR** **upon approval of my health insurance (if applicable).**

If you are also applying for Health Insurance, please check the appropriate box:

Yes, I/we would like vision coverage even if my/our health insurance is **not** approved. **OR**

No, I/we do not want vision coverage if my/our health insurance is **not** approved.

Please list names applying for DeltaVision coverage.

Applicant's Full Name	Relationship	Birthdate (M/D/Y)	Sex	Social Security Number
	Self	/ /		
	Spouse	/ /		
	Child	/ /		
	Child	/ /		
	Child	/ /		
	Child	/ /		

X _____
APPLICANT'S SIGNATURE DATE

X _____
AGENT'S SIGNATURE DATE



PREMIUM CALCULATION AND DELIVERY INSTRUCTIONS

Please fill in amount for all coverages applying for.

1 Monthly Premium (includes \$3 for Life/AD&D) \$ _____
 Spouse Coverage Included? Yes No \$ _____
 Child(ren) Coverage Included? Yes No \$ _____

2 Additional Monthly Premium for Individual Term Life Insurance (if applying) \$ _____
 Spouse Coverage Included? Yes No \$ _____
 Child(ren) Coverage Included? Yes No \$ _____

3 Additional Monthly Premium for the CashBack Plan (if applying) \$ _____

4 Monthly Premium for Dental (if applying) \$ _____
 Spouse Coverage Included? Yes No \$ _____
 Child(ren) Coverage Included? Yes No \$ _____

5 Monthly Premium for Vision (if applying) \$ _____
 Spouse Coverage Included? Yes No \$ _____
 Child(ren) Coverage Included? Yes No \$ _____

6 Monthly Premium for MedPerks (if applying) \$ _____

Monthly Total \$ _____

7 Include one of the following:
 • Semiannual Premium (monthly x 6) \$ _____
 • Quarterly Premium (monthly x 3) \$ _____
 • Monthly Premium \$ _____

Health - Plus \$5 monthly service fee (if monthly non-EFT) \$ _____

Dental/Vision - Plus \$5 monthly service fee (if monthly non-EFT) \$ _____

8 Plus One-Time Rural Health Dept. Fee \$ 5.00

9 Annual Farm Bureau Dues (if not already a member) \$ _____

Total Submitted with Application \$ _____

Please send Certificate of Insurance to:

- Agent for delivery
- Certificateholder

PREMIUM PAYMENT MODE

- Monthly by Check (\$5 monthly service fee applies). Please make checks payable to Nationwide Health Plans.
- Monthly by EFT (Please complete EFT Authorization form on page 9.)
- Monthly by Repetitive Credit Card (Fill out credit card information below.)

Monthly Repetitive Credit Card Authorization - By signing below, I request and authorize NHP to charge my card for monthly recurring premiums on each due date. I understand that the amount may vary as a result of changes I make, such as, but not limited to, adding and deleting dependents, or moving to a new location. The amount may also change as outlined in my Certificate of Insurance. This authorization is to remain in effect until revoked by me by providing NHP a 30-day written notice. I agree that NHP shall be fully protected in honoring such card payments. I further agree if any such payment is dishonored, whether with or without cause and whether intentionally or inadvertently, NHP shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage.

- Quarterly
- Semiannual

If paying by business check, please complete the "Business Disclosure" form on page 9.

Premium Payments include charges for life insurance and AD&D benefits and the California Life & Health Insurance Guarantee Association surcharge (if applicable).

CREDIT CARD PAYMENT FOR INITIAL PREMIUM

The initial premium payment and annual Farm Bureau dues may be charged to your credit card.

- Please charge the total quarterly or semi-annual premium to my credit card including the annual Farm Bureau membership dues.
- Please charge only one month's premium to my credit card and bill me the difference for the quarterly or semi-annual premium mode I selected including the annual Farm Bureau membership dues.

Credit Card Information

Credit Card: VISA MasterCard

Card No. _____

V-Code _____ (Last 3 numbers located on the backside of your card in the signature panel.)

Expiration Date: _____

Cardholder's Name (As it appears on the credit card.)

PRINT NAME X	DATE
------------------------	------

Authorized Signature (As it appears on the credit card.)

SIGNATURE X	DATE
-----------------------	------

Cardholder's Billing Address

ADDRESS		
CITY	STATE	ZIP

PREMIUM RATES

Premium rates for Health Insurance and Individual Term Life Insurance provided under this Certificate (but not for Life Insurance and Accidental Death and Dismemberment benefits) are adjusted for changes in Your and Your spouse's and Your child(ren)'s (if any) ages. Adjustments are effective as of the first of the month following Your and/or Your spouse's (if any) birthday if the age change moves the individual in to a new age bracket. Should a change in premium rates be made for any other reason, you will be notified of the effective date which will be at least 30 days from the date of the notice. The change will be made only after at least 30 days' prior notice to You and the Certificateholder. Premium adjustments will be reflected in Your premium statements due on or next following the effective date of a rate change.

AUTHORIZATION FOR ELECTRONIC FUNDS TRANSFER (EFT) PREMIUM PAYMENT

For Health Certificate Number: _____ For Dental/Vision Certificate Number: _____

I authorize Nationwide Health Plans to send checks or electronic fund transfer (EFT) notices to my bank or other financial institution each month and charge them against my account. I understand these account charges will pay premiums for the health and/or dental or vision certificate being applied for, if the certificate is issued. Insurance will become effective only upon approval by Nationwide and only upon the effective date of the certificate following that approval and acceptance.

I agree that: (a) each such charge shall constitute notice of premiums becoming due the first day of the following month for each charge; and (b) this payment method may be terminated by you or me on 30 days' written notice in either case, or immediately by you if a charge is not honored for any reason.

My preferred draft day of the month is:* 1st 15th

I agree that: (a) my financial institution's rights with respect to each charge shall be the same as if it were personally signed by me; and (b) if any such charge is not honored, whether with or without cause and whether intentionally or inadvertently, my financial institution shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

DEPOSITOR'S NAME (PRINT)

DATE

X _____
SIGNATURE OF DEPOSITOR (AS SHOWN ON RECORD FOR THE ACCOUNT
TO WHICH THIS AUTHORIZATION APPLIES)

X _____
OTHER SIGNATURE (IF JOINT ACCOUNT)

*Actual draft is made on or about the first working day following the date selected.

PLEASE ATTACH VOIDED CHECK HERE
(Do not use deposit slip)

DISCLOSURE NOTICE TO BUSINESS OWNERS

I (Business Owner) and/or some or all of my employees and their eligible dependents have applied for coverage under the California Farm Bureau Federation Members' Health Insurance Program. The Members' Program, which is underwritten by Nationwide Life Insurance Company, (Nationwide) is an association group health insurance program for individual Farm Bureau Members and does not constitute and should not be used as an employee group health insurance plan.

The Members' Program is not designed or intended to replace any group health plan I may have in force now, or had in force previously for my employees and their dependents. Special regulations may apply to the replacement for such coverage which cannot be satisfied by the Members' Program.

In regard to the Members' Program, I certify that: (1) the premium for this coverage is to be paid by the individual insureds only, and not through any salary reduction or reimbursement program nor is this coverage treated by me or any of my employees as part of a plan or program for purposes of Section 106 or 162 of the Internal Revenue Code (the only exception to this is if you have less than 2 full-time employees, including yourself if you work in the business); (2) if the employee elects not to continue coverage, any premium refund will be made payable to the employee; (3) any insurance coverage for my employees and their dependents may not be cancelled by me.

X _____
BUSINESS OWNER'S SIGNATURE/TITLE

DATE

BUSINESS OWNER'S NAME (PLEASE PRINT)

STREET ADDRESS

CITY STATE ZIP

APPLICANT'S NAME

**IMPORTANT NOTICES, RELEASES AND AUTHORIZATIONS
PLEASE READ CAREFULLY**

I (Applicant(s) signing below) understand that the insurance applied for will become effective on the effective date of the certificate of insurance only if (a) this application is approved by Nationwide Health Plans and (b) the full first premium is paid. I understand that Nationwide has no obligation on account of this application, although I may have paid premiums thereon, unless a certificate is issued and received by me while the Applicant(s) is in sound health.

I authorize release to Nationwide of my residence and mailing address and other information, if any, in the records of any state's Department of Motor Vehicles (DMV) and waive any applicable requirements of Section 1808.21 of the California Vehicle Code concerning release of such information. The information released will be used to determine my eligibility for insurance or eligibility for benefits. Any address information the DMV releases to Nationwide will be treated as confidential information and will not be further released except as may be required or authorized by law.

I understand that California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

I authorize the Medical Information Bureau, Inc. ("MIB") to give Nationwide or its reinsuring companies any and all information relating to the diagnosis, treatment and prognosis of any physical or mental condition and/or treatment of me or my minor children that MIB has on record.

I agree that a photographic copy of this authorization will be as valid as the original. If not previously revoked, I agree this authorization will be valid for two and one half years from the date shown below.

I understand that I or my authorized representative is entitled to a copy of this signed acknowledgment and authorization if requested.

I acknowledge that I have read the Notice of Health Information Practices, the Notice to Applicant of Personal Information Practices, the MIB Disclosure Notice, and the Fair Credit Reporting Notice on page 13 and that I have received the document titled "Nationwide Health Information Privacy Practices Notice."

I understand that the insurance applied for will not pay benefits for any expenses incurred during the first 6 months following the effective date on account of any condition for which medical advice, diagnosis, care or treatment (including use of prescription drugs) was recommended or received during the 6 months before the effective date of this insurance. A condition includes any physical or mental illness, injury, mental disorder, physical disfigurement, or birth abnormality. Nationwide will credit each insured with the period of time such person was covered under any prior creditable coverage, as defined in the Certificate of Insurance, provided such person becomes insured hereunder within 63 days of the date that the prior creditable coverage ends.

I certify that the number shown in this application is my correct social security and/or taxpayer identification number and certify that all answers in this application are true and correctly recorded to the best of my knowledge and belief. **I understand that all answers in this application will be relied on by Nationwide in its approval or declination of my application. If any answers are misstated, incorrectly recorded, or are not true, the insurance is subject to rescission, in which case the insurance is deemed to be void from the effective date.** This application will become a part of any certificate issued. No statement or promise will be binding on Nationwide, unless made in writing and attached to this application.

NOTICE OF BINDING ARBITRATION AND WAIVER OF JURY TRIAL

I understand any dispute between myself (and any other Covered Person) and Nationwide Health Plans must be resolved by binding arbitration if the amount in dispute exceeds the jurisdictional limit of the Small Claims Court of California and not by lawsuit or resort to court process of any type, except as California law provides for judicial review of arbitration proceedings. Under this health insurance coverage, both the Covered Person and Nationwide Health Plans is giving up the right to have any dispute decided in a court of law before a judge or a jury. Actions for medical malpractice between my provider and myself are not affected by this provision. Although Nationwide Health Plans and I will accept the finality of this process, to assure fairness, the arbitrator may not be limited in the variety of remedies available.

Signed at: _____
CITY, STATE

On (Date): _____
(MONTH/DAY/YEAR)

SIGNATURE OF PRIMARY APPLICANT OR APPLICANT'S PARENT OR LEGAL GUARDIAN
IF APPLICANT UNDER 18 YEARS OF AGE

SIGNATURE OF SPOUSE (IF APPLYING)

SIGNATURE OF AGENT

AGENT NO. _____

SIGNATURE OF CHILD(REN) (AGE 18 OR OVER)

AGENT'S NAME (PRINT) _____

DATE _____

AGENT'S PHONE NO. _____

FAX NO. _____

AGENT'S EMAIL ADDRESS _____

HEALTH INSURANCE DISCLOSURE NOTICES

The coverage you and your dependents, if any, are applying for under the California Farm Bureau Federation Members' Health Insurance Program (Members' Program) is underwritten by Nationwide Life Insurance Company. The Members' Program is not an employee group insurance plan and does not replace any such existing, or previously in-force, group coverage provided by your employer. Nationwide is not responsible for compliance with any state or federal laws involving employee group health insurance such as the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) and the Employee Retirement Income Security Act (ERISA). (Consult Nationwide Health Plans for further information.)

NOTICE OF HEALTH INFORMATION PRACTICES

To provide insurance coverage, we need to obtain health information about you and any other persons proposed for insurance. Some of that information will come from you and some will come from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization.

In certain circumstances, Nationwide Life Insurance Company or its reinsurer(s) may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

NOTICE TO APPLICANT OF PERSONAL INFORMATION PRACTICES

Personal non-health information may be collected from persons other than you or other individuals proposed for coverage. Any information which we may have or may obtain about you or any other individuals proposed for coverage will be treated as confidential. However, personal or privileged information collected by us or our agents may, in certain circumstances, be disclosed to third parties like the California Department of Insurance or our affiliates for claims handling, servicing, underwriting or insurance marketing.

You have the right to see any personal information collected by us and can request correction of any inaccuracies. If you would like a description of our information practices and your rights regarding information we collect, please write us at the following address: Nationwide Health Plans, Attention: Health Customer Services Division, HS-10, 1601 Exposition Blvd., Sacramento, CA 95815.

FAIR CREDIT REPORTING NOTICE

If we use an independent reporting agency for a report, you have the right to be personally interviewed by them. If you wish to be interviewed, please tell us how the agency can contact you and every effort will be made to interview you. Even if you are not interviewed, you have the further right to request that the reporting agency provide you with a copy of the report it makes. Write us at the address shown below and we'll give you the name and address of any agency we have used to prepare a report on you so that you can contact them directly to find out more about that report.

If you want a more detailed explanation of our information practices or a copy of our Nationwide Health Information Privacy Practices Notice, please write to us at:

Nationwide Health Plans, Attn: HS-60, 1601 Exposition Boulevard, Sacramento, CA 95815

MEDICAL INFORMATION BUREAU DISCLOSURE NOTICE

Upon your written authorization, information regarding your insurability will be treated as confidential. Nationwide Life Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau, a nonprofit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedure set forth in the Federal Credit Reporting Act. The address of the Bureau's information office is:

P.O. Box 105, Essex Station, Boston, MA 02112. Telephone Number: (617) 426-3660

APPLICANT, PLEASE RETAIN FOR YOUR RECORDS.

CONDITIONAL RECEIPT-To be completed by the agent and given to the applicant.

Received from _____ \$ _____ as initial premium, payable to Nationwide Health Plans.

Subject to the following:

IN NO EVENT SHALL NATIONWIDE HEALTH PLANS, OR ANY AFFILIATED COMPANY HAVE ANY LIABILITY TO THE APPLICANT IF THE APPLICATION IS NOT APPROVED, EXCEPT FOR THE OBLIGATION TO RETURN THE MONEY SUBMITTED WITH THIS APPLICATION. NO COVERAGE SHALL EXIST NOR SHALL THE APPLICANT BE ENTITLED TO ANY BENEFITS UNLESS AND UNTIL THIS APPLICATION IS APPROVED BY THE HEALTH UNDERWRITING DEPARTMENT OF NATIONWIDE HEALTH PLANS, IN WHICH CASE COVERAGE SHALL BE EFFECTIVE AS OF THE DATE STATED IN THE CERTIFICATE OF COVERAGE.

Dated this _____ day of _____, 20 _____.
Nationwide's Agent acknowledges receipt of money and delivery of Conditional Receipt.

By _____
SIGNATURE OF AGENT AGENT NUMBER

**ALL CHECKS FOR PREMIUM MUST BE MADE PAYABLE TO NATIONWIDE HEALTH PLANS.
DO NOT MAKE CHECKS PAYABLE TO THE AGENT.**



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 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 information about my
(applicant/enrollee)
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
applicant 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
spouse 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
adult child to underwrite and rate the health plan coverage for which I have applied.

_____ adult child

LIFE

_____ b. Nationwide Life Insurance Company or their affiliates including, but not limited to, their agents,
applicant underwriting operations, claims operations, legal, representatives, its Medical Director or his/her
_____ designees, its sales and marketing operations, to underwrite and rate the life policy for which
spouse 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
adult child this paragraph 2(b) authorizing the information to be used to underwrite and rate the
_____ life coverage.
adult child

- 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, 1601 Exposition Boulevard, 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 Signature

_____ Date: _____
Adult Child Signature

_____ Date: _____
Adult Child Signature

Personal Representative Name, if applicable Date: _____

Personal Representative Signature

