

# Enrolling is Simple. Just Follow These 3 Easy Steps...

## Step 1

**COMPLETE THE APPLICATION IN BLUE OR BLACK INK.** Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at:  
at: Fax:

## Step 2

**SELECT THE TYPE OF BILLING YOU WANT** – Monthly (by checking account deduction), Monthly billing \$5 service charge, Quarterly (every three months), or Semi-annual (twice yearly).

## Step 3

**SEND THE COMPLETED APPLICATION TO:**

### **Please make your check payable to: Nationwide Health Plans**

Please do not forget to add one check payable to: California Farm Bureau Federation, for the annual Farm Bureau dues located on page 9.

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

**If you have questions please contact our office at:**

Thank you for choosing...



**Nationwide**  
Health Plans

**Nationwide Health Plans**



# Application for a Nationwide<sup>®</sup> Medicare Supplement Plan

Underwritten by Nationwide Life Insurance Company

## ELIGIBILITY REQUIREMENTS

**TO BE ELIGIBLE FOR A NATIONWIDE MEDICARE SUPPLEMENT PLAN, PROPOSED INSUREDS MUST SATISFY THE FOLLOWING REQUIREMENTS\*:**

- Be eligible under Medicare and have applied for Medicare Parts A and B; and
- Be a member of a County Farm Bureau of the California Farm Bureau Federation and its Rural Health Department; and
- Not be concurrently insured under any other California Farm Bureau Federation service to member health insurance program; and
- Be an individual age 65 or older who, on the effective date of a Medicare Supplement Plan, is not insured under Nationwide's Master Group Policy No. GH-1000, or be an individual under age 65 who is disabled and has Medicare Parts A & B.

**\*Coverage is subject to Nationwide's approval of this Application.**

### NOTICE

**IN ACCORDANCE WITH FEDERAL REGULATIONS, PROPOSED INSUREDS CANNOT, EVEN IF OTHERWISE ELIGIBLE, APPLY FOR A MEDICARE SUPPLEMENT PLAN IF THEY HAVE ANY OTHER MEDICARE SUPPLEMENT COVERAGE, OR ANY OTHER MEDICAL AND/OR HOSPITAL COVERAGE (INCLUDING SPECIFIED DISEASE AND INDEMNITY PLANS), AND DO NOT INTEND TO REPLACE SUCH COVERAGE WITH ONE OF NATIONWIDE'S MEDICARE SUPPLEMENT PLANS.**



**Nationwide<sup>®</sup>**  
Health Plans





# COUNTY FARM BUREAU® APPLICATION FOR MEMBERSHIP

|                              |               |  |   |
|------------------------------|---------------|--|---|
| Residence or Business County | Dues Enclosed |  | Current/Previous Member#<br><br>_ _ _ _ _ |
|                              | \$            | <input type="checkbox"/> Voting<br><input type="checkbox"/> Sustaining |   |

|  |  |
|--|--|
| <input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/> | Applicant's Name (Last, First, M.I.)<br>Mr.<br>Mrs.<br>Ms. |
|--|--|

|  |   |
|--|---|
| <input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/> | Spouse's Name (Last, First, M.I.)<br>Mr.<br>Mrs.<br>Ms. |
|--|---|

|  |                          |
|--|--------------------------|
| Business Name (DBA)**<br><hr/> Use Business Name as primary membership name? Yes _____ ** No _____<br>**Only <u>individual</u> members are eligible for Accidental Death & Dismemberment policy. | Type of Business<br><br> |
|--|--------------------------|

|         |  |  |
|---------|--|--|
| Address |  |  |
|---------|--|--|

|      |       |          |
|------|-------|----------|
| City | State | Zip Code |
|------|-------|----------|

|  |   |
|--|---|
| Telephone Number<br>Home: (        ) _____<br>Business: (        ) _____<br>Email: _____ May we send you email? <input type="checkbox"/> Yes <input type="checkbox"/> No | Date of Birth (mm / dd / yy)<br>Applicant _____ / _____ / _____<br>Spouse _____ / _____ / _____ |
|--|---|

|                                |                             |
|--------------------------------|-----------------------------|
| Applicant's Primary Occupation | Spouse's Primary Occupation |
|--------------------------------|-----------------------------|

Do you expect to earn any income from the growing/raising of an agricultural product?  Yes  No

If yes, you are a **Voting Member**; if no, you are a **Sustaining Member**. (See appropriate dues for county Farm Bureau.)

Please indicate next to the following descriptions the category that most closely fits your primary occupation field.

Place an "M" for you (Member) or an "S" for your Spouse

|   |  |
|---|--|
| 01 _____ Own/lease a farm/ranch                     | 04 _____ Retired from farm/ranch/ag-related business |
| 02 _____ Own/manage an ag-related business          | 05 _____ Not involved in agriculture                 |
| 03 _____ Employee of farm/ranch/ag-related business | 26 _____ Retired, not involved in agriculture        |

If you checked box **01**, would you please let us know the commodity(ies) you grow/raise:

|          |          |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

|                                |               |
|--------------------------------|---------------|
| _____<br>Applicant's Signature | _____<br>Date |
|--------------------------------|---------------|

If accepted by the County Farm Bureau above, your annual membership will begin on the first day of the month that your application was signed. Dues payments include a one-year subscription to either **Ag Alert®** (\$2) or **California Country®** (\$1) as well as the County Farm Bureau publication where applicable. Contributions or gifts to Farm Bureau are not deductible as charitable contributions for income tax purposes. However, Farm Bureau dues may be tax deductible as an ordinary and necessary business expense. Please consult your tax advisor.

|          |             |                                       |              |
|----------|-------------|---------------------------------------|--------------|
| Approval | Center Code | Recruiter / Agent Name (Please Print) | Agent Number |
|----------|-------------|---------------------------------------|--------------|



(NOTE: IN THIS APPLICATION, THE WORD "YOU" MEANS ANY PERSON APPLYING FOR COVERAGE.)

NATIONWIDE USE ONLY

Approved by

Date

Plan Effective Date

Certificate No.

A. PROPOSED INSURED'S INFORMATION

1. Type of Application: [ ] New [ ] Addition [ ] Plan Change

Applicant(s) (Please Print)

Primary Name (LAST NAME) (FIRST NAME) (M.I.)

Spouse Name (LAST NAME) (FIRST NAME) (M.I.)

Mailing Address

City/State/Zip

County

Primary Social Security #

Spouse Social Security #

Telephone No. ( )

2. Billing Address if Different than Above

Full name (PRINT) (LAST NAME) (FIRST NAME) (M.I.)

Mailing Address

City/State/Zip

3. Proposed Insureds:

Table with columns for SEX (M/F), DATE OF BIRTH (Mo., Day, Yr.), and DATE FIRST ENROLLED IN MEDICARE PART "B" (Mo., Day, Yr.). Rows for Primary and Spouse.

4. Prior, or Current Nationwide Health Plans Certificate No. (if any):

5. C.F.B.F. Membership No:

County:

6. Primary Medicare#

Spouse Medicare# (# from your Medicare Card. Include alpha letter(s).)

7. Plan: [ ] A [ ] C [ ] F [ ] F+ (High Ded.) [ ] J

8. Effective Date Requested

B. PLEASE NOTE THAT:

- 1. You may not have more than one Medicare Supplement plan.
2. If you are age 65 or older, you may be eligible for benefits under Medi-Cal or Medicaid and may not need a Medicare Supplement plan.
3. Benefits and premiums under your Medicare Supplement plan may be suspended during your entitlement to Medi-Cal or Medicaid for up to 24 months.
4. If you want to discuss buying Medicare Supplement insurance with a trained insurance counselor, call the California Department of Insurance's toll-free number 1-800-927-HELP...

C. PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE

1. Do you have any other Medicare Supplement policy or certificate in force? [ ] Yes [ ] No
a) If Yes, is it with a Preferred Provider Organization (PPO)? Which plan? [ ] Yes [ ] No
b) If Yes, is it with a Health Maintenance Organization (HMO)? [ ] Yes [ ] No
c) If Yes, with which company? (b) Effective Date:

2. Do you have any other health insurance policies that provide benefits which this Medicare Supplement plan would duplicate? [ ] Yes [ ] No
a) If Yes, with which company? (b) What kind of policy?

3. If the answer to questions 1 or 2 is Yes, do you intend to replace any of your medical or health insurance coverage policies / certificates with this plan? (Agent: If Yes, include enclosed form GPH 11253.) [ ] Yes [ ] No

4. Are you eligible for or receiving benefits from Medi-Cal or Medicaid? [ ] Yes [ ] No

**D. STATEMENT OF HEALTH**

**NOTE: YOU DO NOT HAVE TO COMPLETE SECTION D IF YOU HAVE FIRST ENROLLED IN PART B OF MEDICARE WITHIN THE PAST 6 MONTHS.**

1. Applicant's: Height \_\_\_\_\_ Weight \_\_\_\_\_ Spouse (if applying): Height \_\_\_\_\_ Weight \_\_\_\_\_

2. Have you been prescribed or taken prescription medication in the last 12 months?  Yes  No  
 If Yes, names of medications/drugs you have been prescribed, as well as all medications/drugs you have taken and provide the reason they are taken:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. Have you, within the past five years,  
 • Received medical advice or treatment, or  
 • Taken or been prescribed prescription medication, or  
 • Been confined for treatment,  
 related to any of the following conditions:

a. Multiple Sclerosis, Parkinson's, Huntington's Chorea, Alzheimer's, Paralysis, Stroke, Rheumatoid/Psoriatic Arthritis, Bone or Joint Disorders or Replacements, Seizures.  Yes  No

b. Heart Trouble, High Blood Pressure, Blood Clot/Blood Disorders, Circulation Problems, Leukemia, Irregular Heartbeat.  Yes  No

c. Liver Disorders, Hepatitis, Ulcerative Colitis.  Yes  No

d. Kidney Disease or Failure, Chronic Lung Disease, Emphysema.  Yes  No

e. Diabetes, AIDS or ARC (AIDS Related Complex), Lupus.  Yes  No

f. Cancer or Malignant Tumors.  Yes  No

g. Alcoholism or Drug Dependency.  Yes  No

h. Severe Depression, Schizophrenia, Suicide Attempt, Bipolar Disorder.  Yes  No

4. Have you ever had a pacemaker, or any type of transplant surgery or any type of heart surgery, such as angioplasty or bypass?  Yes  No

5. Have you been bed-ridden, confined to a hospital, nursing home, convalescent hospital or other institution in the past two years?  Yes  No

6. Have you been advised to enter a hospital, nursing home, convalescent hospital or other institution, but have not done so yet?  Yes  No

7. Has surgery, diagnostic testing or medical treatment been anticipated or recommended but not been done yet?  Yes  No

**Please explain below any "Yes" answers to the above questions.**

**(If application is being made for more than one person, indicate name of person to whom "Yes" answers apply)**

| Quest. No. | Person (Name) | Diagnosis and type of treatment/surgery | Name of Doctor, phone #, and complete address |
|------------|---------------|---|---|
|            |               |   |   |
|            |               |   |   |
|            |               |   |   |
|            |               |   |   |
|            |               |   |   |
|            |               |   |   |

Provide complete name, telephone number and address of personal Doctor for:

Applicant: \_\_\_\_\_

Spouse (if applying): \_\_\_\_\_

**E. ACKNOWLEDGEMENT**

I [Proposed Insured(s) signing below] hereby apply for a Medicare Supplement Plan, and certify that I have received the "Outline of Medicare Supplement Coverage" and "Guide to Health Insurance for People with Medicare" booklets; and, that I have read, understand and satisfy all of the Eligibility Requirements set forth on the front of this Application.

I understand that:

- (1) 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 and (b) the full first premium is paid, but not to exceed one month's premium if paid on a monthly basis. 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 Proposed Insured(s) is in sound health; and
- (2) a copy of this Application will be included with my Certificate of Insurance; and
- (3) if this Application is not approved, Nationwide will promptly refund all premium enclosed with the Application; and
- (4) 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.

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

Signed At (City, State): \_\_\_\_\_

|                           |            |   |            |
|---------------------------|------------|---|------------|
| Applicant Signature _____ | Date _____ | Signature of Spouse (if applying) _____ | Date _____ |
|---------------------------|------------|---|------------|

|                       |            |                             |                 |
|-----------------------|------------|-----------------------------|-----------------|
| Agent Signature _____ | Date _____ | Name of Agent (Print) _____ | Agent No. _____ |
|-----------------------|------------|-----------------------------|-----------------|

|                           |                     |               |
|---------------------------|---------------------|---------------|
| Agent Telephone No. _____ | Agent FAX No. _____ | E-Mail: _____ |
|---------------------------|---------------------|---------------|

Send Certificate of Insurance to:     Agent for Delivery                       Certificateholder

**F. AGENT STATEMENT**

**I certify that the following list represents all disability (health) policies that I (or my agency) have sold to the Proposed Insureds shown in Section A of this Application. (If None, so state.)**

|                              |   |
|------------------------------|---|
| Policies presently in force: | Policies sold in the last 5 years which are no longer in force: |
|------------------------------|---|

|       |       |
|-------|-------|
| _____ | _____ |
| _____ | _____ |

|                         |            |
|-------------------------|------------|
| Agent's Signature _____ | Date _____ |
|-------------------------|------------|

**G. AGENT COMMENTS**

Empty box for agent comments.

**H. 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 below.)
- 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 by Check.
- Semi-annual by Check.
- 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 including the annual Farm Bureau membership dues and bill me the difference for the quarterly or semi-annual premium mode I selected.

**J. PREMIUM CALCULATION**

Premium - Per Mode \$ \_\_\_\_\_  
Add \$5 monthly service fee for  
monthly payment by check.

One-Time Rural Health  
Department Fee \$ \_\_\_\_\_ 5.00

**Total:** \$ \_\_\_\_\_

Annual Farm Bureau Dues \$ \_\_\_\_\_

Benefit Solutions (optional) \$ \_\_\_\_\_

**Total Amount Enclosed:** \$ \_\_\_\_\_

**Make one check payable to Nationwide Health Plans  
OR complete the credit card section below.**

**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 | DATE |
| <b>X</b>   |      |

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

|           |      |
|-----------|------|
| SIGNATURE | DATE |
| <b>X</b>  |      |

Cardholder's Billing Address

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

**I. AUTHORIZATION FOR ELECTRONIC FUND TRANSFER (EFT) PREMIUM PAYMENT**

I authorize the 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 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.

X \_\_\_\_\_  
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)

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

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

## 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, 1651 Exposition Blvd., Suite 100, 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, Att: HS-60, 1651 Exposition Boulevard, Suite 100, 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.**

### PREMIUM RATES

Premium rates for health insurance provided under the Certificate are adjusted for changes in Your and Your spouse'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 Policyholder. Premium adjustments will be reflected in Your premium statements due on or next following the effective date of a rate change.

# Benefit Solutions™ Enrollment

This **OPTIONAL Benefit Solutions™ 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 **Benefit Solutions™ Program**. Participation in the **California Farm Bureau Members' Health and Life Insurance Program** is required to maintain the **Benefit Solutions™ Program**.

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

The **Benefit Solutions™ Program** premium will be included with your **Health Insurance Program** billing.

Applying for:

**Benefit Solutions™ A** (without pharmacy):  
This product is issued to individuals approved for Plan J through the **California Farm Bureau Members' Health and Life Insurance Program**.

**Benefit Solutions™ B** (with pharmacy):  
This product is issued to individuals approved for Plan A, C, F or F+ through the **California Farm Bureau Members' Health and Life Insurance program**.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_



**Nationwide®**  
Health Plans





# Nationwide<sup>®</sup> 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

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.

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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 HM-20, 1651 Exposition Boulevard, Suite 100, Sacramento, CA 95815. The Notice of Privacy Practices of Nationwide is available on the Nationwide Health Plans web site at [www.nationwidehealthplans.com](http://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

**California Farm Bureau Federation  
Annual Membership Dues - Eff. 2/2005**

|    | County<br>Farm Bureau                 | Voting<br>Members | Sustaining<br>Members |
|----|---------------------------------------|-------------------|-----------------------|
| 1  | Alameda                               | \$90.00           | \$65.00               |
| 3  | Amador                                | 85.00             | 65.00                 |
| 4  | Butte                                 | 125.00            | 70.00                 |
| 5  | Calaveras                             | 85.00             | 70.00                 |
| 6  | Colusa                                | 105.00            | 70.00                 |
| 7  | Contra Costa                          | 90.00             | 65.00                 |
| 8  | Del Norte                             | 80.00             | 60.00                 |
| 9  | El Dorado                             | 95.00             | 75.00                 |
| 10 | Fresno                                | 125.00            | 75.00                 |
| 11 | Glenn                                 | 100.00            | 65.00                 |
| 12 | Humboldt                              | 110.00            | 70.00                 |
| 13 | Imperial                              | 150.00            | <b>70.00</b>          |
| 14 | Inyo-Mono                             | 75.00             | 65.00                 |
| 15 | Kern                                  | 155.00            | 70.00                 |
| 16 | Kings                                 | 150.00            | 90.00                 |
| 17 | Lake                                  | 100.00            | 75.00                 |
| 18 | Lassen                                | 85.00             | 60.00                 |
| 19 | Los Angeles                           | 90.00             | 65.00                 |
| 20 | Madera                                | 125.00            | 60.00                 |
| 21 | Marin                                 | 120.00            | 70.00                 |
| 22 | Mariposa                              | 90.00             | 70.00                 |
| 23 | Mendocino                             | 100.00            | 85.00                 |
| 24 | Merced                                | 125.00            | 75.00                 |
| 25 | Modoc                                 | 90.00             | 65.00                 |
| 27 | Monterey                              | 300.00            | 85.00                 |
| 28 | Napa                                  | 150.00            | 85.00                 |
| 29 | Nevada                                | 75.00             | 75.00                 |
| 30 | Orange                                | 160.00            | 65.00                 |
| 31 | Placer                                | 80.00             | 70.00                 |
| 32 | Plumas-Sierra                         | 70.00             | 70.00                 |
| 33 | Riverside                             | 150.00            | 75.00                 |
| 34 | Sacramento                            | 115.00            | 85.00                 |
| 35 | San Benito                            | 110.00            | 60.00                 |
| 36 | San Bernardino                        | 150.00            | 60.00                 |
| 37 | San Diego (1st yr. voting-\$95.00)    | 160.00            | 75.00                 |
| 39 | San Joaquin                           | 125.00            | 75.00                 |
| 40 | San Luis Obispo                       | 120.00            | 75.00                 |
| 41 | San Mateo                             | 185.00            | 90.00                 |
| 42 | Santa Barbara                         | 145.00            | 85.00                 |
| 43 | Santa Clara                           | 190.00            | 80.00                 |
| 44 | Santa Cruz (1st yr. sustain.-\$55.00) | 200.00            | 100.00                |
| 45 | Shasta                                | 110.00            | 65.00                 |
| 47 | Siskiyou                              | 115.00            | 75.00                 |
| 48 | Solano                                | 120.00            | 85.00                 |
| 49 | Sonoma                                | 125.00            | 75.00                 |
| 50 | Stanislaus                            | 125.00            | 75.00                 |
| 52 | Tehama                                | 100.00            | 75.00                 |
| 53 | Trinity                               | 75.00             | 65.00                 |
| 54 | Tulare                                | 125.00            | 105.00                |
| 55 | Tuolumne                              | 80.00             | 68.00                 |
| 56 | Ventura                               | 125.00            | 75.00                 |
| 57 | Yolo                                  | 105.00            | 70.00                 |
| 58 | Yuba-Sutter                           | 125.00            | 75.00                 |

For Alpine and San Francisco Counties, please choose any County Farm Bureau.

A Voting Member is: Any member who, during the current membership year, expects to receive income from actual farming operations, either as an owner, lessor, lessee, or officer, substantial shareholder or full-time employee of such owner, lessor or lessee. A Sustaining Member is: Any member who is not a voting member.

Dues are subject to change. Contact your county Farm Bureau for more information.