

Application for Medicare

Please follow the instructions so that we can process your application quickly.

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
Health Plans[®]

On Your SideSM



County Farm Bureau Application For Membership

Residence or Business County	Dues Enclosed \$ <input type="checkbox"/> Voting <input type="checkbox"/> Sustaining	Current/Previous Member# _____
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Applicant's Name (Last, First, M.I.) Mr. Mrs. Ms.

Spouse's or Registered Domestic Partner's Name (Last, First, M.I.) Mr. Mrs. Ms.

Business Name (DBA)** _____	Type of Business
Use Business Name as primary membership name? <input type="checkbox"/> Yes <input type="checkbox"/> ** No **Only <u>individual</u> members are eligible for Accidental Death & Dismemberment policy.	

Address

City	State	Zip Code
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Telephone Numbers Home: () _____ Business: () _____	Date of Birth (mm /dd / yy) Applicant: / / Spouse: / /
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Email: _____ May we send you email? Yes No

Applicant's Primary Occupation	Spouse's or Registered Domestic Partner's Primary Occupation
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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/Registered Domestic Partner

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. _____

Applicant's Signature	Date
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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
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NATIONWIDE USE ONLY

Approved by _____

Date _____

Plan Effective Date _____

Certificate No. _____

A. AS A MEMBER OF THE CALIFORNIA FARM BUREAU FEDERATION, I APPLY FOR MEDICARE SUPPLEMENT INSURANCE BASED ON THE FOLLOWING REPRESENTATIONS:

Applicant(s) (Please Print):

Primary Name _____ Sex: M F

Spouse/Registered Domestic Partner(RDP) Name _____ Sex: M F

Mailing Address _____

Billing Address (If Different) _____

Member Social Security # _____ - _____ - _____ Spouse/RDP Social Security # _____ - _____ - _____

Telephone Number _____

Date First enrolled in:

Proposed Insureds:

Primary _____ D.O.B. ____/____/____

Spouse/RDP _____ D.O.B. ____/____/____

Medicare Part "B"	Medicare Part "D"
____/____/____	____/____/____
____/____/____	____/____/____

B. PLEASE COMPLETE THE MEDICARE INFORMATION:

Prior or Current Nationwide Health Plans Certificate Number (if any): _____

C.F.B.F. Membership Number: _____ County: _____

Primary Medicare # _____ Spouse Medicare # _____
(# from your Medicare Card. Include alpha letters)

Plan: A C F F+ (High Ded.) J*

Effective Date Requested: _____

C. PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

- You may not have more than one Medicare Supplement plan.
- 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.
- Benefits and premiums under your Medicare Supplement plan may be suspended during your entitlement to Medi-Cal or Medicaid for up to 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal or Medicaid. Once you are no longer eligible for Medi-Cal or Medicaid your Medicare Supplement plan will be reinstated without evidence of insurability, if requested within 90 days after losing Medi-Cal or Medicaid eligibility.
- Counseling services are available with a trained insurance counselor. Call Health Insurance Counseling and Advocacy Program (HICAP) office at 800-434-0222. HICAP is a service provided free of charge by the State of California.

D. 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? _____ (d) 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

E. STATEMENT OF HEALTH

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

1. Applicant's: Height _____ Weight _____ Spouse/RDP (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/RDP (if applying): _____

F. 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): _____

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

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

Agent Telephone No. _____	Agent FAX No. _____	E-Mail: _____
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Send Certificate of Insurance to: Agent for Delivery Certificateholder

G. 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

H. AGENT COMMENTS

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

Applicant's Signature _____ Date _____





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.

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 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.
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.

Applicant/Enrollee Signature	Date: _____
Spouse Signature	Date: _____
Adult Child Signature	Date: _____
Adult Child Signature	Date: _____
Personal Representative Name, if applicable	
Personal Representative Signature	Date: _____