California Farm Bureau Federation Members' Group Dental and Group Vision plans

Application for Dental/Vision Coverage

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

Instructions

- Fully complete this application to avoid a return of the application and delay in processing. If any information is mis-stated, incorrectly recorded, or not true, this coverage may be considered void from the effective date.
- Print clearly in ink.
- The application must be signed at the bottom of page 6 by the applicant and the applicant's agent.
- If you are not currently a Farm Bureau member, please fill out the Farm Bureau application on page 3.
- Mail application to your agent or to: 1651 Exposition Blvd., Suite 100, Sacramento, CA 95815

The SafeGuard application will become part of your dental and vision evidence of coverage booklets. Coverage will become effective on the first day of the month following SafeGuard's approval of the application and with payment of the first full premium.

Nationwide
Health Plans®

On Your Side℠

MKTG 20049 [11/05]

County Farm Bureau Application For Membership

Residence or Business County	Dues Enclosed	Current/Previous Member#
	$ ❑ Voting ❑ Sustaining	___ ___ ___ ___ ___ ___ ___

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? ❑ Yes ❑ ** No **Only individual members are eligible for Accidental Death & Dismemberment policy.	

Address

City	State	Zip Code

Telephone Numbers	Date of Birth (mm /dd / yy)
Home: ( ) ____________ Business: ( ) ____________	Applicant: / / Spouse: / /

Email: ______________________ May we send you email? ❑ Yes ❑ No

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

01 ______ Own/lease a farm/ranch

02 ______ Own/manage an ag-related business

03 ______ Employee of farm/ranch/ag-related business

04 ______ Retired from farm/ranch/ag-related business

05 ______ Not involved in agriculture

26 ______ Retired, not involved in agriculture

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

1. ______________________
2. ______________________
3. ______________________
4. ______________________

______________________ Applicant's Signature

__________ 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

Application for C.F.B.F. Members' Group Dental and Vision Plans

Requested Effective Date
/ /
(Must be received no later than the 15th of the month for an effective date of the 1st of the next month.)

Primary Plan Participant's Last Name	First		M.I.
Home Address		D.O.B. (M/D/Y) / /	
City	State	Zip	
❑ Billing Address ❑ Mailing Address	❑ Both (if other than home address)		
City	State	Zip	
Telephone ( )	Farm Bureau Membership Number ___ ___ ___ ___ ___ ___ ___	Membership County	❑ Male ❑ Female

Choose the Plan That's Best for You and Your Family.

(Please complete and sign this form and return it to your agent. **Choose only one dental plan.** You and your dependents must enroll in the same plan.)

SafeGuard Scheduled Reimbursement Dental Plan

I want to enroll the following in the SafeGuard Scheduled Reimbursement Dental Plan: (Check all that apply) ❑ Myself ❑ My Spouse ❑ RDP* ❑ _____ Dependents (fill in #)

Spouse/RDP* Name (First)	M.I.	Last (if different)
D.O.B.(M/D/Y) / /	❑ Male ❑ Female	

Child Name (First)	M.I.	Last (if different)
D.O.B.(M/D/Y) / /	❑ Male ❑ Female	

Child Name (First)	M.I.	Last (if different)
D.O.B.(M/D/Y) / /	❑ Male ❑ Female	

Child Name (First)	M.I.	Last (if different)
D.O.B.(M/D/Y) / /	❑ Male ❑ Female	

Child Name (First)	M.I.	Last (if different)
D.O.B.(M/D/Y) / /	❑ Male ❑ Female	

Child Name (First)	M.I.	Last (if different)
D.O.B.(M/D/Y) / /	❑ Male ❑ Female	

* Registered Domestic Partner

SafeGuard HMO Dental Plan

I want to enroll the following in the SafeGuard HMO Dental Plan: (Check all that apply.)

❑ Myself ❑ My Spouse ❑ RDP* ❑ _____ Dependents (fill in #) **Dental Office Number** __ __ __ __ __ __

(You **must** choose a dental office from the SafeGuard HMO directory. Enter office # in space provided.)

Spouse/RDP* Name (First)	M.I.	Last (if different)
D.O.B.(M/D/Y) / /	❑ Male ❑ Female	

Child Name (First)	M.I.	Last (if different)
D.O.B.(M/D/Y) / /	❑ Male ❑ Female	

Child Name (First)	M.I.	Last (if different)
D.O.B.(M/D/Y) / /	❑ Male ❑ Female	

Child Name (First)	M.I.	Last (if different)
D.O.B.(M/D/Y) / /	❑ Male ❑ Female	

Child Name (First)	M.I.	Last (if different)
D.O.B.(M/D/Y) / /	❑ Male ❑ Female	

Child Name (First)	M.I.	Last (if different)
D.O.B.(M/D/Y) / /	❑ Male ❑ Female	

* Registered Domestic Partner

SafeGuard PPO Vision Plan

Benefits are higher when you select a contracted PPO provider from the SafeGuard Vision directory.

I want to enroll the following in the SafeGuard PPO Vision Plan: (Check all that apply.) ☐ Myself ☐ My Spouse ☐ RDP* ☐ _____ Dependents (fill in #)

Spouse/RDP* Name (First)	M.I.	Last (if different)
D.O.B.(M/D/Y) / /	☐ Male ☐ Female	

Child Name (First)	M.I.	Last (if different)
D.O.B.(M/D/Y) / /	☐ Male ☐ Female	

Child Name (First)	M.I.	Last (if different)
D.O.B.(M/D/Y) / /	☐ Male ☐ Female	

Child Name (First)	M.I.	Last (if different)
D.O.B.(M/D/Y) / /	☐ Male ☐ Female	

Child Name (First)	M.I.	Last (if different)
D.O.B.(M/D/Y) / /	☐ Male ☐ Female	

Child Name (First)	M.I.	Last (if different)
D.O.B.(M/D/Y) / /	☐ Male ☐ Female	

* Registered Domestic Partner

IMPORTANT! PLEASE COMPLETE THIS SECTION.

Applicant's Signature:

X ____ Date ____________________

Agent's Signature: I certify that I have thoroughly explained all of the details of the group dental and group vision plans.

Agent Name____ Agent # ____________________

(Please Print)

Agent Signature____ Date ____________________

Agent Phone Number(______)____________________ Agent Fax Number(______)____________________

F O R A D M I N I S T R A T I V E U S E O N L Y

Date Received	Effective Date	Date Approved	Dental Certificate Number	Vision Certificate Number

PREMIUM CALCULATION

Please fill in amount for all coverages applying for.

1 Premium for Dental (if applying) $ ___________

Spouse/RDP* Coverage Included? ☐ **Yes** ☐ **No** $ ___________

Child(ren) Coverage Included? ☐ **Yes** ☐ **No** $ ___________

Monthly Dental Total $ ___________

2 Monthly Premium for Vision (if applying) $ ___________

Spouse/RDP* Coverage Included? ☐ **Yes** ☐ **No** $ ___________

Child(ren) Coverage Included? ☐ **Yes** ☐ **No** $ ___________

Monthly Vision Total $ ___________

3 Calculate one of the following payment modes:

- Monthly Premium (dental total + vision total) $ ___________
- Semiannual Premium (monthly x 6) $ ___________
- Quarterly Premium (monthly x 3) $ ___________

+

4 Dental/Vision - Plus $5 monthly service (if monthly non-EFT) $ ___________

+

5 Annual Farm Bureau Dues (if not already a member) $ ___________

=

Total Submitted with Application $ ___________

* Registered Domestic Partner

PREMIUM PAYMENT MODE

☐ **Monthly by Check** ($5 monthly service fee applies). Please make checks payable to Nationwide Health Plans.Payments that do not equal the exact amount that is due may delay the processing of your application.

☐ **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 on page 7, 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 Billing** (Monthly Premium x 3)

☐ **Semiannual Billing** (Monthly Premium x 6)

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 and the annual Farm Bureau membership dues to my credit card and bill me the difference for the quarterly or semi-annual premium mode I selected.

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
x	

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

SIGNATURE	DATE
x	

Cardholder's Billing Address

ADDRESS		
CITY	STATE	ZIP

AUTHORIZATION FOR ELECTRONIC FUND TRANSFER (EFT) PREMIUM PAYMENT

Dental and/or Vision Certificate Number: ____________________

I authorize the California Farm Bureau Federation (you) 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 dental and/or vision certificate being applied for, if the certificate is issued. Insurance will become effective only upon approval by SafeGuard 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** (Premium drafted 2 weeks prior to due date)

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

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.

____________________ Date

X ____________________
Depositor's name (please print)

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)

Dental and Vision
Benefits provided by SafeGuard Health Plans, Inc.
Underwritten by SafeHealth Life Insurance Company

Underwritten By Nationwide Life Insurance Company

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