

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: _____ 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.

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

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, LifestyleSM Series, Individual Term Life Insurance, CashBack PlanSM, Benefit SolutionsTM, or SafeGuard 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. Corrections to answers can be made by drawing a straight line through the incorrect answer and printing the correct response above the lined out answer. Applicant must then initial and date the correction.

Your new insurance with Nationwide Health Plans will be in force when all of the following events take place:

1. The application has been approved for issuance by the Home Office Underwriting Department.
2. Any amendments to the certificate have been signed by the applicant and our Home Office.
3. The first full premium has been paid and received by Nationwide Health Plans.
4. Coverages will become effective based upon the effective date that you selected, subject to underwriting approval. Once approved, the effective date will not be changed without proof of other existing coverage.

If you have questions or are not sure how to answer a question, call your agent or Nationwide Health Plans, toll free at (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 7 and 11**. 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 and 6.
- If approved, this application will become part of your health Certificate of Insurance. Coverage will become effective on the first day of the month upon 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 11.

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

CashBack PlanSM

If you are applying for the optional CashBack PlanSM, 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.

Benefit SolutionsTM

If you are applying for the optional Benefit SolutionsTM 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.

SafeGuard Dental

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

SafeGuard Vision

If you are applying for a Vision plan, please **complete sections A and I**.

Premium Payment

Ask your Nationwide agent for monthly rates. You may use the Premium Calculation section on page 9 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 10. If you are paying with a Business check, please complete the "Disclosure Notice to Business Owners" form on page 10.

If you prefer to pay by credit card, please complete information section on page 9.

Checks should be made payable to Nationwide Health Plans.

Submit your application to: **1651 Exposition Blvd., Suite 100
Sacramento, CA 95815**

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



County Farm Bureau Application For Membership

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

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
------	-------	----------

Telephone Numbers Home: () _____ Business: () _____	Date of Birth (mm /dd / yy) 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	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
--------------------------------	---------------

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
----------	-------------	---------------------------------------	--------------

Individual and Family Enrollment Application

Desired Effective Date: ____ / 01 / ____ . The effective date cannot precede the signature date of the application nor be more than 60 days from the date the application was completed subject to underwriting approval.
Please refer to the bottom of page 12 for instructions.

This application is for: (Check all that apply) Health Individual Term Life CashBack PlanSM Benefit SolutionsTM Dental Vision

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)		Age		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				Street			
City		State		Zip		City	
						State	
						Zip	
11 County of Residence		12 Home Phone ()		13 Driver's Lic. No.		14 Farm Bureau Member No./County	
		Work Phone ()					

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

- New Coverage Addition to Plan Change of Plan Conversion to Separate Certificate Reinstatement
- Single Medical Coverage Couple Medical Coverage Single w/ 1 Child Medical Coverage Family w/ 1 Child Medical Coverage
- Family w/ Children Medical Coverage Single w/ Children Medical Coverage Child(ren) Only Medical Coverage

Current Members list your certificate number here.

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 Saver Select \$1,750 Single Deductible (Plan X) | <input type="checkbox"/> Lifestyle 1750 \$1,750 Deductible w/ Generic Rx only (Plan DL) | <input type="checkbox"/> PPO Choice 30 \$750 Deductible (Plan W) |
| <input type="checkbox"/> PPO Choice Saver Select \$2,400 Single Deductible (Plan X) | <input type="checkbox"/> Lifestyle 1750 \$1,750 Deductible w/ 3-Tier Rx (Plan DL) | <input type="checkbox"/> PPO Choice 30 \$1,500 Deductible (Plan W) |
| <input type="checkbox"/> PPO Choice Saver Select \$3,600 Single Deductible (Plan X) | <input type="checkbox"/> Lifestyle 2500 \$2,500 Deductible w/ Generic Rx only (Plan AL) | <input type="checkbox"/> PPO Choice 30 \$2,500 Deductible (Plan W) |
| <input type="checkbox"/> PPO Choice Saver Select \$4,800 Single Deductible (Plan X) | <input type="checkbox"/> Lifestyle 2500 \$2,500 Deductible w/ 3-Tier Rx (Plan AL) | |
| <input type="checkbox"/> PPO Choice Saver Select \$3,500 Family Deductible (Plan X) | <input type="checkbox"/> Lifestyle 3500 \$3,500 Deductible w/ Generic Rx only (Plan BL) | |
| <input type="checkbox"/> PPO Choice Saver Select \$4,800 Family Deductible (Plan X) | <input type="checkbox"/> Lifestyle 3500 \$3,500 Deductible w/ 3-Tier Rx (Plan BL) | |
| <input type="checkbox"/> PPO Choice Saver Select \$7,200 Family Deductible (Plan X) | <input type="checkbox"/> Lifestyle 4500 \$4,500 Deductible w/ Generic Rx only (Plan CL) | |
| <input type="checkbox"/> PPO Choice Saver Select \$9,600 Family Deductible (Plan X) | <input type="checkbox"/> Lifestyle 4500 \$4,500 Deductible w/ 3-Tier Rx (Plan CL) | |

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 or RDP*	/ /						
	Child	/ /						
	Child	/ /						
	Child	/ /						
	Child	/ /						
	Child	/ /						

*Registered Domestic Partner

FOR HOME OFFICE USE ONLY

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

Underwriter _____ Date Approved _____ Eff. Date _____

Health Plan _____ Health Cert. No. _____

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 or RDP*'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, Relationship, Address and Phone #).

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? Yes No

If "Yes", give name(s), Application/Certificate No(s), and date(s) last insured.

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? Yes No**c.** Is that prior coverage COBRA or continuation coverage provided by a former employer? Yes No**6** Do all additional Applicants listed on this page meet the following definition for dependent eligibility? Yes No

Primary Applicant's (a) spouse/RDP*; (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. Children or child under age 24 who is a full-time student at an accredited school or college (12 units or more).

* Registered Domestic Partner

7 a. Have you lived outside the United States within the past 12 months? Yes No

If so, Where? _____ Date of Re-entry _____

b. Do you plan to travel or reside outside the United States for longer than a month in the next 12 months? Yes No

If so, Where? _____ How Long? _____

D Medical Information To the best of your knowledge and belief, circle the condition(s) for which each "yes" answer applies, then provide full details in the spaces provided on pages 5-6.**1** Within the **past 10 years**, has any applicant:**a.** used alcoholic beverages? Yes No

If yes, for how long? _____

Average more than three drinks daily? Yes NoAverage more than 25 drinks weekly? Yes No*(One drink equals one 12 oz. beer or one 4 oz. wine or one 2 oz. cocktail)***b.** been treated for or diagnosed with alcoholism or advised to reduce alcohol or drug use? Yes No**c.** used marijuana, cocaine, heroin, methamphetamines, LSD, or any other non-prescription drugs? Yes No
(If YES, identify drug and frequency of use.)**d.** 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 No**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:**a.** high blood pressure, chest pain, heart murmur, heart valve disorder, heart attack, heart surgery, irregular heart beat, stroke, TIA, aneurysm, varicose veins, vein or artery disease or disorder; or any other disease, disorder or injury of the heart or circulatory system? (Not including HIV). Yes No**b.** headaches, migraines, dizziness, fainting, Down's syndrome, multiple sclerosis, myasthenia gravis, cerebral palsy, muscular dystrophy, tremors, convulsions or seizures, vertigo, paralysis, brain disorder or disease? Yes No**c.** diabetes or sugar intolerance, adrenal gland disorder, parathyroid gland disorder, thyroid gland disorder, pituitary gland disorder, hemochromatosis, high cholesterol or high triglycerides? Yes No**d.** any disease, disorder or injury of the kidney, bladder, prostate, ureter, or urinary tract (to include kidney stones, prostatitis, or bladder infections)? Yes No**e.** any disease, disorder or injury of the breasts or had breast implants? Yes No**f.** any disease, disorder or injury of the male/female reproductive organ system, including but not limited to disorders of the penis, testes, vagina, cervix or uterus, 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 No**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 No**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 No

D Medical Information (Continued)

<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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <hr/> <p>j. eye (including cataracts), ears (including ear infections or ear tubes), nose, throat, tongue, or skin disease, disorder or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <hr/> <p>k. cancer, tumor, polyp or cysts? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <hr/> <p>l. depression, panic attacks, anxiety, bipolar disorder, obsessive-compulsive disorder, schizophrenia, attention deficit disorder, attention deficit hyperactivity disorder or eating disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <hr/> <p>m. AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS-Related Complex)? (Not including HIV). <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <hr/> <p>n. Chronic fatigue syndrome, Lyme disease, Marfan syndrome, anemia, weight loss, loss of appetite, lymph node enlargement or any other disease or disorder of the blood? <input type="checkbox"/> Yes <input type="checkbox"/> No</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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <hr/> <p>9 a. Are you, your spouse/RDP*, or any of your dependents currently pregnant or had a positive home pregnancy test within the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of person expecting. _____</p> <p>b. Are you, your spouse/RDP*, or any of your dependents expecting a child with anyone, including a surrogate? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of person expecting. _____</p> <p>c. Do any of the female applicants listed on this application menstruate? <input type="checkbox"/> Yes <input type="checkbox"/> No 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain. _____</p> <p style="text-align: center; font-size: small;">* Registered Domestic Partner</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)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <hr/> <p>b. had an abnormal laboratory test, diagnostic test, physical exam, blood study, including but not limited to MRI, CT Scan, EKG, PET, EEG or X-ray? <input type="checkbox"/> Yes <input type="checkbox"/> No</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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <hr/> <p>11 Are you, your spouse/RDP*, or any of your dependents planning to adopt a child or becoming a legal guardian of a child? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, expected date of adoption, guardianship or placement for adoption. _____</p> <p style="text-align: center; font-size: small;">* Registered Domestic Partner</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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <hr/> <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. <input type="checkbox"/> Yes <input type="checkbox"/> No</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. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <hr/> <p>13 Is any applicant currently receiving insurance or government benefits due to a disability? <input type="checkbox"/> Yes <input type="checkbox"/> No</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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>7 Does any applicant have any physical abnormality, deformity or disfigurement? <input type="checkbox"/> Yes <input type="checkbox"/> No</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.

Use this space for Medical Information questions answered "Yes".

Quest. No.	Name of Applicant	Symptoms, condition or injury.	Treatment, advice given, prescriptions, results of physical examinations.	Duration		Does the condition still exist? (Yes or No)	Was surgery performed? State Type	Name, address, zip code and telephone number of hospital and attending doctor	Date Last Seen
				Start Date (Mo./Year)	End Date (Mo./Year)				

Continued space for Medical Information questions answered "Yes".

Quest. No.	Name of Applicant	Symptoms, condition or injury.	Treatment, advice given, prescriptions, results of physical examinations.	Duration		Does the condition still exist? (Yes or No)	Was surgery performed? State Type	Name, address, zip code and telephone number of hospital and attending doctor	Date Last Seen
				Start Date (Mo./Year)	End Date (Mo./Year)				

If more space is needed, please continue on a blank sheet of paper and include it with the application when submitting.

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 required \$5,000** Life & AD&D coverage at \$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"/> \$30,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$40,000		
	Spouse/RDP*	/ /	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$30,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$40,000		
	Child	/ /	\$10,000		
	Child	/ /	\$10,000		
	Child	/ /	\$10,000		
	Child	/ /	\$10,000		
	Child	/ /	\$10,000		

Applicant's Name _____ **X** Applicant's Signature _____ Date _____

Spouse or RDP's* Name _____ **X** Spouse or RDP's* Signature _____ Date _____

* Registered Domestic Partner

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

F CashBack PlanSM

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 Lifestyle Series 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.

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

X _____ Date _____
Applicant's Signature

G OPTIONAL Benefit SolutionsTM Enrollment

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

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

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

Applying for:

Benefit SolutionsTM (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.

Benefit SolutionsTM (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 _____ Date _____
Applicant's Signature

H SafeGuard Dental Coverage SafeGuard Dental is a standalone product.

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

SafeGuard Scheduled Reimbursement Dental Plan (No Ortho) **OR**

SafeGuard HMO (You must choose a dental office from the SafeGuard 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 SafeGuard Dental coverage.

Applicant's Full Name	Relationship	Birthdate (M/D/Y)	Sex
	Self	/ /	
	Spouse or RDP*	/ /	
	Child	/ /	
	Child	/ /	
	Child	/ /	
	Child	/ /	
	Child	/ /	

* Registered Domestic Partner

X _____
Applicant's Signature Date

X _____
Agent's Signature Date



I SafeGuard Vision Coverage SafeGuard Vision is a standalone product.

Applying for SafeGuard PPO Vision

For a higher level of coverage, please select a vision office from the SafeGuard Directory.

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 SafeGuard PPO Vision coverage.

Applicant's Full Name	Relationship	Birthdate (M/D/Y)	Sex
	Self	/ /	
	Spouse or RDP*	/ /	
	Child	/ /	
	Child	/ /	
	Child	/ /	
	Child	/ /	
	Child	/ /	

* Registered Domestic Partner

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/RDP* Coverage Included? Yes No \$ _____
 Child(ren) Coverage Included? Yes No \$ _____

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

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

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

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

6 Monthly Premium for Benefit SolutionsTM (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 \$ _____

* Registered Domestic Partner

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. 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 on page 10.)

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 10.

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

By choosing this payment option, the initial premium payment and annual Farm Bureau dues will be charged to your credit card upon approval.

Please charge the total monthly, 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

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/RDP'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, and 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. Premium rates may be adjusted when Your residence address changes. Adjustments are effective as of the first of the month following your residence address change if the change moves you into a new rate area, and does not require a 30-day notice.

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 (15th draft date is 2 weeks prior to your premium due date)

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

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)

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, arising under the contract of insurance, 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)

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

X _____
SIGNATURE OF SPOUSE OR REGISTERED DOMESTIC PARTNER (IF APPLYING)

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

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

X _____
SIGNATURE OF AGENT

AGENT NUMBER

AGENT'S PHONE NUMBER

FAX NUMBER

AGENT'S NAME (PRINT)

DATE

AGENT'S EMAIL ADDRESS

REASONS FOR ADVERSE UNDERWRITING DECISIONS

In the event of an adverse underwriting decision, Nationwide Health Plans shall:

1. Either provide the Applicant, certificateholder or individual proposed for coverage with the specific reason(s) for the adverse underwriting decision in writing or advise such person that, upon written request, he or she may receive the specific reason(s) in writing.
2. Upon receipt of a written request, Nationwide Health Plans shall furnish to such person within twenty-one (21) business days from the date of receipt of written request the specific reason(s) for the adverse underwriting decision, in writing.

INSTRUCTIONS FOR EFFECTIVE DATE CHANGES

General Procedures to Move an Effective Date Forward

All effective date change requests where the application signature date is sixty days or more, prior to the requested effective date, will require a new application.

If a decision is made on an application forty-five days after the stated effective date on the application, the Underwriter will contact the agent to verify the effective date. If a response is not received within forty-eight hours, the effective date requested on the application will be used. Responses should be followed up in writing to provide file documentation.

Effective dates can be changed at anytime during the underwriting process by contacting the underwriting department with the new date requested, assuming the application is not signed more than sixty days prior to the requested effective date. These requests should be followed up in writing to provide file documentation.

Following a Decision

If an applicant has existing coverage with another carrier, they will have thirty days after the decision date to request an effective date change. This request must be made in writing and must also include proof that existing coverage is paid up to the new effective date being requested. Any request made thirty days after the decision date will require a new application.

If an applicant requests a new effective date and does not currently have existing coverage, effective date changes will not be allowed. Not taken, canceled or incomplete cases that are resubmitted with a new application for underwriting (to secure a new effective date) will not be accepted within six (6) months of the original application date unless applying for a new plan of insurance. Requests for new plans of insurance require new applications and underwriting.

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 TO APPLICANT OF PERSONAL INFORMATION PRACTICES

To provide insurance coverage, we need to obtain health information about you and any other person proposed for insurance, i.e., some of that information will come from you and some will come from other sources, such as attending physician statements and medical records.

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.

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., Ste. 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

Information regarding your insurability will be treated as confidential. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such a company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866 692-6901 (TTY 866 346-3642). If you question the accuracy of information in the MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

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 **X** _____
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 Life Insurance Company



Nationwide
Health Plans[®]

On Your SideSM

Underwritten by Nationwide Life Insurance Company



SafeGuard[®]



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/registered domestic partner/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
(applicant/enrollee)

information about my 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

- _____ applicant
- _____ spouse/RDP*
- _____ adult child
- a. Nationwide Life Insurance Company and it’s affiliates including, but not limited to, its agents, underwriting 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 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 to underwrite and rate the health plan coverage for which I have applied.

_____ adult child *registered domestic partner

LIFE

_____ applicant
_____ spouse/RDP*
_____ adult child

b. Nationwide Life Insurance Company or their affiliates including, but not limited to, their agents, underwriting operations, claims operations, legal, representatives, its Medical Director or his/her esignees, its sales and marketing operations, to underwrite and rate the life policy for which 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 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, 1651 Exposition Boulevard, Ste. 100 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/Registered Domestic Partner Signature

_____ Date: _____
Adult Child Signature

_____ Date: _____
Adult Child Signature

Personal Representative Name, if applicable

_____ Date: _____
Personal Representative Signature

*registered domestic partner

**California Farm Bureau Federation
2006 Annual Membership Dues**

	County Farm Bureau	Voting Members	Sustaining 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	70.00
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 (effective 1/1/06)	150.00	65.00
37	San Diego (1st yr. voting-\$95.00)	160.00	75.00
39	San Joaquin	125.00	75.00
40	San Luis Obispo	160.00	80.00
41	San Mateo	185.00	90.00
42	Santa Barbara	145.00	85.00
43	Santa Clara	200.00	85.00
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 (effective 3/1/06)	200.00	80.00
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 effective 11/01/05 unless otherwise noted. Dues are subject to change. Contact your county Farm Bureau for more information.