Nationwide® Health Plans

California Farm Bureau Federation *

Underwritten By Nationwide Life Insurance Company

AUTHORIZATION FOR REPETITIVE CREDIT CARD PREMIUM PAYMENT

Health or Medicare Certificate No. _____ Dental Certificate No._____

Member Name_____

I authorize Nationwide Health Plans (you) to initiate a credit card transaction notice to my financial institution each month for all certificates listed above and charge them against my account. I understand these account charges will pay premiums for the health and/or dental 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.

All credit card transactions will be processed on the first of each month for that month's premium.

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.

PREMIUM RATES

Premium rates for health insurance provided under this Certificate (but not for Life Insurance and Accidental Death and Dismemberment benefits) will be different if any of the factors that determine your premium change. Your actual premium is determined by Your and Your spouse's (if any) age, plan type, dependent status and residence location. Adjustments are effective as of the first of the month following any such change. Should a change in premium rates be made for any other reason, the change will be made only after 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.

Cardholder's Name: _____

AS IT APPEARS ON CREDIT CARD (PLEASE PRINT)

Choose One: ☐ VISA ☐ MASTERCARD

Cardholder Number: | | | | | | | | | | | | | | | | Expiration Date:_____

(REQUIRED) (REQUIRED)

Cardholder's Billing Address: _____

(STREET, APT # REQUIRED)

_____

(CITY, STATE, AND ZIP REQUIRED)

E-Mail Address: _____

(OPTIONAL)

_____ X _____

DATE AUTHORIZED SIGNATURE (AS IT APPEARS ON THE CREDIT CARD)

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