Nationwide® Health Plans

Underwritten by Nationwide Life Insurance Company

Plan Transfer Application

CALIFORNIA FARM BUREAU FEDERATION *

* Service mark used under license by the California Farm Bureau Federation.

Use only for transfers from a PPO Choice or Lifestyle Series Plan with full benefits at standard rates, for current insureds only (see Underwriting Plan Change Matrix Chart). This form may be used for transfers from the Lifestyle Series, Value, Saver Plus and Saver to Saver Select $1,750 or $2,400 and from Lifestyle 4500 and Saver Plus to Saver Select $3,600 or $4,800. Transfers from Primary 30 and Primary 45 to PPO Choice Value, Saver Plus, Saver, PPO Choice Advantage $1,500 deductible or Lifestyle Series Plans also use this form. Flex plans can transfer to the Advantage $2,500 or $5,000 deductibles only. This form may also be used to add the CashBack Plan to a PPO Choice 30, Classic, Advantage, Saver, Saver Plus, Saver Select, Value or Lifestyle Series Plan. Use form GPH 11281 for all other plan changes.

A GENERAL INFORMATION

1 Primary Applicant's Name

Last First M.I.

2 Sex

3 Certificate No.

4 Height

5 Weight

6 Primary Applicant's Birth Date

7 Place of Birth

B Please Check the Health Plan You Currently Have (Please refer to Plan Change Matrix Chart.)

☐ PPO Choice Advantage $1,500 Deductible (Plan Y)
☐ PPO Choice Advantage $2,500 Deductible (Plan Y)
☐ PPO Choice Advantage $5,000 Deductible (Plan Y)

☐ PPO Choice Classic $2,500 Deductible (Plan CX)
☐ PPO Choice Classic $5,000 Deductible (Plan CX)

☐ PPO Choice 15 $500 Deductible (Plan T)*
☐ PPO Choice 15 $1,000 Deductible (Plan T)*
☐ PPO Choice 15 $2,500 Deductible (Plan T)*

☐ PPO Choice 30 $750 Deductible (Plan W)
☐ PPO Choice 30 $1,000 Deductible (Plan W)
☐ PPO Choice 30 $1,500 Deductible (Plan W)
☐ PPO Choice 30 $2,500 Deductible (Plan W)

☐ PPO Choice Select $500 Deductible $25 Co-Pay (Plan AHL-B)
☐ PPO Choice Select $500 Deductible $40 Co-Pay (Plan AHL-G)

Note: A full application is required for a plan change from Saver to Saver Plus.

☐ PPO Choice Saver Individual $2,400 Deductible (Plan M)
☐ PPO Choice Saver Family $4,800 Deductible (Plan M)

☐ Other ______________________

*Additional $250 calendar-year deductible applies out-of-network.

Primary 30 and Primary 45 can transfer to the PPO Choice Value, Lifestyle℠, Saver and Saver Plus Plans and the Advantage Plan $1,500 deductible only.

☐ Primary 30 $500 Deductible (Plan K)
☐ Primary 30 $1,000 Deductible (Plan K)
☐ Primary 30 $2,500 Deductible (Plan K)

☐ Primary 45 $500 Deductible (Plan N)
☐ Primary 45 $1,500 Deductible (Plan N)
☐ Primary 45 $2,500 Deductible (Plan N)

Flex Basic, Plus and Premier Plans can transfer to the Advantage Plan $2,500 and $5,000 deductibles only.

☐ Basic (Plan B) Deductible Amount $ ____________
☐ Plus (Plan F) Deductible Amount $ ____________
☐ Premier (Plan L) Deductible Amount $ ____________

C Please Check the Health Plan You are Changing To (Please refer to Plan Change Matrix Chart.)

☐ PPO Choice Advantage $1,500 Deductible (Plan Y)
☐ PPO Choice Advantage $2,500 Deductible (Plan Y)
☐ PPO Choice Advantage $5,000 Deductible (Plan Y)
☐ PPO Choice Classic $2,500 Deductible (Plan CX)
☐ PPO Choice Classic $5,000 Deductible (Plan CX)
☐ PPO Choice 15 $500 Deductible (Plan T)*
☐ PPO Choice 15 $1,000 Deductible (Plan T)*
☐ PPO Choice 15 $2,500 Deductible (Plan T)*
☐ PPO Choice 30 $750 Deductible (Plan W)
☐ PPO Choice 30 $1,000 Deductible (Plan W)
☐ PPO Choice 30 $1,500 Deductible (Plan W)
☐ PPO Choice 30 $2,500 Deductible (Plan W)
☐ PPO Choice Select $500 Ded. $40 Co-Pay (Plan AHL-G)
☐ PPO Choice Select $1,000 Ded. $40 Co-Pay (Plan AHL-G)
☐ PPO Choice Saver Individual $2,400 Ded. (Plan M)
☐ PPO Choice Saver Family $4,800 Ded. (Plan M)
☐ PPO Choice Saver Plus Individual $1,750 Ded. (Plan V)
☐ PPO Choice Saver Plus Family $3,500 Ded. (Plan V)
☐ PPO Choice Saver Plus Individual $2,400 Deductible (Plan V)
☐ PPO Choice Saver Plus Family $4,800 Deductible (Plan V)
☐ PPO Choice Saver Plus Individual $3,600 Deductible (Plan V)
☐ PPO Choice Saver Plus Family $7,200 Deductible (Plan V)

☐ PPO Choice Saver Plus Individual $4,800 Deductible (Plan V)
☐ PPO Choice Saver Plus Family $9,600 Deductible (Plan V)
☐ PPO Choice Value $3,500 Deductible (Plan U)
☐ PPO Choice Value $3,500 Ded. w/Brand Rx Option (Plan U)
☐ Lifestyle 1750 $1,750 Deductible w/Generic Rx (Plan DL)
☐ Lifestyle 1750 $1,750 Ded. w/3-Tier Rx (Plan DL)
☐ Lifestyle 2500 $2,500 Deductible w/Generic Rx (Plan AL)
☐ Lifestyle 2500 $2,500 Ded. w/3-Tier Rx (Plan AL)
☐ Lifestyle 3500 $3,500 Deductible w/Generic Rx (Plan BL)
☐ Lifestyle 3500 $3,500 Ded. w/3-Tier Rx (Plan BL)
☐ Lifestyle 4500 $4,500 Deductible w/Generic Rx (Plan CL)
☐ Lifestyle 4500 $4,500 Ded. w/3-Tier Rx (Plan CL)
☐ PPO Choice Saver Select Individual $1,750 Ded. (Plan X)
☐ PPO Choice Saver Select Family $3,500 Ded. (Plan X)
☐ PPO Choice Saver Select Individual $2,400 Deductible (Plan X)
☐ PPO Choice Saver Select Family $4,800 Deductible (Plan X)
☐ PPO Choice Saver Select Individual $3,600 Deductible (Plan X)
☐ PPO Choice Saver Select Family $7,200 Deductible (Plan X)
☐ PPO Choice Saver Select Individual $4,800 Deductible (Plan X)
☐ PPO Choice Saver Select Family $9,600 Deductible (Plan X)

D Add the CashBack Plan To:

☐ PPO Choice 30 (Plan W)
Deductible Amount $____________

☐ PPO Choice Classic (Plan CX)
Deductible Amount $____________

☐ PPO Choice Advantage (Plan Y)
Deductible Amount $____________

☐ PPO Choice Saver (Plan M)
Individual Plan Deductible Amount $________
Family Plan Deductible Amount $ ________

☐ PPO Choice Saver Plus (Plan V)
Individual Plan Deductible Amount $________
Family Plan Deductible Amount $ ________

☐ PPO Choice Value $3,500 Deductible (Plan U)

☐ Lifestyle Plan (Plan AL, BL , CL or DL)
Deductible Amount $____________

☐ PPO Choice Saver Select (Plan X)
Individual Plan Deductible Amount $________
Family Plan Deductible Amount $ ________

E Conversion to Separate Certificate ☐

F Preferred Effective Date / /

G Additional Applicants (Dependents)

Full Name	Relationship To Primary Applicant	Birthdate (M/D/Y)	Age	Sex	Place of Birth	Height	Weight
	Spouse or RDP*	/ /					
	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 ____________ Certificate No. ____________

H MEDICAL INFORMATION To the best of your knowledge and belief, check the condition(s) for which each "yes" answer applies and provide full details in the space provided.

1. **Within the past 10 years has any applicant been advised to have consultations or referrals to another physician, diagnostic tests, treatment, surgery or hospitalization (whether completed or not)?** Yes ☐ No ☐
2. **Does any applicant have any illness, injury, or physical symptoms for which he/she has not yet consulted or plans to consult a doctor?** Yes ☐ No ☐
3. **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.** Yes ☐ No ☐
4. **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?** Yes ☐ No ☐
5. **a) Are you, your spouse, or any of your dependents currently pregnant or had a positive home pregnancy test within the last 6 months?** Yes ☐ No ☐

   If yes, name of person expecting. ____________________

   b) Are you, your spouse, or any of your dependents expecting a child with anyone, including a surrogate? Yes ☐ No ☐

   If yes, name of person expecting. ____________________
6. **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?** Yes ☐ No ☐

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". If additional space is needed, please attach a separate sheet.

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)				

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 5 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: ______________________________ On (Date): ______________________________
CITY, STATE (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.

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.

Nationwide®
Health Plans

Underwritten by Nationwide Life Insurance Company

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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

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.

________ applicant

________ spouse/RDP*

________ adult child

________ adult child

*registered domestic partner

LIFE

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.

_________ applicant

_________ spouse/RDP*

_________ adult child

_________ 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