ELIGIBILITY REQUIREMENTS

TO BE ELIGIBLE FOR A NATIONWIDE MEDICARE SUPPLEMENT PLAN, PROPOSED INSUREDS MUST SATISFY THE FOLLOWING REQUIREMENTS*:

- Be eligible under Medicare and have applied for Medicare Parts A and B; and
- Be a member of a County Farm Bureau of the California Farm Bureau Federation and its Rural Health Department; and
- Not be concurrently insured under any other California Farm Bureau Federation service to member health insurance program; and
- Be an individual age 65 or older who, on the effective date of a Medicare Supplement Plan, is not insured under Nationwide’s Master Group Policy No. GH-1000, or be an individual under age 65 who is disabled and has Medicare Parts A & B.

*Coverage is subject to Nationwide’s approval of this Application.

NOTICE
IN ACCORDANCE WITH FEDERAL REGULATIONS, PROPOSED INSUREDS CANNOT, EVEN IF OTHERWISE ELIGIBLE, APPLY FOR A MEDICARE SUPPLEMENT PLAN IF THEY HAVE ANY OTHER MEDICARE SUPPLEMENT COVERAGE, AND DO NOT INTEND TO REPLACE SUCH COVERAGE WITH ONE OF NATIONWIDE’S MEDICARE SUPPLEMENT PLANS.
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.

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Own/lease a farm/ranch</td>
</tr>
<tr>
<td>02</td>
<td>Own/manage an ag-related business</td>
</tr>
<tr>
<td>03</td>
<td>Employee of farm/ranch/ag-related business</td>
</tr>
<tr>
<td>04</td>
<td>Retired from farm/ranch/ag-related business</td>
</tr>
<tr>
<td>05</td>
<td>Not involved in agriculture</td>
</tr>
<tr>
<td>26</td>
<td>Retired, not involved in agriculture</td>
</tr>
</tbody>
</table>

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

1. 
2. 
3. 
4. 

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.

Applicant’s Signature __________________________ Date ____________

Agent Number
C. PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

- You may not have more than one Medicare Supplement plan.
- If you are age 65 or older, you may be eligible for benefits under Medi-Cal or Medicaid and may not need a Medicare Supplement plan.
- Benefits and premiums under your Medicare Supplement plan may be suspended during your entitlement to Medi-Cal or Medicaid for up to 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal or Medicaid. Once you are no longer eligible for Medi-Cal or Medicaid your Medicare Supplement plan will be reinstated without evidence of insurability, if requested within 90 days after losing Medi-Cal or Medicaid eligibility.
- Counseling services are available with a trained insurance counselor. Call Health Insurance Counseling and Advocacy Program (HICAP) office at 800-434-0222. HICAP is a service provided free of charge by the State of California.

D. PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE

1. Do you have any other Medicare Supplement policy or certificate in force? □ Yes □ No
   a) If Yes, is it with a Preferred Provider Organization (PPO)? Which plan? □ Yes □ No
   b) If Yes, is it with a Health Maintenance Organization (HMO)? □ Yes □ No
   c) If Yes, with which company? (d) Effective Date:

2. Do you have any other health insurance policies that provide benefits which this Medicare Supplement plan would duplicate? □ Yes □ No
   a) If Yes, with which company? (b) What kind of policy?

3. If the answer to questions 1 or 2 is Yes, do you intend to replace any of your medical or health insurance coverage policies / certificates with this plan? (Agent: If Yes, include enclosed form GPH 11253.) □ Yes □ No

4. Are you eligible for or receiving benefits from Medi-Cal or Medicaid? □ Yes □ No
E. STATEMENT OF HEALTH

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

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

2. Have you been prescribed or taken prescription medication in the last 12 months? □ Yes □ No
   If Yes, names of medications/drugs you have been prescribed, as well as all medications/drugs you have taken and provide the reason they are taken:
   __________________________________________
   __________________________________________
   __________________________________________

3. Have you, within the past five years,
   - Received medical advice or treatment, or
   - Taken or been prescribed prescription medication, or
   - Been confined for treatment, related to any of the following conditions:
     a. Multiple Sclerosis, Parkinson's, Huntington's Chorea, Alzheimer's, Paralysis, Stroke, Rheumatoid/Psoriatic Arthritis, Bone or Joint Disorders or Replacements, Seizures. □ Yes □ No
     b. Heart Trouble, High Blood Pressure, Blood Clot/Blood Disorders, Circulation Problems, Leukemia, Irregular Heartbeat. □ Yes □ No
     c. Liver Disorders, Hepatitis, Ulcerative Colitis. □ Yes □ No
     d. Kidney Disease or Failure, Chronic Lung Disease, Emphysema. □ Yes □ No
     e. Diabetes, AIDS or ARC (AIDS Related Complex), Lupus. □ Yes □ No
     f. Cancer or Malignant Tumors. □ Yes □ No
     g. Alcoholism or Drug Dependency. □ Yes □ No
     h. Severe Depression, Schizophrenia, Suicide Attempt, Bipolar Disorder. □ Yes □ No

4. Have you ever had a pacemaker, or any type of transplant surgery or any type of heart surgery, such as angioplasty or bypass? □ Yes □ No

5. Have you been bed-ridden, confined to a hospital, nursing home, convalescent hospital or other institution in the past two years? □ Yes □ No

6. Have you been advised to enter a hospital, nursing home, convalescent hospital or other institution, but have not done so yet? □ Yes □ No

7. Has a medical professional recommended surgery, diagnostic testing, or medical treatment, but has not yet been done? □ Yes □ No

Please explain below any “Yes” answers to the above questions.
(If application is being made for more than one person, indicate name of person to whom “Yes” answers apply)

<table>
<thead>
<tr>
<th>Quest. No.</th>
<th>Person (Name)</th>
<th>Diagnosis and type of treatment/surgery</th>
<th>Name of Doctor, phone #, and complete address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Provide complete name, telephone number and address of personal Doctor for:
Applicant: ________________________________________________________________
Spouse/RDP (if applying): ________________________________________________
F. ACKNOWLEDGEMENT

I [Proposed Insured(s) signing below] hereby apply for a Medicare Supplement Plan, and certify that I have received the “Outline of Medicare Supplement Coverage” and “Guide to Health Insurance for People with Medicare” booklets; and, that I have read, understand and satisfy all of the Eligibility Requirements set forth on the front of this Application.

I understand that:

(1) the insurance applied for will become effective on the effective date of the Certificate of Insurance only if (a) this application is approved by Nationwide and (b) the full first premium is paid, but not to exceed one month’s premium if paid on a monthly basis. I understand that Nationwide has no obligation on account of this application, although I may have paid premiums thereon, unless a certificate is issued and received by me while the Proposed Insured(s) is in sound health; and

(2) a copy of this Application will be included with my Certificate of Insurance; and

(3) if this Application is not approved, Nationwide will promptly refund all premium enclosed with the Application; and

(4) the insurance applied for will not pay benefits for any expenses incurred during the first 6 months following the effective date on account of any condition for which medical advice, diagnosis, care or treatment (including use of prescription drugs) was recommended or received during the 6 months before the effective date of this insurance. A condition includes any physical or mental illness, injury, mental disorder, physical disfigurement, or birth abnormality. Nationwide will credit each insured with the period of time such person was covered under any prior creditable coverage, as defined in the Certificate of Insurance, provided such person becomes insured hereunder within 63 days of the date that the prior creditable coverage ends.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Signed At (City, State): ______________________________

Applicant Signature Date Signature of Spouse (if applying) Date

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

Agent Telephone No. Agent FAX No. E-Mail: ________________

G. AGENT STATEMENT

I certify that the following list represents all disability (health) policies that I (or my agency) have sold to the Proposed Insureds shown in Section A of this Application. (If None, so state.)

Policies presently in force: ______________________________

__________________________________________________________________________

Policies sold in the last 5 years which are no longer in force: ______________________________

__________________________________________________________________________

Agent's Signature Date

H. AGENT COMMENTS
I. PREMIUM PAYMENT MODE

☐ Monthly by Check.
   Please make checks payable to Nationwide Health Plans.

☐ 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 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 by Check.

☐ Semi-annual by Check.

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

J. PREMIUM CALCULATION

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premium - Per Mode</td>
<td>$ _____________</td>
</tr>
<tr>
<td>One-Time Rural Health Department Fee</td>
<td>$ 5.00</td>
</tr>
<tr>
<td>Total</td>
<td>$ _____________</td>
</tr>
<tr>
<td>Annual Farm Bureau Dues</td>
<td>$ _____________</td>
</tr>
<tr>
<td>Benefit Solutions (optional)</td>
<td>$ _____________</td>
</tr>
<tr>
<td>Total Amount Enclosed</td>
<td>$ _____________</td>
</tr>
</tbody>
</table>

Make one check payable to Nationwide Health Plans OR complete the credit card section below.

Credit Card Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Credit Card</td>
<td>☐ VISA ☐ MasterCard</td>
</tr>
<tr>
<td>Card No.</td>
<td></td>
</tr>
<tr>
<td>V-Code</td>
<td></td>
</tr>
<tr>
<td>Expiration Date</td>
<td></td>
</tr>
</tbody>
</table>

Cardholder’s Name (As it appears on the credit card.)

PRINT NAME DATE

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

SIGNATURE DATE

K. AUTHORIZATION FOR ELECTRONIC FUND TRANSFER (EFT) PREMIUM PAYMENT

I authorize the 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 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 (drafts two 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.

☐ ________________________________
   DEPOSITOR’S NAME (PRINT)

☐ ________________________________
   SIGNATURE OF DEPOSITOR (AS SHOWN ON RECORD FOR THE ACCOUNT TO WHICH THIS AUTHORIZATION APPLIES)

☐ ________________________________
   OTHER SIGNATURE (IF JOINT ACCOUNT)

PLEASE ATTACH VOIUED CHECK HERE
(Do not use deposit slip)
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) Medicare Supplement Plan is underwritten by Nationwide Life Insurance Company. The Members’ Program is not an employee group insurance plan and does not replace any such existing, or previously in-force, group coverage provided by your employer. Nationwide is not responsible for compliance with any state or federal laws involving employee group health insurance such as the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) and the Employee Retirement Income Security Act (ERISA). (Consult Nationwide Health Plans for further information.)

NOTICE OF HEALTH INFORMATION PRACTICES
To provide insurance coverage, we need to obtain health information about you and any other persons proposed for insurance. Some of that information will come from you and some will come from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization. In certain circumstances, Nationwide Life Insurance Company or its reinsurer(s) may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

NOTICE TO APPLICANT OF PERSONAL INFORMATION PRACTICES
Personal non-health information may be collected from persons other than you or other individuals proposed for coverage. Any information which we may have or may obtain about you or any other individuals proposed for coverage will be treated as confidential. However, personal or privileged information collected by us or our agents may, in certain circumstances, be disclosed to third parties like the California Department of Insurance or our affiliates for claims handling, servicing, underwriting or insurance marketing.

You have the right to see any personal information collected by us and can request correction of any inaccuracies. If you would like a description of our information practices and your rights regarding information we collect, please write us at the following address: Nationwide Health Plans, Attention: Health Customer Services Division, HS-10, 1651 Exposition Blvd., Suite 100, Sacramento, CA 95815.

FAIR CREDIT REPORTING NOTICE
If we use an independent reporting agency for a report, you have the right to be personally interviewed by them. If you wish to be interviewed, please tell us how the agency can contact you and every effort will be made to interview you. Even if you are not interviewed, you have the further right to request that the reporting agency provide you with a copy of the report it makes. Write us at the address shown below and we’ll give you the name and address of any agency we have used to prepare a report on you so that you can contact them directly to find out more about that report.

If you want a more detailed explanation of our information practices or a copy of our Nationwide Health Information Privacy Practices Notice, please write to us at: Nationwide Health Plans, Att: HS-60, 1651 Exposition Boulevard, Suite 100, Sacramento, CA 95815

MEDICAL INFORMATION BUREAU DISCLOSURE NOTICE
Upon your written authorization, information regarding your insurability will be treated as confidential. Nationwide Life Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau, a nonprofit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau’s file, you may contact the Bureau and seek a correction in accordance with the procedure set forth in the Federal Credit Reporting Act. The address of the Bureau’s information office is: P.O. Box 105, Essex Station, Boston, MA 02112. Telephone Number: (617) 426-3660

APPLICANT, PLEASE RETAIN FOR YOUR RECORDS.

PREMIUM RATES
Premium rates for health insurance provided under the Certificate are adjusted for changes in Your and Your spouse’s (if any) ages. Adjustments are effective as of the first of the month following Your and/or Your spouse’s (if any) birthday if the age change moves the individual into a new age bracket. Should a change in premium rates be made for any other reason, you will be notified of the effective date which will be at least 30 days from the date of the notice. The change will be made only after at least 30 days’ prior notice to You and the Policyholder. Premium adjustments will be reflected in Your premium statements due on or next following the effective date of a rate change.
Benefit Solutions™ Enrollment

This OPTIONAL Benefit Solutions™ Program is not insurance. Only those applicants that are approved for health insurance coverage through the California Farm Bureau Members' Health and Life Insurance Program are eligible for the Benefit Solutions™ Program. Participation in the California Farm Bureau Members' Health and Life Insurance Program is required to maintain the Benefit Solutions™ Program.

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

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

Applying for:

☐ Benefit Solutions™ B (with pharmacy):

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

Applicant’s Signature ___________________________________________ Date ______________

*Servicemark used under license from the California Farm Bureau Federation. GPH 11022 [8/06]
AUTHORIZATION FORM FOR MEDICARE SUPPLEMENT 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.

I, _________________________________________________, _____________________________________________
(applicant/enrollee print name)                                                                 (spouse/registered domestic partner/print name)

hereby authorize the use or disclosure of health information as described below.

(applicant/enrollee)
As the parent, I ______________________________also authorize the use or disclosure of health information about my
(applicant/enrollee)
minor dependent(s), age 17 and under (who is on SS disability) 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 its 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.

*registered domestic partner
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

   __________________________________________________________________________
   Personal Representative Name, if applicable

   __________________________________________________________________________ Date: __________
   Personal Representative Signature

*registered domestic partner

GPH 11553 MS [8/06]