Nationwide Health Plans

Underwritten by Nationwide Life Insurance Company

SIMPLIFIED

Supplemental Term Life Application

Please use this form if you **currently** have a Nationwide Health Plans PPO Choice certificate and would like to apply for Term Life Insurance.

California Farm Bureau Federation*

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

A GENERAL INFORMATION

1 Primary Applicant's Name			2 Sex	3 Certificate No.
Last	First	M.I.	4 Height	5 Weight
6 Primary Applicant's Birth Date			7 Place of Birth	

B Preferred Effective Date / /

C Individual Term Life Insurance

Member, spouse and/or dependents who currently have a Nationwide Health Plans certificate can apply 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 $5,000* Life & AD&D coverage you purchase for $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	/ /	☐ $10,000 ☐ $30,000 ☐ $20,000 ☐ $40,000		
	Spouse	/ /	☐ $10,000 ☐ $30,000 ☐ $20,000 ☐ $40,000		
	Child	/ /	☐ $10,000		
	Child	/ /	☐ $10,000		
	Child	/ /	☐ $10,000		
	Child	/ /	☐ $10,000		

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

D 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:

a) been treated for, diagnosed with alcoholism, advised to seek treatment for, sought help for or advised to reduce alcohol or drug use? (If YES, include frequency of use and amount consumed.) — Yes ☐ No ☐

b) used marijuana, cocaine, heroin, methamphetamines, LSD, or any other non-prescription drugs? (If YES, identify drug and frequency of use.) — Yes ☐ No ☐

c) 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:

a) been advised to have consultations or referrals to another physician, diagnostic tests, treatment, surgery or hospitalization (whether completed or not)? — Yes ☐ No ☐

b) had an abnormal laboratory test, diagnostic test, physical exam, including but not limited to MRI, CT Scan, EKG, PET, EEG or X-ray? — Yes ☐ No ☐

3. 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 ☐

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. 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.

6. Within the past 10 years has any applicant been refused, waivered or offered a health policy at other than standard rate? If YES, provide name of applicant(s) and details. — Yes ☐ No ☐

7. Is any applicant currently receiving insurance or government benefits due to a disability? — Yes ☐ No ☐

FOR HOME OFFICE USE ONLY

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

Underwriter _____ Date Approved _____ Eff. Date _____

Life Amount _____ Certificate No. _____

USE THIS SPACE FOR MEDICAL INFORMATION QUESTIONS ANSWERED "YES".						
Quest. No.	Name of Applicant	Condition, injury, or findings of examination, prescriptions (if surgery performed, state type)	Duration		Does the condition still exist? (Yes or No)	Name, address, zip code and telephone number of hospital and attending doctor
			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 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 4 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 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 (IF APPLYING)

X _____ _____
SIGNATURE OF AGENT | AGENT NO.

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

_____ _____
AGENT'S NAME (PRINT) | DATE

_____ _____
AGENT'S PHONE NO. | FAX NO.

_____
AGENT'S EMAIL ADDRESS

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 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, 1601 Exposition Blvd., 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.

Nationwide Health Plans®

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