



Plan Transfer Application



Use only for transfers from a PPO Choice plan with full benefits at standard rates, for current insureds only and transfers from Primary 30 and Primary 45 to PPO Choice Saver Plus or PPO Choice Advantage \$1,500 deductible. 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 Classic, Select, Advantage, Saver or Saver Plus Plan with a \$1,000 deductible or higher.

Use form GPH 11281 for all other plan changes.

A GENERAL INFORMATION

Form A: General Information fields including Name, Sex, Certificate No., Height, Weight, Birth Date, and Place of Birth.

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

Form B: Current Health Plan selection checkboxes for various PPO Choice plans and notes regarding transfer rules.

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

Form C: Health Plan You are Changing To checkboxes for various PPO Choice plans.

D Add the CashBack Plan To:

Form D: Add the CashBack Plan To checkboxes for various PPO Choice plans.

E Conversion to Separate Certificate

F Preferred Effective Date

G Additional Applicants (Dependents)

Table G: Additional Applicants (Dependents) with columns for Full Name, Relationship To Primary Applicant, Birthdate, Age, Sex, Place of Birth, Height, and Weight.

FOR HOME OFFICE USE ONLY

Form for Home Office Use Only: Agent No., Trans. No., Date Rec'd., Amt. Rec'd. with App. \$, Underwriter, Certificate No., Date Approved, Eff. Date.

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	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 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 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)

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

SIGNATURE OF SPOUSE (IF APPLYING)

SIGNATURE OF AGENT

AGENT NO.

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

AGENT'S NAME (PRINT)

DATE

AGENT'S PHONE NO.

FAX NO.

AGENT'S EMAIL ADDRESS

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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 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, 1601 Exposition Boulevard, 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

Underwritten by Nationwide Life Insurance Company