Nationwide
Health Plans®

On Your Side℠

my health℠
a health plan as individual as you.

Underwritten by Nationwide Life Insurance Company

Nationwide Health Plans, Farm Bureau New Business, CO-03-36, P.O. Box 8026, Dublin, OH 43016

Health Insurance Application

Please follow these instructions so that we can process your application efficiently.

Health Application Instructions

- Fully complete this application and the included authorization forms to avoid a return of the application and delay in processing. If any information is misstated, incorrectly recorded, or not true, this insurance may be considered void from the effective date.
- Print clearly in blue or black ink.
- If you have questions or are not sure how to answer a question, call your agent or Nationwide Health Plans, toll-free at 1-800-928-7378.
- Give complete name, address, and phone number of all doctors indicated on page 6.
- Primary Applicants aged 15 years and older must sign and date the application on page 7. If applicable, the applicant's spouse and dependents aged 18 and older must also sign and date the application. We cannot underwrite an application without a signed Authorization Form for Enrollment with each adult's (age 18 and older) signature.
- Return this application, authorizations, and check (made payable to Nationwide Life Insurance) or ACH one-time draft, credit card, or Electronic Funds Transfer (EFT) form, to your agent within 10 days after signing. If selecting monthly payment mode, please include the $4.25 fee with the initial premium.
- Membership in the Ohio Farm Bureau is required. If currently a member, please note on the first page of the application and provide your member number. If not, please complete the membership form and include the membership fee with your initial premium deposit.

SPECIAL INSTRUCTIONS FOR CHILD ONLY APPLICATIONS

1. You do not need to answer questions 16, 17, 21 and 24.
2. Be sure to check "Child Only Plan" in Box 20A and 23. (Ages 1 through 14 years)
3. A separate application will be needed for each child.
4. Billing address is required if different from home address of the child to be covered.
5. Parent or Legal Guardian must be a member of the Ohio Farm Bureau.
6. Parent or Legal Guardian's signature is required on page 7.

If Parent(s) or Legal Guardian(s) is also applying for health insurance, a family application must be submitted.

Do not terminate any existing coverage until you have been notified that your Nationwide coverage is in effect. Benefits will not be paid for a pre-existing condition (a condition which existed within the prior 24 months which is not listed on the application) until a covered person has completed 12 consecutive months from the effective date of coverage.

If approved, this application will become part of your health Certificate of Insurance. Coverage will become effective based upon the effective date that you select, subject to underwriting approval. Once approved, the effective date will not be changed without a newly completed application.

Farm Bureau Application for Membership

County Farm Bureau	Date	Dues (enclosed) for ______ Membership Year $______________

Applicant Name (Last, First, Middle)	Social Security #	County of Residence

Address (Must have House Number, P.O. Box or Route Number)

City	State	ZIP	Township of Residence

Spouse Name (Last, First, Middle)	Spouse Social Security #

Applicant Date of Birth (m/d/y)

_______/_______/_______

Spouse Date of Birth if Applicable (m/d/y)

_______/_______/_______

Dependent Names, Birth Dates (Under 23, Oldest First) & County of Residence

______________________________ ______/______/______ ___________

______________________________ ______/______/______ ___________

______________________________ ______/______/______ ___________

Do you expect to earn any income from the growing/raising of an agricultural product? Yes ❑ No ❑

Please indicate next to the following descriptions the general category that most closely fits your general occupational field.

01 _______ Full-time Farmer
02 _______ Part-time Farmer
03 _______ Retired Farmer
04 _______ Absentee Farm Owner
05 _______ Non Farmer

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

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

I understand my dues include an accidental death and specific loss insurance policy, which makes me a voting policyholder of the Nationwide Mutual Insurance Company of Columbus, Ohio. I name the Ohio Farm Bureau Federation, Inc. to be my proxy in any policyholder meeting, unless notified otherwise. I understand that $1.50 of my Farm Bureau dues pays for a subscription to Our Ohio and/or $1 of my dues pays for a subscription to the Buckeye Farm News. My membership indicates an interest in agriculture and furthering the objectives of the Ohio Farm Bureau. Contributions or gifts to the Farm Bureau are not deductible as charitable contributions for Federal Income Tax purposes. If you have tax questions, professional advice should be sought.

Producer's Name

Producer's Number ______________________________

❑ NW Agent ❑ NW Associate Agent
❑ Broker ❑ Other

Applicant's Signature

Applicant's Phone Number ( )

Solicitor's Phone Number ( )

Principal Agent/GA

Principal Agent/GA Stamp

Benefits Network Insurance Agency
340092790

Visit www.ofbf.org for more information about Ohio Farm Bureau benefits.

Nationwide Health Plans®

Health Insurance Application

PRODUCER USE

Select Network: ❑ NHP ❑ CCN Mail Cert Packet to: ❑ Producer ❑ Member GA# 340092790

Benefits Network Insurance Agency

Producer Name and Number ________________

❑ Change in Agent

HOME OFFICE USE ONLY

Policy No. ________________ Eff. Date: Member ________________ Premium $ ________
Cov. Class ________________ Dependent ________________ ❑ Check held
Waiver No. ________________ For: ________________ ❑ Check booked
Pers. Exclusion for: ________________ ❑ ACH ❑ Credit Card

Are you a current Ohio County Farm Bureau Member? Yes ❑ No ❑
If yes, please indicate your Farm Bureau member number: ___________ If no, please complete and submit Page 2 with appropriate dues.

As a member of the Ohio Farm Bureau Federation, I apply for insurance based on the following representations:

1. Primary Applicant's Name (Last, First, Middle Initial)	1a. Email Address

2. County of Residence	3. Social Security #	3a. Drivers License #

4. Applicant Address	City	State	ZIP Code

5. If Child Only, Parent or Legal Guardian's Name

6. Alternate Billing Address	City	State	ZIP Code

7. Height	8. Weight	9. Male/Female	10. Birthdate (m/d/y)	11. State of Birth

12.U.S. Citizen (y/n)	13. Marital Status	14. Phone (home)	15. Phone (work)

16. Additional Applicants (Dependents)	Relationship to Primary Applicant	Birthdate (m/d/y)	State of Birth	Social Security #	Sex	Ht.	Wt.

17. An eligible dependent is an Applicant's (a) spouse, (b) unmarried natural or adopted children from birth to age 19 (c) unmarried stepchildren, or legal wards from birth to age 19, if Applicant contributes at least 50% to their support and claims them as an exemption for Federal and/or State Income Tax Purposes. A child under the age of 23 who is a full-time student at an accredited school or college is also eligible (please submit proof of full-time status). Do all dependents listed above meet the definition for dependent eligibility? ___ Yes ___ No

18. Are all children ages 6 months to 5 years listed above current on all well-child check ups and immunizations? ___ Yes ___ No

19. Have you or any of your dependents smoked or used tobacco within the last 12 months? ___ Yes ___ No
 a. If yes, name(s) of individual(s)________________
 b. Type of tobacco used________________
 c. Date last smoked/used________________

20. a) Applying for: ___New Enrollment ___Child Only Plan
 b) Applying for: ___Change in Plan ___Change in Beneficiary ___Adding Spouse ___Adding Child Date Acquired________
 ___Insured Child attaining age 19 or 23 ___Reinstatement Policy Number ________________
 ___Waiver Removal________ ___Splitting from family plan Policy Number ________________

NOTE: Life Insurance and AD&D coverage are included (except on Child Only plans).

21. a) Name of Beneficiary (**required**) ________________
 b) Relationship to Applicant________________

22. Desired Effective Date (MM/DD/YY): ____________________________ The effective date cannot precede the signature date of the Application nor be more than 90 days from the date the Application was completed subject to underwriting approval. Plan Changes are effective first of the month only. **Pre-existing limitations may apply.**

23. Health Benefits Plan/Plan Change Desired **Non-network PPO deductibles are equal to 2 times the network level (except for HSA).**
    - ___ PPO Plan (90% network/70% non-network coinsurance) Deductible __$750 __$1,500 __$2,500
    - ___ PPO Plan (80% network/50% non-network coinsurance) Deductible __$750 __$1,500 __$2,500
    - ___ PPO Plan (70% network/50% non-network coinsurance) Deductible __$1,500 __$2,500 __$5,000
    - ___ PPO Plan LifeStyle 1750 (100% network/50% non-network) __3 Tier Copay Drug Plan __Generic Drug Plan
    - ___ PPO Plan LifeStyle 2500 (100% network/50% non-network) __3 Tier Copay Drug Plan __Generic Drug Plan
    - ___ PPO Plan LifeStyle 3500 (100% network/50% non-network) __3 Tier Copay Drug Plan __Generic Drug Plan
    - ___ HSA Plan (100% network/50% non-network coinsurance) __HSA I __HSA II __HSA III __HSA IV
    - ___ Child Only PPO Plan (90% network/70% non-network coinsurance) $750 Deductible Only
    - ___ Other ____

24. **Optional Benefits** (Check desired options)

___ **Supplemental Individual Term Life Insurance**

Applicant and/or dependents that are approved for a Nationwide Health Plans certificate will also qualify for Supplemental Individual Term Life coverage at an additional charge (child-only plans are not eligible). Dependents under the age of one year are not eligible for Supplemental Life Insurance. This coverage does not replace the Term Life and AD&D coverage included with the plan. You must maintain a qualifying health coverage with Nationwide Health Plans in order to keep the Supplemental Term Life Insurance.

Applicant:	___$10,000	___$20,000	___$30,000	___$40,000
Spouse:	___$10,000	___$20,000	___$30,000	___$40,000
Children*:	___$10,000	___None		

*Must purchase applicant or spouse coverage in order to purchase

___ **CashBack Plan (Supplemental Medical Expense Plan) Includes $500 Accident Benefit**

This product ***is a supplement to the health plans and is not a substitute for hospital or medical expense insurance***. All applicants listed in Section 16 must apply if you are interested in coverage.

___ **Benefit Solutions Discount Program Enrollment**

This OPTIONAL Benefit Solutions Discount Program is not insurance. Only those applicants that are approved for health insurance coverage under the MyHealth PPO Choice plans are eligible for the Optional Benefit Solutions Program. Participation in the health plan is required to maintain the discount program.

The Benefit Solutions Program will become effective on the same date as your Coverage under the health plan. The Benefit Solutions fee will be included with your health insurance billing.

25. Do you, your spouse, or any of your dependents currently have health coverage under a group or individual health insurance policy?
    - a) If yes, please indicate the type of policy, name of insurance company, and provide the policy number:____ Yes ❑ No ❑
    - b) If yes, is it intended that coverage applied for will replace it? If so and continuous coverage is desired, the coverage to be replaced should be kept in force until the certificate applied for becomes effective and is received. Yes ❑ No ❑

Medical Information

1. a) Are you, your spouse, or any of your dependents currently pregnant or had a positive home pregnancy test within the last 3 months, or are you, your spouse, or any of your dependents expecting a child with anyone, including a surrogate? Yes ❑ No ❑

   b) If yes, name of person expecting ________________________________ Anticipated delivery date______________________ Yes ❑ No ❑

   c) Are you, your spouse, or any of your dependents planning to adopt a child? Yes ❑ No ❑ If yes, expected date of adoption or placement for adoption _______________. If applying prior to the expected date, please complete a separate application for this child and attach to your application.

2. Are you or any of your dependents currently taking prescribed or over-the-counter medications (including fertility drugs), nutritional supplements, or herbal medications? Yes ❑ No ❑
If yes, please provide:

Name of Individual	Name of medication/amounts per day	For what condition:

3. Have you or any of your dependents ever been diagnosed, treated, or referred for treatment (including medications), or are currently being treated for any of the following:

a) Any disease or disorder of the liver, pancreas, colon, intestines, digestive system, stomach, esophagus, or gastroesophageal reflux? Yes ❑ No ❑

b) Heart disorders, bypass surgery/angioplasty/stents, pacemaker, coronary artery disease, mitral valve prolapse, palpitations, or a heart murmur? Yes ❑ No ❑

c) AIDS/AIDS-Related Complex, Venereal Disease or other immune disorder? Yes ❑ No ❑

d) Emphysema, chronic bronchitis, asthma, allergies, or other lung disorders? Yes ❑ No ❑

e) Back/Spinal disorders, back strain/sprain, scoliosis, or neck pain? Yes ❑ No ❑

f) Kidney stones, any disease or disorder of the kidneys, urinary tract or bladder, or male/female reproductive system? Yes ❑ No ❑

g) Stroke, TIA (Transient Ischemic Attack), high blood pressure, dizziness, headaches, or migraines? Yes ❑ No ❑

h) Paralysis, Multiple Sclerosis, Cerebral Palsy, Parkinson's, Alzheimer's, Epilepsy, seizures, tremors, other neurological disorder? Yes ❑ No ❑

i) Any congenital disease or disorder, birth defect, deafness, blindness, or any other disease or disorder of the ears or eyes? Yes ❑ No ❑

j) Depression, panic attacks, anxiety, bipolar disorder, obsessive-compulsive disorder, schizophrenia, attention deficit disorder, eating disorder, or attempted suicide? Yes ❑ No ❑

k) Psoriasis, rosacea, acne, or any disease or disorder of the skin? Yes ❑ No ❑

l) Any disease or disorder of the breasts or had breast implants? Yes ❑ No ❑

m) Chronic Fatigue Syndrome, Fibromyalgia, Sleep Apnea or sleep disorder? Yes ❑ No ❑

n) Chronic venous insufficiency, phlebitis, varicose veins, or peripheral vascular disease? Yes ❑ No ❑

o) Diabetes or a sugar intolerance? Yes ❑ No ❑

p) Any disease or disorder of the adrenal, parathyroid, thyroid, or pituitary gland? Yes ❑ No ❑

q) Cancer, Leukemia, tumor, cyst, or polyp? Yes ❑ No ❑

r) Osteoarthritis, rheumatoid arthritis, osteoporosis, connective tissue disease, or other disease or disorder of the bones, joints, or muscles? Yes ❑ No ❑

4. Within the past five years, has any applicant:

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

b) Used marijuana, cocaine, heroin, methamphetamines, LSD, or any other non-prescribed 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), drivers license number and details. Yes ❑ No ❑

5. Within the past three years, have you or any of your dependents:
   a) Been advised to have consultations or referrals to another physician, diagnostic tests, treatment, surgery, or hospitalization? Yes ❑ No ❑
   b) Had an abnormal laboratory test, diagnostic test, physical exam, including but not limited to MRI, CT scan, EKG, EEG, cardiac stress test or x-ray? Yes ❑ No ❑

6. Have you or any of your dependents 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 three years? Yes ❑ No ❑

7. Do you or any of your dependents have any illness, injury, or physical symptoms not listed above for which he/she has not yet consulted a physician? Yes ❑ No ❑

8. Have you or any of your dependents received a disability pension or been forced to terminate employment for health reasons? Yes ❑ No ❑

9. Have you or any of your dependents ever been refused, waivered, or offered a policy at other than a standard rate? Yes ❑ No ❑

10. Do you or any of your dependents participate in sports activities for pay? If yes, explain below. Yes ❑ No ❑

11. a) Primary Applicant's Occupation:______________________________
    b) Is occupation covered under Workers' Compensation Yes ❑ No ❑
    c) Spouse's Occupation:______________________________
    d) Is occupation covered under Workers' Compensation? Yes ❑ No ❑

If you answered "yes" to any of the medical information questions 1 through 7, please provide details below. **Include all physicians seen in the last three years** (unless question refers to longer period of time). Attach additional sheets (signed and dated) if necessary.

Question Number	Name	Medical Condition	Medication and Dosage	Treatment Dates	Does this Condition Still Exist?	Physician Name, Address and Phone Number

If additional space is required, please attach separate sheets. Each attached sheet should be signed and dated.

It is agreed: (a) that the information set forth in this Application is correctly recorded, complete and true to the best of my knowledge and belief, and that it forms the basis of my insurance; (b) that the certificate together with this Application will completely describe the benefits and conditions of the insurance agreement; (c) that no Agent has authority on behalf of the Company to make or modify any application or to make any promise or representation.

I understand that no insurance will become effective without approval of the Insurance Company. If a member is in a hospital at the time this insurance would become effective, it is agreed that coverage will not become effective until the member is out of the hospital. It is agreed that a dependent who is confined in a hospital on the date his or her coverage would otherwise become effective will not become covered until he or she is out of the hospital. In no event will the effective date of any dependent precede that of the member.

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, consumer reporting agency, the Medical Information Bureau or employer, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment, including but not limited to, HIV, AIDS, substance abuse, or other mental or physical disorder, of me or my minor children and any other non-medical information of me or my minor children to give NATIONWIDE LIFE INSURANCE COMPANY, its reinsurers or its legal representatives any and all such information.

FRAUD WARNING - Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

We reserve the right to retroactively adjust the Premium rate at any time in the event We determine that inaccurate information regarding a Covered Person's tobacco use was provided to Us, upon which We relied in determining the Premium Rate.

This insurance coverage is not sold as an employment benefit plan. No business owner is responsible for payment of premium or benefits.

Date signed____________________ Signed at______________________________
Month/Day/Year City State

____
Primary Applicant's Signature or applicant's parent or Legal Guardian if applying for the Child-Only Plan

____
Spouse's Signature

____
Adult Dependent's (age 18 or over) Signature

____
Adult Dependent's (age 18 or over) Signature

(Adult dependents can not be processed on this application without appropriate signatures)

Application must be accompanied by Authorization Form for Enrollment

I acknowledge that I have received and reviewed the application.

Agent/Producer ____________________ Agent/Producer No. ______________ Date__________

Agent/Producer Phone No.____________________ Agent/Producer Fax No.____________________

Agent/Producer E-mail____________________

Benefits Network Insurance Agency
340092790

Payment Mode and Premium Options

Initial Premium Payment Methods *Select an initial premium payment option*

___Check ___ One-Time Credit Card ___One-Time ACH

Premium will be charged upon application approval. If a monthly payment mode (monthly bill or EFT) is selected, we will charge for the current month due, up to two months. Initial premium for quarterly, semi-annual or annual modes will be charged as requested, based on selection above. Any transaction returned unpaid by the bank will be subject to a $25 fee. If the application is closed out, canceled or declined for coverage, this document will be shredded. I (We) authorize Nationwide Life Insurance Company to charge my (our) account shown below.

On-Going Premium Payment Mode

___Monthly by Check ($4.25 monthly service fee applies) ___Quarterly ___Semi-Annual ___Annual

___Monthly by EFT (Please complete EFT Authorization below) ___Monthly by Credit Card (Please complete Credit Card Authorization below)

Payment of Farm Bureau Membership Dues

___ Yes, please charge the annual Farm Bureau membership dues with the initial premium to the method shown above. A copy of the Farm Bureau membership form is attached. County of Membership________________________________ Amount of Dues $__________

Authorized Signature ____ ***Date***______________________

AUTHORIZATION FOR REPETITIVE CREDIT CARD PREMIUM PAYMENT

I authorize Nationwide Health Plans (you) to initiate a credit card transaction notice to my financial institutions 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.

All credit card transactions will be processed between the 22nd and the 26th of each month for the following 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 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.

One-Time Credit Card Information

Credit Card: ❑ VISA ❑ MasterCard Exp. Date:__________

Card No. __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

V-Code __ __ __ (Last 3 numbers located on the backside of your card in the signature panel.)

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

______________________________ ____________

Print Name Date

Authorized Signature (As it appears on the credit card)

______________________________ ____________

Signature Date

Cardholder's Billing Address

____

Address

____

City State ZIP

Request and Authorization for Electronic Funds Transfer Payment Plan (on-going monthly EFT payment mode)

I (We) request and authorize Nationwide Health Plans to charge my (our) checking account for payment(s) due. The draft will be drawn between the 8th and the 15th of the month, depending on the financial institution. It is understood and agreed that the Electronic Funds Transfer will not alter any policy provision and that:

1. The month of the initial draft will be determined by Nationwide. The payment frequency is monthly and the initial premium or ACH must be submitted with the application. No monthly bill will be mailed.
2. In the event a monthly draft is inadvertently not made, Nationwide may charge my (our) account at a later date.
3. This plan may be terminated by either the Accountholder or Nationwide by the first of the month in which the draft is to occur. Also, Nationwide may terminate this plan if any draft is not paid upon presentation.
4. If the EFT is terminated, premium will be payable directly to Nationwide by the first of the month and may include an additional billing fee.
5. If you change your banking arrangements, Nationwide should be notified of this at least 31 days in advance. If this advance notice is not provided, sufficient funds should be left in your old account to honor interim drafts.

__*Initial EFT Set-Up* __*Change in Banks* __*Change in Accounts*

Authorized Signature (As it appears on the account)

______________________________ ____________

Signature Date

Bank Information
(To be completed for One-Time ACH or Monthly EFT)

Depository (Bank) Name______________________________

Bank Account Number ❷______________________________

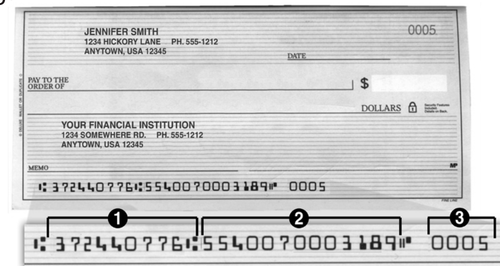
Bank Routing/Transit Number ❶______________________________

❑ Checking or ❑ Savings

❶ Bank Routing/Transit Number

❷ Bank Account Number

❸ Check Number



Attach a Voided Check Here

FOR OFFICE USE ONLY

Applicant's Name____

NW Account Number __ __ __ __ __ __ __   __ __ __ __ __ __ __   __ __ __ __   __ __ __ __ __ __ __ __ __ $______________

PRODUCT CASE UNIT CERTIFICATE Amount of Draft or Charge

____________ ________ ________ ____________ ____________

Admin Tech Signature Date Time NHP Finance Date Received

Nationwide Life Insurance Company

1. Notice of Insurance Information Practices

To provide insurance coverage, we need to obtain 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. You have the right of access and correction with respect to the information collected about you except information that is related to a claim or a civil or criminal proceeding.

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, please write to us at:

Nationwide Life Insurance Company
P.O. Box 2399
Columbus, Ohio 43216

2. Pre-Notice of Procedures as Required by the Fair Credit Reporting Act

This notice is to inform you that as part of our normal underwriting procedures in connection with an application for insurance:

A. An investigative consumer report may be made whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. This inquiry will include information as to character, general reputation, personal characteristics and mode of living, with respect to you, members of your family and others having an interest in or closely connected with the insurance transaction; and

B. Upon your written request, made within a reasonable time after you receive this notice, additional information as to the nature and scope of the investigation, if one is made, will be provided. Request for additional information should be directed to the same address as shown above, under NOTICE OF INSURANCE INFORMATION PRACTICES.

3. Medical Information Bureau (MIB) Disclosure Notice

Information regarding your insurability will be treated as confidential. Nationwide Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, a not for profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. 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 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 MIB's file, you may contact MIB and seek a correction in accordance with the procedure set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is:

P.O. Box 105
Essex Station
Boston, Massachusetts 02112

Nationwide Life Insurance Company or its reinsurers 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.

PLEASE DETACH THIS PAGE AND RETAIN FOR YOUR RECORDS.

PLEASE DETACH THIS PAGE

AND RETAIN FOR YOUR RECORDS.

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 POLICY/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 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.

As the parent, I ____________________ also authorize the use or disclosure of health information about my
(applicant/enrollee)

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

_____ applicant
_____ spouse
_____ adult child
_____ adult child

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.

LIFE

_____ applicant
_____ spouse
_____ adult child
_____ adult child

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 designees, 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.

DISABILITY, not applicable to Farm Bureau

_____ applicant

c. 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 disability policy for which I applied. I understand that if I have applied for disability coverage, Nationwide Life Insurance Company may condition the issuance of the disability policy on the signing of this authorization and checking this paragraph 2(c) authorizing the information to be used to underwrite and rate the disability coverage.

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) and/or 2(c) 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) and/or 2(c).

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, e.g. Power of Attorney.

____

____

7. As described in the <u>Notice of Privacy Practices</u>, 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, PO Box 2399, Columbus, OH 43272-4296. The <u>Notice of Privacy Practices of Nationwide</u> 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 Signature

____ Date: _______________
Adult Child Signature

____ Date: _______________
Adult Child Signature

____
Personal Representative Name, if applicable
(as described above in #6)

____ Date: _______________
Personal Representative Signature

NH-0522 022604

Nationwide®
Health Plans

On Your Side℠

AUTHORIZATION FORM FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Nationwide Life Insurance Company, dba Nationwide Health Plans ("NHP") is required by law to maintain the privacy of our members' health information. Unless you have signed a form authorizing the use or disclosure, we will not use or disclose your health information for any purpose other than NHP's role in treatment, payment or for health care operations. **With your written approval, we may disclose your health information to others, including designated family, friends, or others who are involved in your health care or in payment for your health care. This form allows you to designate this/these person(s).** A copy of this form is as valid as the original.

I understand that I am not required to sign this authorization form and that NHP will not condition initial enrollment or continued enrollment in the health plan or the provision of payment to me on the signing of this authorization.

A SEPARATE FORM MUST BE COMPLETED FOR EACH ADULT FAMILY MEMBER/APPLICANT including dependents age 18 and over. Additional copies can be reproduced or are available on www.nationwidehealthplans.com**.**

I, ____, hereby authorize the use or disclosure of health
(print member/applicant name)
information about me as described below.

As the parent, I authorize the use or disclosure of health information about my minor dependent(s), age 17 and under as described below.

_____________________________, ____________________________, ____________________________.
(print dependent'(s) full name)

1. Person(s) or group of persons authorized to disclose the information:
   - NHP.

2. Person(s) or group of persons authorized to receive and use the information from NHP.
   ☐ **Medical Information Bureau, Inc;.**
   ☐ **Family and friends**: check all that apply if you wish a family member or friend to be able to discuss your coverage and claims with NHP, and to receive health information which NHP maintains about you:
   - Spouse (write in name and address): ___________________________________
     ____
   - Family member (write in name and address): ____________________________
     ____
     Explain relationship: ____
   - Friend(s) or Other(s) (write in name and address): _________________________
     ____
     Explain relationship: ____

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 and any other plan related information.

4. I understand that if the person or entity that receives the information described in item 2 herein is not a health care provider or health plan covered by federal privacy regulations, the information described here may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

5. If the person completing this authorization is the personal representative of the member/applicant or dependent, describe your authority to act on this person's behalf, e.g. Power of Attorney.

   ____

6. 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 NHP in reliance on this authorization by sending a written signed and dated revocation to Compliance Department, Nationwide Health Plans, 5525 Parkcenter Circle, CO-01-15, Dublin, Oh 43017. The Notice of Privacy Practices is available on the Nationwide Health Plans web site at www.nationwidehealthplans.com.

7. 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.

8. This authorization will expire 30 months from the date of signature if I am declined for coverage or upon termination of my coverage under this plan if I am approved for coverage.

Member Signature: ____ Date: __________

Member ID#, if applicable: ____

Personal Representative Name, if applicable: ____
(as described above in #5)

Personal Representative Signature: ____________________________________ Date:___________

Return form to:
Compliance, CO-01-15, 5525 Parkcenter Circle, Dublin, OH 43017