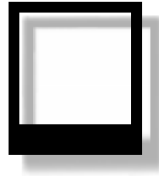


Have Questions? Need Assistance? Call Us At: (877)-433-7868



**CalFarm
Insurance**

a member of Nationwide Insurance

HEALTH INSURANCE APPLICATION

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

Health Application Instructions

- **Fully complete this application 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 ink. (Black or blue preferred.)
- If you have questions or are not sure how to answer a question call your agent .
- Give complete name, address, and phone number of all doctors indicated on pages 3 and 6.
- Have all Applicants, age 18 and over, sign and date the application on page 4.
- Return this application, and checks, to your agent within 10 days after signing.

If approved, this application will become part of your health Certificate of Insurance. Coverage will become effective on the first day of the month following CalFarm's approval of the application and with payment of the first full premium.

SPECIAL INSTRUCTIONS FOR CHILD(REN)-ONLY APPLICATIONS:

1. For Boxes 1, 3, 8, 9, 10 and 11 enter Parent or Guardian's information.
2. Be sure to check "Child(ren)-Only Certificate" in Box 16.
3. For Boxes 15-25, enter information for all Dependent Child Applicants.
4. Parent or Legal Guardian's signature is required on Page 4.

If Parent(s) or Legal Guardian(s) are also applying for health insurance under a separate Plan or program, the Parent(s) or Legal Guardian(s) must complete a separate application.

Do not terminate any existing coverage until you have been notified that your CalFarm coverage is in effect.



California Farm Bureau Members'
Health and Life Insurance Program

*FARM BUREAU and the FB Designs are registered service marks of the American Farm Bureau Federation used under license by CalFarm Insurance Company. Neither American Farm Bureau Federation or California Farm Bureau Federation nor any of its members solicits or participates in the transaction of CalFarm's insurance.



COUNTY FARM BUREAU® APPLICATION FOR MEMBERSHIP

Residence or Business County	Dues Enclosed		Current/Previous Member# _ _ _ _ _
	\$	<input type="checkbox"/> Voting <input type="checkbox"/> Sustaining	

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Applicant's Name (Last, First, M.I.)
---	--------------------------------------

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Spouse's Name (Last, First, M.I.)
---	-----------------------------------

Business Name (DBA)** _____ Use Business Name as primary membership name? Yes _____ ** No _____ <small>**Only individual members are eligible for Accidental Death & Dismemberment policy.</small>	Type of Business
--	------------------

Address		
---------	--	--

City	State	Zip Code
------	-------	----------

Telephone Number Home: () _____ Business: () _____	Date of Birth (mm / dd / yy) Applicant _____ / _____ / _____ Spouse _____ / _____ / _____
--	---

Applicant's Primary Occupation	Spouse's Primary Occupation
--------------------------------	-----------------------------

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.

Place an "M" for you (Member) or an "S" for your Spouse

01 _____ Own/lease a farm/ranch	04 _____ Retired from farm/ranch/ag-related business
02 _____ Own/manage an ag-related business	05 _____ Not involved in agriculture
03 _____ Employee of farm/ranch/ag-related business	26 _____ Retired, not involved in agriculture

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

1. _____	3. _____
2. _____	4. _____

_____ Applicant's Signature	_____ Date
--------------------------------	---------------

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.

Approval	Center Code	Recruiter / Agent Name (Please Print)	Agent Number
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CalFarm Insurance Health Application

for the California Farm Bureau® Members' Health and Life Insurance Program

Home Office Use: Date Received _____

GENERAL INFORMATION

1 Primary Applicant's Name (Please see instructions on cover if this is a Child(ren)-Only Application.) Last _____ First _____ M.I. _____			2 Sex _____		3 Social Security/Tax I.D. No. _____		
4 Birthdate (M/D/Y) _____			5 Ht _____		6 Wt _____		7 Marital Status _____
8 Home Address Street _____ City _____ State _____ Zip _____			9 <input type="checkbox"/> Billing Address <input type="checkbox"/> Mailing Address <input type="checkbox"/> Both (if other than home address) Street _____ City _____ State _____ Zip _____				
10 County of Residence _____			11 Home Ph. No. () _____ Work Ph. No. () _____		12 Driver's License No. _____		
13 a. What is Primary Applicant's occupation and duties? _____ b. Is occupation covered under Workers' Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No							
14 a. What is Spouse's occupation and duties (if applying)? _____ b. Is occupation covered under Workers' Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No							
15 Additional Applicants (Dependents)							
Full Name	Relationship To Primary Applicant	Birthdate (M/D/Y)	Age	Sex	Social Security Number	Ht	Wt
	Spouse						
	Child						
	Child						
	Child						
	Child						

HEALTH INSURANCE INFORMATION

16 Applying for <input type="checkbox"/> New Coverage <input type="checkbox"/> Addition to Plan <input type="checkbox"/> Change of Plan <input type="checkbox"/> Conversion to Separate Certificate <input type="checkbox"/> Reinstatement <i>(Check all that apply.)</i> <input type="checkbox"/> Child(ren)-Only Certificate								
17 Plan <input type="checkbox"/> FLEX Primary15 (Plan S) <input type="checkbox"/> FLEX Primary 30 (Plan K) <input type="checkbox"/> FLEX Primary 45 (Plan N) <input type="checkbox"/> A Health \$25 Co-pay(Plan AHL-B) <input type="checkbox"/> A Health \$40 Co-pay(Plan AHL-G) <input type="checkbox"/> FLEX Premier+ (Plan T)* <input type="checkbox"/> FLEX Basic (Plan B) <input type="checkbox"/> FLEX Plus (Plan F) <input type="checkbox"/> FLEX Premier (Plan L) <i>*Additional \$250 calendar-year deductible applies out-of-network.</i>								
18 Deductible Amount <input type="checkbox"/> None (Applicable to Premier+ and Primary 15 & 30 in-network only.) <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500								
19 Benefit Option (Applicable to B, F and L): <input type="checkbox"/> Rx Drug Card? <input type="checkbox"/> Yes <input type="checkbox"/> No								
20 Premium Payment Mode <input type="checkbox"/> Monthly by Check (\$3 monthly service fee applies) <input type="checkbox"/> Monthly by EFT (see page 5) <input type="checkbox"/> Quarterly <input type="checkbox"/> Semiannual <i>Premium Payments include charges for life insurance and AD&D benefits and the California Life & Health Insurance Guarantee Association surcharge.</i>								
21 Farm Bureau Member No. _____				County _____				
22 Primary Applicant's Beneficiary - Full Name and Relationship. (Life insurance and AD&D program is underwritten by CalAmerica Life Insurance Company, Los Angeles, CA.)								
23 Has any Applicant previously applied for insurance under this program? If "Yes", give name(s), Certificate No(s)., and date(s) last insured.							Yes <input type="checkbox"/>	No <input type="checkbox"/>
24 Is any Applicant currently (or within the last 63 days) insured under any group or individual health insurance plan? If "Yes", a. Give name, address, and telephone number of insurance company(s) and specify policy number(s), name of insured(s), and how long insured. b. Will that insurance be replaced by coverage applied for with CalFarm? c. Is that prior coverage COBRA or continuation coverage provided by a former employer?							<input type="checkbox"/>	<input type="checkbox"/>
25 Do all additional Applicants listed above meet the following definition for dependent eligibility? Primary Insured's (a) spouse; (b) unmarried natural or adopted children from birth to 18 years of age; or (c) unmarried stepchildren, or legal wards from birth to 18 years of age, if Primary Insured contributes at least 50% to their support and claims them as an exemption for Federal and/or State Income Tax purposes. A child under age 24 who is a full-time student at an accredited school or college (12 units or more) is also eligible.							<input type="checkbox"/>	<input type="checkbox"/>

FOR HOME OFFICE USE ONLY

Agent No. _____	Trans. No. _____	Date Rec'd. _____	Amt. Rec'd. with App. \$ _____
Underwriter _____	Date Approved _____	Eff. Date _____	
Health Plan _____	Certificate No. _____		

MEDICAL INFORMATION

Answer questions to the best of your knowledge and belief for all Applicants and provide details in space provided for all questions answered "Yes." Please circle the items that are applicable.

1	Has ANY Applicant, within the past 5 years, received professional advice, treatment or diagnosis for:	Yes	No
	a. Heart attack, stroke, irregular heart beats, chest pain, heart murmur or had heart surgery?	<input type="checkbox"/>	<input type="checkbox"/>
	b. High blood pressure or any disease of the blood or blood vessels (except HIV)?	<input type="checkbox"/>	<input type="checkbox"/>
	c. Epilepsy, convulsions or any neurological disease?	<input type="checkbox"/>	<input type="checkbox"/>
	d. Asthma, allergies, emphysema, sleep apnea or any disease of the lungs or respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>
	e. Ulcer, colitis, or any disease of the stomach, intestines, rectum, gallbladder, spleen, liver, pancreas, or hernia?	<input type="checkbox"/>	<input type="checkbox"/>
	f. Diabetes, sugar, protein or albumin in the urine?	<input type="checkbox"/>	<input type="checkbox"/>
	g. Kidney stones, kidney disease, bladder, prostate or urinary system disease?	<input type="checkbox"/>	<input type="checkbox"/>
	h. Cancer or any tumor, growth, or skin disease?	<input type="checkbox"/>	<input type="checkbox"/>
	i. Breast disease or surgery including breast implants; uterine disease or any disease of the reproductive organs?	<input type="checkbox"/>	<input type="checkbox"/>
	j. Thyroid or other glandular disease, or any disease of the eyes, ears, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>
	k. Arthritis, rheumatoid arthritis, lupus, gout, rheumatism, back pains or any disease of the bones, joints, spine or muscles?	<input type="checkbox"/>	<input type="checkbox"/>
	l. Acquired Immune Deficiency Syndrome (AIDS) or the AIDS-related complex (ARC)?	<input type="checkbox"/>	<input type="checkbox"/>
	m. Any sexually transmitted disease (not including HIV)?	<input type="checkbox"/>	<input type="checkbox"/>
	n. Complications of pregnancy or premature birth?	<input type="checkbox"/>	<input type="checkbox"/>
	o. Infertility (male or female) or male impotence?	<input type="checkbox"/>	<input type="checkbox"/>
	p. Any physical abnormality, deformity or disfigurement?	<input type="checkbox"/>	<input type="checkbox"/>
	q. Depression, panic attacks, anxiety or other mental/nervous disease or disorder?	<input type="checkbox"/>	<input type="checkbox"/>
2	Has any Applicant, within the past 5 years:		
	a. Used marijuana, cocaine, heroin, methamphetamines, LSD or any derivatives thereof?	<input type="checkbox"/>	<input type="checkbox"/>
	b. Been advised to reduce alcohol intake?	<input type="checkbox"/>	<input type="checkbox"/>
3	Has any Applicant had an exam, consultation, checkup, been hospitalized or been treated by a doctor, acupuncturist, chiropractor, psychiatrist, psychologist or licensed mental health counselor for any reason within the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
4	Has any Applicant, within the past 5 years:		
	a. Had an abnormal diagnostic test (not including HIV blood tests or studies), physical exam, MRI, CT scan, EKG, or x-ray?	<input type="checkbox"/>	<input type="checkbox"/>
	b. Been advised to have diagnostic tests (not including HIV blood tests or studies), treatment, surgery, or hospitalization (whether completed or not)?	<input type="checkbox"/>	<input type="checkbox"/>
5	Does any Applicant have any illness or injury for which he/she has not yet consulted or plans to consult a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
6	Does any Applicant have any physical abnormality, deformity or disfigurement for which reconstructive or corrective surgery would improve function or create a normal appearance?	<input type="checkbox"/>	<input type="checkbox"/>
7	Has any Applicant been prescribed or taken prescription medication in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
8	If you are a male listed on this application, are you expecting a child with anyone, even if the mother is not listed on this application?	<input type="checkbox"/>	<input type="checkbox"/>
9	a. Is either the primary applicant, spouse, or female dependent currently pregnant or had a positive home pregnancy test within the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
	b. Does she/they menstruate?	<input type="checkbox"/>	<input type="checkbox"/>
	c. If yes, what was the date of the first day of her/their last normal menstrual period? If last menstrual period is not within 30 days of the application signature date, please provide details.		
	Name _____ Last menstrual period (M/D/Y) _____/_____/_____		
	Name _____ Last menstrual period (M/D/Y) _____/_____/_____		
	Name _____ Last menstrual period (M/D/Y) _____/_____/_____		
	Name _____ Last menstrual period (M/D/Y) _____/_____/_____		
10	Is any Applicant currently receiving insurance or governmental benefits due to a disability?	<input type="checkbox"/>	<input type="checkbox"/>
11	Has any Applicant within the past 5 years had any moving violations, a driver's license revoked, suspended, or been arrested for driving under the influence? If yes, provide name of applicant(s), driver's license no. and details.	<input type="checkbox"/>	<input type="checkbox"/>
12	Give full name, address and telephone number of personal doctor(s) for each applicant and date last seen.		

Use this space for Medical Information questions answered "Yes" above. *

Ques. No.	Name of Applicant	Condition, injury, or findings of examination, prescriptions (if surgery performed, state type)	Month and Year	Duration	Result of Exam/Degree of Recovery	Name, address, zip code and telephone number of hospital and attending doctor

**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 CalFarm and (b) the full first premium is paid. I understand that CalFarm 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 CalFarm 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 CalFarm 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 any insurance company, physician, hospital, clinic, health care provider, health maintenance organization, third party administrator, pharmacist, or the Medical Information Bureau, Inc., or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children and any other non-medical information of me or my minor children to give CalFarm or its reinsuring companies any and all such information. I understand such information will be used by CalFarm to determine eligibility for insurance or eligibility for benefits. Any information obtained will only be released by CalFarm to reinsuring companies, the Medical Information Bureau, Inc., or insurance support organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required or as I may further authorize. This also authorizes the underwriters of CalFarm to request medical information from my previous insurance company; and, it also authorizes the underwriters and/or claims personnel of my previous insurance company to disclose such requested information to CalFarm's underwriters. I know that I may request to receive a copy of this authorization. This authorization may be revoked at anytime, in writing, except to the extent that disclosure has been made in reliance on it.

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 **Health Insurance Disclosure Notice** on Page 6 and have received the **Notice to Applicant of Personal Information Practices**.

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. CalFarm 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 CalFarm 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 CalFarm, 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 CalFarm Insurance Company 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 CalFarm Insurance Company 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 CalFarm Insurance Company 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)

_____ **0V049** _____
SIGNATURE OF AGENT AGENT NO.

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

Marsha Andrews Tax ID 95-3860414 _____
AGENT'S NAME (PRINT) L.D. 0670130 DATE

1-877-433-7868 _____ **1-714-279-1990** _____
AGENT'S PHONE NO. FAX NO.

PREMIUM CALCULATION AND DELIVERY INSTRUCTIONS

1 Monthly Premium (includes \$3 for Life/AD&D) \$ _____
 Spouse Coverage Included? Yes No
 Child(ren) Coverage Included? Yes No
 Additional Benefit Option:
 Rx Drug Card Included? Yes No
 Plus MedPerks Payment (if applying) \$ _____
 Monthly Total \$ _____

4 Total Submitted with Application
 Include one of the following:
 • Semiannual Premium (monthly x 6) \$ _____
 • Quarterly Premium (monthly x 3) \$ _____
 • Monthly Premium \$ _____
 Plus \$3 monthly service fee (if monthly non-EFT) \$ _____
 Plus One-Time Rural Health Dept. Fee \$ 5.00
 Total \$ _____

2 Send Certificate of Insurance to: Agent for delivery
 Certificateholder

(Make one check for health premium, Rural Health fee and MedPerks (if applicable) payable to CalFarm Insurance Company.)

Annual Farm Bureau Dues \$ _____

3 Preferred Effective Date: _____

(Make one check for annual Farm Bureau dues payable to California Farm Bureau Federation.)

AUTHORIZATION FOR ELECTRONIC FUNDS TRANSFER (EFT) PREMIUM PAYMENT

Health Certificate Number: _____

I authorize CalFarm Insurance Company 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 CalFarm 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

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) 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 in to 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.

 DEPOSITOR'S NAME (PRINT)

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

 OTHER SIGNATURE (IF JOINT ACCOUNT)

*Actual draft is made on or about the first working day following the date selected.

**PLEASE ATTACH VOIDED CHECK HERE
 (Do not use deposit slip)**

County Farm Bureau	Sustaining member
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This Program is available only to California County Farm Bureau Members.

If applicant is not already a county Farm Bureau Member, Include Annual Farm Bureau Dues with Application.

Please return this application to:
M.E. Andrews Insurance
8190 E. Kaiser Blvd., #100
Anaheim Hills, CA 92808

1. Alameda	45.00
3. Amador	45.00
4. Butte	50.00
5. Calaveras	45.00
6. Colusa	50.00
7. Contra Costa	45.00
8. Del Norte	40.00
9. El Dorado	45.00
10. Fresno	50.00
11. Glenn	45.00
12. Humboldt	50.00
13. Imperial	50.00
14. Inyo-Mono	55.00
15. Kern	50.00
16. Kings	65.00
17. Lake	50.00
18. Lassen	40.00
19. Los Angeles	50.00
20. Madera	60.00
21. Marin	50.00
22. Mariposa	45.00
23. Mendocino	55.00
24. Merced	50.00
25. Modoc	45.00
27. Monterey	75.00
28. Napa	50.00
29. Nevada	55.00
30. Orange	45.00
31. Placer	50.00
32. Plumar	50.00
33. Riverside	60.00
34. Sacramento	50.00
35. San Benito	45.00
36. San Bernardino	55.00
37. San Diego	50.00
39. San Joaquin	55.00
40. San Luis Obispo	55.00
41. San Mateo	75.00
42. Santa Barbara	60.00
43. Santa Clara	75.00
44. Santa Cruz	50.00
45. Shast	50.00
47. Siskiyou	65.00
48. Solano	65.00
49. Sonoma	52.00
50. Stanislaus	52.00
52. Tehama	50.00
53. Trinity	45.00
54. Tulare	70.00
55. Tuolumne	48.00
56. Ventura	75.00
57. Yolo	50.00
58. Yuba-Sutter	50.00

MedPerks Enrollment



This OPTIONAL MedPerks 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 MedPerks Program. Participation in the California Farm Bureau Members' Health and Life Insurance Program is required to maintain the MedPerks Program.

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

The MedPerks Program premium will be included with your Health Insurance Program billing.

Applying for:

MedPerks A (without pharmacy):

This product is issued to individuals approved for a health coverage plan through the California Farm Bureau Members' Health and Life Insurance Program that includes prescription drug coverage.

MedPerks B (with pharmacy):

This product is issued to individuals approved for a health coverage plan through the California Farm Bureau Members' Health and Life Insurance program that does not include prescription drug coverage.

1 Applicant's Name				
Last	First	M.I.		
2 Home Address				
Street				
City		State	Zip	Telephone No. ()
3 Birthdate (M/D/Y)		4 Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		5 Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single
6 Additional Dependents				
Last	First	Relationship To Applicant		Birthdate (M/D/Y)
		Spouse		
		Child		
		Child		
		Child		
		Child		
Applicant's Signature _____ Date _____				

NOTICE TO APPLICANT OF PERSONAL INFORMATION PRACTICES (Detach and retain)

Privacy Disclosure. Personal 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: CalFarm Insurance Company, Attention: Health Customer Services Division, HS-1, 1601 Exposition Blvd., Sacramento, CA 95815.