National Slovak Society
Of the United States of America

NSS Life®
Family Matters...

A Fraternal Benefit Society

For Home Office Use:

Assembly/Circle # ______________

Certificate #: ________________

351 Valley Brook Road
McMurray, PA 15317-3337
Phone (724) 731-0094 • Fax (724) 731-0146 • **www.nsslife.org**

Application for Life Insurance

Membership: Is the Applicant a member of the National Slovak Society of the United States of America?
☐ Yes ☐ No (If no, apply for membership on separate form.)

Proposed Insured: (Complete in all cases. This person will also be the Policy Owner, unless the Owner section is completed below.)

Full Name ____

Street Address ____

City ______________________________ **State** _________ **Zip Code** ____________

Phone # (______**)** ______ **–** __________ **Social Security #** _______ **–** _____ **–** _________ ☐ **Male** ☐ **Female**

Date of Birth ____________________ **Place of Birth** ______________________________

Name of Employer ____

Occupation ______________________________ **How Long at this Occupation?** ______________

Employer's Address/Phone ____

Owner: (Complete in all cases for Proposed Insured 17 years of age and under; for adults only if **other** than the Proposed Insured above)

Full Name of Individual/Entity* ______________________________ **Date of Birth** ______________

Address ____

City ______________________________ **State** _________ **Zip Code** ____________

Phone # (______**)** ______ **–** __________ **Social Security/Tax ID#** ______________ **Relationship** ______________

***If an Entity, name a contact Person** ______________________________ **Phone # (**______**)** ______ **–** __________

Beneficiary (To name additional Primary and Contingent Beneficiaries, sign, date, and list names on separate sheet of paper)

Primary:

Full Name ____

Social Security # _______ **–** _____ **–** _________ **Relationship** ____________________ **Share** ____________

Full Name ____

Social Security # _______ **–** _____ **–** _________ **Relationship** ____________________ **Share** ____________

Contingent:
Full Name ______________________________

Social Security # _______ – _____ – _________ **Relationship**______________________ **Share** ____________

Full Name ______________________________

Social Security # _______ – _____ – _________ **Relationship**______________________ **Share** ____________

Trust as Beneficiary: (Complete Verifications of Trust Form if section b is completed below)

	Primary	Contingent
a) **Trust under the Insured's last will**	☐	☐
b) **Trust Name**______________________ **Trust Dated**__________ **as amended**	☐	☐

Coverage Information:

Base Coverage:

Plan Name______________________ **Face Amount $** __________

Riders/ Benefits:

- ☐ **Waiver of Premium**
- ☐ **Accidental Death Benefit** **Amount $**__________
- ☐ **Payor Waiver of Premium**
- ☐ **Term Rider** **Amount $**__________
- ☐ **Annuity Rider** **Amount $**__________

Include Automatic Premium Loan? ☐ Yes ☐ No

Premium Received

$ __________ **Code** __________
$ __________ **Term Policy Fee**

$ __________ **Code** __________
$ __________ **Code** __________
$ __________ **Code** __________
$ __________ **Code** __________
$ __________ **Code** __________

$ __________ **Total**

Premium Mode Information: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly (Complete EFT Authorization) ☐ Single

Dividend Election: ☐ Paid-Up Additions ☐ Cash ☐ Reduce Premium ☐ Accumulate at Interest

Will the insurance applied for replace or change any existing insurance or annuity contracts? ☐ Yes ☐ No
If *yes*, show the name of the Company and Policy Number(s): ______________________________

____

____

Secondary Addressee: (Purpose of notification of past due premium payment or possible lapse in coverage)

____

____

General Information:

1) Foreign Travel, Aviation, and Military:

a) Does any person to be covered intend to travel outside the U.S. or Canada within two years? ☐ Yes ☐ No

b) Except as a passenger on regularly scheduled flight, does any person to be covered intend to fly or has he/she flown during the past two years? ☐ Yes ☐ No

c) Is any person to be covered a member, or does he/she intend to become a member of the Armed Forces (including Reserves and National Guard)? ☐ Yes ☐ No

2) Avocation and Sports:

In the past three years, has any person to be covered participated in any form of racing, skin or scuba diving, parachuting, hang gliding, rock climbing or any similar sport or avocation? ☐ Yes ☐ No

Remarks: Give details for any question answered *Yes.* Identify person affected. ______________________________

____

____

3) Driving Information:

a) Drivers License:

Proposed Insured's #____________________ State ______ Proposed Insured's # ____________________ State ______

b) Has any Proposed Insured been charged with any moving violation or accident, had driving license suspended, or been convicted of driving under the influence of drugs or alcohol within the last 5 years? ☐ Yes ☐ No

4) Other Insurance:

a) Has any company declined to issue, renew, or reinstate: rated, modified, postponed or cancelled any life or health insurance on any person covered? ☐ Yes ☐ No

b) Will insurance, including annuities, in any company, be discontinued or changed, or subject to borrowing of cash value, if the insurance applied for is issued? ☐ Yes ☐ No

c) Is any application for life or health insurance on any person to be covered pending in any other company? ☐ Yes ☐ No

5) Annual Income Information: Proposed Insured: $ __________________ Other/Spouse: $ __________________

Personal Measurements:

Height: ______ ft. ______ in. Weight: ________ lbs.

Medical Information:

1) **During the past seven years**, has any person to be covered been examined or prescribed medication by a physician or medical practitioner? ☐ Yes ☐ No

2) Has any person to be covered **ever** been treated for, or been diagnosed by a physician as having:

   a) Cancer, diabetes or high blood pressure? ☐ Yes ☐ No

   b) Disease or disorder of the heart or blood? ☐ Yes ☐ No

   c) Nervous or mental condition, or any disease or abnormality of the brain or nervous system? ☐ Yes ☐ No

   d) Any disease or abnormality of the lungs or respiratory system? ☐ Yes ☐ No

   e) Disease or abnormality of the kidneys, liver, prostrate or genitourinary system? ☐ Yes ☐ No

   f) Disease or abnormality of the gastrointestinal system? ☐ Yes ☐ No

   g) Disorder of the muscles, bones or joints? ☐ Yes ☐ No

3) Has any person to be covered **ever** been advised to seek treatment or counseling, been treated for or received counseling, or joined a support group for the use of alcohol? ☐ Yes ☐ No

4) Has member of the medical profession **ever** diagnosed any person to be covered as having, or treated any applicant for AIDS (Acquired Immune Deficiency Syndrome) or ARC (Aids Related Complex)? ☐ Yes ☐ No

5) During the last 5 years has any person to be covered been hospitalized or had surgery of any kind? ☐ Yes ☐ No

6) Has any person to be covered:

   a) Other than a one-time or experimental basis, used barbiturates, heroin, cocaine, marijuana, or any illegal, restricted or controlled substance, except as prescribed by a physician? ☐ Yes ☐ No

   b) Been advised to seek, or received treatment for drug use, or been arrested for drug use or distribution? ☐ Yes ☐ No

7) Has any person to be covered used any nicotine products (cigarettes, cigars, chewing tobacco, pipe, nicotine gum patch, or other)

   a) In the past 12 months ☐ Yes ☐ No

   b) In the past 36 months ☐ Yes ☐ No

   (If *Yes*, indicate the name of the person and list all products used)

8) Is any person to be covered pregnant or expect to become pregnant within nine months? ☐ Yes ☐ No
   (If *Yes*, indicate anticipated date of delivery)

9) Is any medication currently prescribed for any person to be covered?
   (If *Yes*, name them and for whom they are prescribed.) ☐ Yes ☐ No

10) Has any person to be covered had a parent or sibling:

   a) Diagnosed with cardiovascular disease, stroke or cancer prior to age 60? ☐ Yes ☐ No

   b) Die from cardiovascular disease below age 60? ☐ Yes ☐ No

Give Details for all *"Yes"* answers:

Question #	Dates	Medical Condition	Name of Doctor

(Please place additional Information on a separate sheet)

Physician Information:

Name of Doctor:	Address:	Phone Number:

Fraud Warning:

Florida:
Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Acknowledgement:

Each person signing this application: (1) REPRESENTS that, to the best of such person's knowledge and belief, all statements and answers included herein are complete, true and accurately recorded; (2) AGREES that this application shall be the basis for and part of any life insurance certificate issued; and (3) UNDERSTANDS that no agent or person other than the President or Secretary of the Society may, in writing: (a) change, modify or waive any of the printed statements herein; or (b) waive any of the rights or requirements of the Society.

Except as may be provided in a Conditional Receipt, bearing the same date and payment as shown in this application, no insurance will take effect unless and until: (1) this application is approved by the National Slovak Society of the United States of America; (2) a certificate of life insurance is issued; and (3) the full first premium is paid. All such conditions must be met while the health and other factors affecting the insurability of the Proposed Insured remain as described in this application.

AUTHORIZATION:

The undersigned hereby authorize any of the following who may have any records or information regarding the Proposed Insured: Physician or medical practitioner; medical care facility; the Medical Information Bureau (MIB); insurer; employer; institution; organization; or, person, to provide such records or information to: the National Slovak Society of the United States of America its reinsurer; or, except for the MIB, its legal representative. The National Slovak Society of America or its reinsurer may release any such records or information: to the MIB; to other insurers in which the Proposed Insured may have insurance or to whom the Proposed Insured may apply for insurance or to whom a claim may be submitted; or, as may be lawfully required. Any records or information obtained will: be treated as confidential; and, be used to determine eligibility for insurance or benefits.

On request, the National Slovak Society of the United States of America will provide a copy of this Authorization. This Authorization shall be valid for a period of 24 months from the date shown below. This Authorization may be revoked, by written notice, at any time prior to its expiry. A photocopy shall be valid as the original.

Signed at: ______________________ This __________ Day of ______________________, 20 ________

____
Proposed Insured (Age 18 or older)

____
Owner, if other than Proposed insured

____
Witness (Licensed Agent and Number where required)

____
Adult and/or Member Applicant

____
Print: Licensed Agent Name and Florida Licensed ID # **required**

Agent's Statement: To the best of your knowledge and belief, will the insurance applied for replace or change any existing insurance or annuity? ☐ No ☐ Yes If *Yes*, any replacement regulations must be complied with.

ADDENDUM TO LIFE INSURANCE APPLICATION
FORM LA-04

A. Those portions of the "Notice to Proposed Insured" and/or the authorization on application, Form LA-04 which make reference to the Medical Information Bureau (MIB) are deleted in their entirety and replaced with the following wording which will amend part of the application Form LA-04.

Notice to Proposed Insured:

I understand that information regarding insurability will be treated as confidential. The National Slovak Society of the USA (NSS Life) or its reinsurer(s), may, however make a brief report of my personal health information to MIB, Inc., a not for profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. Should I 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 it may have about you in its files. NSS Life or its reinsurer(s) may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. (Medical information will be disclosed to my attending physician only). If you question the accuracy of the information in the MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

B. I authorize NSS Life, or its reinsurers, to make a brief report of my personal health information to MIB. I further hereby authorize any licensed physician, medical practitioner, hospital, clinic or medical or medically related facility, insurance company, MIB Inc., ("MIB") or other organization, institution or person, that has any records or knowledge of me or my health, to give NSS Life, or its representatives, including Equifax or bearer, or reinsurer, any such information. NSS Life may disclose such information to its reinsurer(s) MIB, Inc. The applicant or a duly authorized representative of the applicant is entitled to a copy of this authorization. This authorization is valid for 30 months after the date shown below.

A photographic copy of this authorization shall be as valid as the original.

Signed at:____________________ On:______/______/ 20______

____________________ ____________________

Signature of Proposed Insured (Parent or Guardian) Signature of Owner

FLORIDA SUPPLEMENTAL APPLICATION

Supplement to Form's LA-04-FL and LA-05-FL

Florida Insurance applicants have the right to name a secondary addressee for the purpose of notification of past due premium and Possible lapse in insurance coverage.

Secondary Addressee:

Name:____

Address: ____

____

____

I choose not to name a secondary addressee

Applicant Signature:____ Date:______________________

Agent Signature:____ Agent #:______________________

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION PURSUANT TO HIPAA

____ ______________________

Name of Proposed Insured/Patient *(please print)* Date of Birth

I, ____ , authorize ____

Name of Physician and/or Medical Facility

and any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past seven (7) years (My Providers) to disclose my entire medical record, prescription history, medications prescribed, and any other protected health information concerning me. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

This information should be released to:

THE NATIONAL SLOVAK SOCIETY OF THE USA (NSS LIFE)
351 VALLEY BROOK ROAD
MCMURRAY, PA 15317

Requested Service Dates: From: ____________________ to ____________________

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so The National Slovak Society of the USA (NSS Life) may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with NSS Life.

This authorization shall remain in force for 36 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to receive a copy of this authorization. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to the entity identified above. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that NSS Life, has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand I have the right to inspect or copy the health Information to be used or disclosed by this Authorization. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be re-disclosed by (the recipient) except as authorized by me or as required by law.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, NSS Life, may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I agree that a photo static copy of this authorization shall be considered as effective and valid as the original.

____ ______________________

Signature of Proposed Insured/Patient or Personal Representative Date

____

Description of Personal Representative's Authority or Relationship to Patient

APPLICATION FOR NEW MEMBERS

New Member's Full Name: ____
(Please Print Clearly)

Male Female

Address: ____

____

Email Address: ____

Social Security #: ______________________

Date of Birth: ______________________

Home Phone #: ______________________

Work Phone #: ______________________

Dated at: ______________________ On: ______________________

Applicant's Signature: ____

Home Office Use

______________________ National President

______________________ Certificate Number

______________________ National Secretary-Treasurer

______________________ Assembly / Circle Number

______________________ Date Accepted

Form **W-9** (Rev. August 2013) Department of the Treasury Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:

☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ ________

☐ Other (see instructions) ▶

Exemptions (see instructions):

Exempt payee code (if any) ________

Exemption from FATCA reporting code (if any) ________

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

☐☐☐ – ☐☐ – ☐☐☐☐

Employer identification number

☐☐ – ☐☐☐☐☐☐☐

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below), and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here **Signature of U.S. person** ▶ **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. The IRS has created a page on IRS.gov for information about Form W-9, at *www.irs.gov/w9*. Information about any future developments affecting Form W-9 (such as legislation enacted after we release it) will be posted on that page.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, payments made to you in settlement of payment card and third party network transactions, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and

4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct.

Note. If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.