

National Slovak Society Of the United States of America

A Fraternal Benefit Society

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



NSS Life
Family Matters...

For Home Office Use:

Assembly/Circle # _____

Certificate #: _____

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 | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Trust Name _____ Trust Dated _____ as amended | <input type="checkbox"/> | <input type="checkbox"/> |

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 _____
\$ _____	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): _____

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, prostate 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? (If Yes, indicate anticipated date of delivery) Yes No
- 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:

Pennsylvania: Any person who knowing and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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.

New Jersey: Any person who includes any false or misleading information on an application for any insurance policy is subject to criminal and civil penalties.

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

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.

Notice to Proposed Insured:

I understand that information regarding insurability will be treated as confidential. NSS 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 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.

AUTHORIZATION:

I authorize NSS, 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, or its representatives, including Equifax or bearer, or reinsurer, any such information. NSS 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: _____ 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

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.

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

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: <input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____ <input type="checkbox"/> 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.

Social security number									

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

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 ▶
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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.