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 #** (_____) _____ – _____

☐ If Payor of insurance is other than the Owner, complete the following information:

Full Name _____ **Relationship** _____

Address _____ **Phone #** (_____) _____ – _____

City _____ **State** _____ **Zip Code** _____

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** _____

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

Do you have an existing Life Insurance or Annuity Certificate? ☐ Yes ☐ No

If *Yes*, is it intended to replace the existing policies? ☐ Yes ☐ No (If *Yes*, complete the replacement of Life Insurance and Annuities Form)

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
If *Yes*, please explain: _____

_____

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:

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.

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 15 or older)

_____ Owner, if other than Proposed insured

_____ Witness (Licensed Agent and Number where required)

_____ Adult (Parent or Guardian) 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.

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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

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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

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NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE AND ANNUITIES – EXTERNAL

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements. Please read it carefully.

Whether it is to your advantage to replace your existing insurance or annuity coverage, can only be decided by you. It is in your best interest; however, to have adequate information before a decision to replace your present coverage becomes final so that you may understand the essential features of the proposed policy and your existing insurance or annuity coverage.

You may want to contact your existing life insurance, or annuity company, or its agent for additional information, or discuss your purchase with other advisors. Your existing company will provide this information to you. The information you receive should be of value to you in reaching a final decision.

If either the proposed coverage or the existing coverage you intend to replace is a dividend paying plan; you should be aware that dividends may materially reduce the cost of insurance and are an important factor to consider. Dividends, however, are not guaranteed.

You should recognize that a policy which has been in existence for a period of time may have certain advantages to you over a new policy. If the policy coverage's are basically similar, the premiums for a new policy may be higher because rates increase as your age increases. Under your existing policy, the period of time during which the issuing company could deny coverage for death caused by suicide may have expired, or may expire earlier than it will under the proposed policy. Your existing policy may have options which are not available under the policy being proposed to you, or may not come into effect under the proposed policy until a later time during your life. Also, your proposed policy's cash values and dividends, if any, may grow slower initially because the company will incur the cost of issuing your new policy. On the other hand, the proposed policy may offer advantages which are more important to you.

If you are considering borrowing against your existing policy to pay the premiums on the proposed policy, you should understand that in the event of your death, the amount of any unpaid loan, including interest, will be deducted from the benefits of your existing policy thereby reducing your total insurance coverage.

After we have issued your policy, you will have 30 days from the date the new policy is received by you to notify us you are cancelling the policy issued on your application and you will receive back all payments you made to us.

You are urged not to take action to terminate, or alter your existing life insurance, or annuity coverage until you have been issued the new policy, examined it and found it acceptable to you.

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:
- Are they affordable?
- Could they change?
- You're older—are premiums higher for the proposed new policy?
- How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:
- New policies usually take longer to build cash values and to pay dividends.
- Acquisition costs for the old policy may have been paid, you will incur costs for the new one.
- What surrender charges do the policies have?
- What expense and sales charges will you pay on the new policy?
- Does the new policy provide more insurance coverage?

INSURABILITY:
- If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
- You may need a medical exam for a new policy.
- Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
- Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

- How are premiums for both policies being paid?
- How will the premiums on your existing policy be affected?
- Will a loan be deducted from death benefits?
- What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

- Will you pay surrender charges on your old contract?
- What are the interest rate guarantees for the new contract?
- Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

- What are the tax consequences of buying the new policy?
- Is this a tax free exchange? (See your tax advisor.)
- Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
- Will the existing insurer be willing to modify the old policy?
- How does the quality and financial stability of the new company compare with your existing company?

1) Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ☐ No ☐ Yes

2) Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ☐ No ☐ Yes

3) If you answered *Yes* to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

Full Name of Insurance Company And Home Office Address:	Policy or Contract Number(s):	Insured Name(s):	Replaced (R) or Financing (F)

4) The existing policy or contract is being replaced because: _____

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

I certify that the responses herein are, to the best of my knowledge, accurate:

_____ _____
Applicant Signature Date

_____ _____ _____
Agent Signature Date Agent Number

I do not want this notice read aloud to me. _____ (Applicants must initial only if they do not want the notice read aloud.)

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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
jhdvgjhgfm

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.