NSS Life
Family Matters...

NATIONAL SLOVAK SOCIETY OF THE UNITED STATES OF AMERICA

A Fraternal Benefit Society

Application for Life Insurance

Assembly/Circle #: _____ Certificate #: _____

1. Proposed Insured: ☐ Male ☐ Female Height _____ Weight _____

Full Name: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security #: _____ Occupation: _____

Is the applicant a member of the National Slovak Society? ☐ Yes ☐ No If not, applying for membership.

2. Owner: (Complete only if Owner is other than Proposed Insured)

Full Name: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security #: _____ Relationship: _____

3. Plan: _____ Code: _____ Face Amount: $ _____ Payment: $ _____

Riders: ☐ Accidental Death Benefit; Amount: $ _____ ☐ Waiver of Premium

☐ Term, Plan: _____ Benefit Amount: $ _____ ☐ Other: _____

Premium Mode: ☐ Single ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

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

Will the insurance applied for replace or change any existing insurance or annuity? ☐ No ☐ Yes If Yes, Show the name of Company and Policy Number(s): _____

4. Beneficiary:

Full Name: _____ Date of Birth: _____

Address: _____

Social Security #: _____ Relationship: _____ Share: _____

Full Name: _____ Date of Birth: _____

Address: _____

Social Security #: _____ Relationship: _____ Share: _____

Contingent:

Full Name: _____ Date of Birth: _____

Social Security #: _____ Relationship: _____ Share: _____

5. In the past 2 Years, has the Proposed Insured:

	Yes	No
a. used tobacco in any form?	☐	☐
b. flown as the pilot or crew member of any form of aircraft, or intend to do so?	☐	☐
c. had any license to drive suspended or revoked?	☐	☐

Detail any *Yes* answer: _____

6. Health Questions:

a. In the past 5 years, has the Proposed Insured: received diagnosis or treatment from a physician; or, been confined in a medical care facility, for: (Circle any applicable condition)

(1) cancer, tumor or malignancy; diabetes; heart or circulatory disease or disorder; high blood pressure; kidney or genito-urinary disease or disorder; lung or respiratory disease or disorder; epilepsy or mental or nervous disease or disorder; stroke; use of alcohol or non-prescription drugs; any disease or disorder of the stomach, intestines, gall bladder, liver or rectum? ☐ No ☐ Yes

(2) any deformity or disease or disorder not listed above or any surgical operation scheduled or contemplated? ☐ No ☐ Yes

b. 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)? ☐ No ☐ Yes

c. Details, any *Yes* answer, a. or b., above. Show: condition; dates; and name(s) and address(es) of physician(s) and medical care facilities.

_____

_____

_____

(If additional space is needed, use a separate sheet, dated and signed.)

7. 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.

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 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

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.

NSS Life®
® Family Matters...

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

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.