

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 Wei	ight					
Full Name:			Phone Number:					
Address:		City:	Stat	e: Zip:				
Date of Birth:	Social Security #:	Occupation:						
Is the applicant a member	of the National Slovak Society? [☐ Yes ☐ No If not, applying f	or membership.					
2. Owner: (Complete onl	2. Owner: (Complete only if Owner is other than Proposed Insured)							
Full Name:		Phone	Number:					
Address:		City:	Stat	e: Zip:				
Social Security #:	Relationship	:						
3. Plan:	Code:	Face Amount: \$	Pay	ment: \$				
Riders: Accidental De	ath Benefit; Amount: \$	Waiver of Premium	1					
☐ Term, Plan: _	Benefit A	mount: \$	☐ Other:					
Premium Mode: Sin	gle 🗆 Annual 🗆 Semi-Annual	☐ Quarterly ☐ Monthly						
Dividend Election: C	Cash 🗆 Reduce Premium 🗆 A	ccumulate at Interest	Up Additions					
Will the insurance applied	for replace or change any existing ir	nsurance or annuity? No	Yes If Yes, Show the nan	ne of				
Company and Policy Num	ber(s):							
4. Beneficiary: Full Name:			Date of Birth	·				
			Sh	are.				
•	Relationship: Da			ate of Birth:				
Address:								
	Re	lationship:	Sh	are:				
Contingent:		•						
=			Date of Birth	i:				
Social Security #:	Re	lationship:	Sh	are:				
5. In the past 2 Years, ha	s the Proposed Insured:			<u>Yes</u> <u>No</u>				
a. used tobacco in an	y form?							
b. flown as the pilot or	crew member of any form of aircraf	t, or intend to do so?						
c. had any license to	drive suspended or revoked?							
Detail any Yes answer: _								

	Page
6. Health Questions:	
 a. In the past 5 years, has the Proposed Insured: received diagnosis or trea (Circle any applicable condition) 	atment from a physician; or, been confined in a medical care facility, for:
 (1) cancer, tumor or malignancy; diabetes; heart or circulatory disea disorder; lung or respiratory disease or disorder; epilepsy or men prescription drugs; any disease or disorder of the stomach, intest (2) any deformity or disease or disorder not listed above or any surg 	tines, gall bladder, liver or rectum? No Yes
b. Has member of the medical profession ever diagnosed any person to be Immune Deficiency Syndrome) or ARC (Aids Related Complex)?	e covered as having, or treated any applicant for AIDS (Acquired ☐ No ☐ Yes
c. Details, any Yes answer, a. or b., above. Show: condition; dates; and na	ime(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 instantament of claim containing any materially false information or conceals for thereto commits a fraudulent insurance act, which is a crime and subjects such	r the purpose of misleading, information concerning any fact material
Florida: Any person who knowingly and with intent to injure, defraud or dece any false, incomplete, or misleading information is guilty of a felony of the third	
New Jersey: Any person who includes any false or misleading information on an a	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 a false or deceptive statement is guilty of insurance fraud.	fraud against an insurer, submits application or files a claim containing
Each person signing this application; (1) REPRESENTS that, to the best of su herein are complete, true and accurately recorded; (2) AGREES that this application; and (3) UNDERSTANDS that no agent or person other than the Pres waive any of the printed statements herein; or (b) waive any of the rights or requ	plication shall be the basis for and part of any life insurance certificate ident or Secretary of the Society may, in writing: (a) change, modify or
Except as may be provided in a Conditional Receipt, bearing the same dateffect unless and until: (1) this application is approved by the National Skinsurance is issued; and (3) the full first premium is paid. All such condinsurability of the Proposed Insured remain as described in this application	ovak Society of the United States of America; (2) a certificate of life itions must be met while the health and other factors affecting the
AUTHORIZATION. The undersigned hereby authorize any of the following who physician or medical practitioner; medical care facility; the Medical Information provide such records or information to: the National Slovak Society of the Unite. The National Slovak Society of America or its reinsurer may release any such re Insured may have insurance or to whom the Proposed Insured may apply for required. Any records or information obtained will: be treated as confidential; and	Bureau (MIB); insurer; employer; institution; organization; or, person, to d of America its reinsurer; or, except for the MIB, its legal representative. ecords or information: to the MIB; to other insurers in which the Proposed insurance or to whom a claim may be submitted; or, as may be lawfully
On request, the National Slovak Society of the United States of America will preperiod of 24 months from the date shown below. This authorization may be revibe 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?

 $\ \square$ Yes If Yes, any replacement regulations must be complied with.

☐ No

FORM # LA-05 002 G - 05/01/2011



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION PURSUANT TO HIPAA

Name of Propos	ed Insured/Patient (please print)	Date of Birth
I.	, authorize	
,		Name of Physician and/or Medical Facility
health care provider that has provided pays my entire medical record, prescription histo information on the diagnosis or treatment of	ment, treatment or services to me or on my behalf ory, medications prescribed, and any other protect	cy or pharmacy benefit manager, medical facility, or other f within the past seven (7) years (My Providers) to disclose ted health information concerning me. This includes and sexually transmitted diseases. This also includes nd 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	
		ected health information do not apply to this authorization er health care provider to release and disclose my entire
my application for coverage, make eligibilit	y, risk rating, policy issuance and enrollment dete ge and provision of benefits; 4) administer covera	Slovak Society of the USA (NSS Life) may: 1) underwrite rminations; 2) obtain reinsurance; 3) administer claims and ge; and 5) conduct other legally permissible activities that
original. I understand that I have the right t at any time, by providing written notification Providers has relied on this Authorization of policy itself. I understand I have the right to information that is disclosed pursuant to th	o receive a copy of this authorization. I understand to the entity identified above. I understand that a or to the extent that NSS Life, has a legal right to conspect or copy the health Information to be used	ow, and a copy of this authorization is as valid as the and that I have the right to revoke this authorization in writing a revocation is not effective to the extent that any of My contest a claim under an insurance policy or to contest the d or disclosed by this Authorization. I understand that any les governing privacy and confidentiality of health is required by law.
understand that if I refuse to sign this author	orization to release my complete medical record, N	are services if I refuse to sign this authorization. I further NSS Life, may not be able to process my application, or if oto static copy of this authorization shall be considered as
Signature of Proposed Insured/Patient or F	Personal Representative	Date
	uuthority or Polationship to Patient	



Request for Taxpayer Identification Number and Certification

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

	Nam	e (as shown on your income tax return)									
Je 2.	Busi	ess name/disregarded entity name, if different from above									
on page	1 —	Check appropriate box for federal tax classification: Individual/sole proprietor C Corporation S Corporation Partnership Trust/estate				Exemptions (see instructions):					
oe ons	_					Exempt payee code (if any)					
Print or type		☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶				Exemption from FATCA reporting code (if any)					
rin Ins	$ \Box$	Other (ace instructions)			ľ	000 (11 0	,				
_ ப்	Add	Under (see instructions) ► Address (number, street, and apt. or suite no.) Requester's name a				and address (optional)					
ēĊ	/ 100	Address (number, street, and apt. or suite no.)				addioo	o (opt	ioriai,			
Print or type See Specific Instructions on	City	state, and ZIP code									
	List	ccount number(s) here (optional)									
Pai	43	Taxpayer Identification Number (TIN)									
		IN in the appropriate box. The TIN provided must match the name given on the "Name"	line S	ocial s	secur	ity num	ber				
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 <i>How to get a</i>			a =			-		-[
TIN on page 3.			mployer identification number								
Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.			Прісу	1 [T 1	T	<u> </u>		\dashv	
				-							
Par	t II	Certification									
Unde	r pena	ties of perjury, I certify that:									
1. Th	e nun	ber shown on this form is my correct taxpayer identification number (or I am waiting for	a number	to be	issu	ed to n	ne), a	nd			
Se	rvice	subject to backup withholding because: (a) I am exempt from backup withholding, or (b) IRS) that I am subject to backup withholding as a result of a failure to report all interest or subject to backup withholding, and									
3. I a	m a l	S. citizen or other U.S. person (defined below), and									
4. The	e FAT	CA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting	g is correc	t.							
becau intere gener instru	use yo st pai ally, p ctions	n instructions. You must cross out item 2 above if you have been notified by the IRS the have failed to report all interest and dividends on your tax return. For real estate transation, acquisition or abandonment of secured property, cancellation of debt, contributions to ayments other than interest and dividends, you are not required to sign the certification, on page 3.	actions, ite an individ	m 2 c	does etirer	not ap nent ar	oly. F	or m	ortg 1t (IF	age RA), aı	nd
Sign Here		Signature of U.S. person ► Da	te ▶								

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.