National Slovak Society
Of the United States of America

A Fraternal Benefit Society

1301 Ashwood Drive
Canonsburg, PA 15317-4988
Phone (800) 488-1890 • (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 _____ **Address** _____

Social Security # _____ **Relationship** _____ **Phone #** _____ **Share** _____

Full Name _____ **Address** _____

Social Security # _____ **Relationship** _____ **Phone #** _____ **Share** _____

Contingent:

Full Name _____ **Address** _____

Social Security # _____ **Relationship** _____ **Phone #** _____ **Share** _____

Full Name _____ **Address** _____

Social Security # _____ **Relationship** _____ **Phone #** _____ **Share** _____

Trust as Beneficiary: (Complete Verification 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 (If Applicable)? ☐ 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): _____

_____

_____

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 a regularly scheduled flight, does any person to be covered intend to fly within the next two years 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, or rock climbing? ☐ Yes ☐ No

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

_____

_____

3) Driving Information:

a) Driver's License:

Proposed Insured's # _____ State _____ Proposed Insured's # _____ State _____

b) Has any Proposed Insured been convicted with any moving violation or accident at fault within the last 5 years? ☐ Yes ☐ No

4) Other Insurance:

a) Does any person to be covered have an existing life insurance or annuity contracts with the company or any other company? ☐ Yes ☐ No

b) 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

c) 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

d) 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 five years**, has any person to be covered been examined or prescribed medication by a physician or a member of the medical profession? ☐ 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 medical treatment or counseling, been treated for or received counseling, or joined a support group for the use of alcohol? ☐ Yes ☐ No

4) Has any person to be covered **ever** been diagnosed by a member of the of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS Virus) or Acquired Immune Deficiency Syndrome (AIDS) ☐ 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 convicted for drug use or pled guilty to charges of 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?
(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 or treated by a member of the medical profession 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 # _____

Fraud Warning:

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

AGREEMENT - AUTHORIZATION - ACKNOWLEDGEMENT – National Slovak Society of the United States of America

This authorization complies with the HIPAA Privacy Rule.

I understand I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Life Underwriting Department of National Slovak Society of the United States of America.

I, the Primary Proposed Insured (and any Spouse or Owner signing below), by my signature set forth hereafter: **AGREE** to the following:

a) All Statements and answers in this application are complete and true to the best of my knowledge and belief.

b) Except as stated in the Conditional Receipt, no insurance will take effect unless the first full premium is paid and a policy is delivered while the health of any proposed insured continues, without material change, to be as represented in this application.

c) No agent has authority to waive any answer or otherwise modify this application or to bind National Slovak Society of the United States of America, hereinafter called "Company", in any way by making any promise or representation which is not set out in writing in this application.

d) $_____ has been deposited toward payment of the first premium on the policy applied for. The terms of the Conditional Receipt received for that premium deposit are accepted.

AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, pharmacy benefits manager, insurance support organization, pharmacy/government agency, insurance or reinsuring company, MIB, Inc. ("MIB"), consumer reporting agency, or any other organization, institution or person to give to the Company or its reinsurer(s) all information it holds that pertains to medical consultations, treatments, surgeries, and hospital confinements which relate to the physical and mental condition of myself or my minor children. This authorization also includes information about drugs or alcoholism or any other non-health (non-medical) history information. I understand that such information will be used to determine eligibility for insurance, or for benefits under existing insurance. I further authorize the Company, or its reinsurers, to release any information including my personal health information obtained to reinsuring companies, MIB, or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required or as I may further authorize. As to this authorization, I agree that a photographic copy will be as valid as the original and that it will be valid for the maximum length of time permitted by applicable law in the state where the policy/certificate is delivered or issued for delivery. I know that I or my representative may request a copy of this authorization.

It is understood that National Slovak Society of the United States of America underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may re-disclose it resulting in loss of protection by federal regulations. I understand that there are limitations on my right to revoke this authorization. Any action taken in reliance on this authorization will be valid if such action has been taken prior to receipt of notice of revocation. If this authorization is used to collect information in connection with a claim for benefits, it will be valid for the duration of the claim. If the law of my state so provides, my authorization may not be revoked during a contestable investigation. I also understand that my revocation of this authorization will not result in the deletion of codes in the MIB database if such codes are reported by the Company, or its reinsurer, (or the Company, or its reinsurers, becomes obligated to report such codes to MIB) while this authorization is in force. I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain life insurance coverage.

ACKNOWLEDGE receipt of the following notices:

a) "Notice of Information Practices" required by Public Law 91-508 and other information practices statutes, and

b) MIB Pre-Notice.

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.

This Notice must be given to Proposed Insured

In making this application for insurance it is understood that an investigative report may be made whereby information is obtained through personal interviews with third parties, such as family members, business associates, financial sources, friends, neighbors, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living, whichever may be applicable. You have the right to make a written request within a reasonable period of time for a complete accurate disclosure of additional information concerning the nature and scope of the investigation.

NOTIFICATION REGARDING MIB, Inc. ("MIB")

Information regarding your insurability will be treated as confidential. National Slovak Society of the United States of America, or its Reinsurer(s) may, however, make a brief report thereon to the MIB, a non-for profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you 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 in its file. Upon receipt of a request from you, MIB will arrange disclosure of and information it may have in your file by calling (866) 692-6901 or you can go to their website www.mib.com. If you question the accuracy of information in 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 is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184.

National Slovak Society of the United States of America, or its Reinsurer(s), may also release information in its files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

NSS Life®
® Family Matters...

CONDITIONAL RECEIPT

THIS RECEIPT DOES NOT PROVIDE INSURANCE UNTIL ITS CONDITIONS ARE MET.

Received from _____ in connection with an application on the life of

_____, the sum of $_____.

Agent: _____ Date: _____

Provided the following conditions are met, exactly, the insurance applied for will be effective on the later of: (1) The date of the application; or (2) The last date of any initially required test(s) or examination(s).

1. Proposed Insured is found to be a standard risk for the amount and plan applied for in accordance with our underwriting rules then in effect.
2. The amount paid is sufficient to pay the first mode premium for the amount and plan applied for including any Riders.
3. The amount paid is good and collectible.

Maximum Amount: The maximum amount of insurance which may become effective under this Conditional Receipt is $50,000. The maximum amount shall include: (1) any accidental death benefits applied for, and (2) any other pending application for the Proposed Insured.

MAKE ALL PAYMENTS TO THE *NATIONAL SLOVAK SOCIETY (NSS LIFE)*.

DO NOT MAKE PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

Please contact the Society if, within 60 days after the date of this Conditional Receipt, you have not received the Life Insurance Certificate applied for or a refund of the amount paid. Please include the Amount paid, the Date of the payment and the Name of the Agent receiving the payment.

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)
1301 ASHWOOD DRIVE
CANONSBURG, 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

NSS Life®
® Family Matters...

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.)

NSS Life
Family Matters...

BANK DRAFT AUTHORIZATION

By signing below, I am authorizing the National Slovak Society of the USA (NSS Life) to draft the amount indicated directly from my bank account. I understand that receipt of funds by NSS Life does not indicate an immediate issuance of a policy contract. All applications are subject to review and/or underwriting guidelines prior to issuance.

PLEASE CALL 724-731-0094 OR 1-800-488-1890 IF YOU HAVE ANY QUESTIONS

Initial Premium Payment:

Certificate #: _____

I, _____ , authorize the National Slovak Society to withdraw $_____

from my Bank Account indicated: ☐ Checking ☐ Savings

Routing # _____ Account # _____

Print Name as listed on bank account: _____

Address: _____

_____

Phone # _____ Email Address: _____

Authorized Signature:_____ Date: _____

Recurring Premium Payments:

By completing this section, I am also authorizing the National Slovak Society of the USA (NSS Life) to draft future amounts, as indicated below, directly from my bank account as indicated in the section above. I understand the bank draft will continue, as directed, on the date and frequency selected, and in the amount indicated, until NSS Life receives written notice to stop the bank draft.

Amount to withdraw: $_____ Beginning Effective Date: _____

Preferred Day of Withdrawal: ☐ 5th ☐ 15th ☐ 20th ☐ Other _____

Frequency:

☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

NSS Life®
® *Family Matters...*

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. March 2024)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Go to *www.irs.gov/FormW9* for instructions and the latest information.

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

Before you begin. For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

Print or type. See ***Specific Instructions*** on page 3.

1 Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)

2 Business name/disregarded entity name, if different from above.

3a Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only **one** of the following seven boxes.

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

☐ LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) . . . . .

Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner.

☐ Other (see instructions)

3b If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions . . . . . ☐

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any)

Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any)

(Applies to accounts maintained outside the United States.)

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

6 City, state, and ZIP code

Requester's name and address (optional)

National Slovak Society of the USA
1301 Ashwood Drive
Canonsburg, PA 15317-4988

7 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 line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. See also *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–		–				

or

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 for Part II, later.

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

General Instructions

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

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3. See the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they