



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:

	<u>Yes</u>	<u>No</u>
a. used tobacco in any form?	<input type="checkbox"/>	<input type="checkbox"/>
b. flown as the pilot or crew member of any form of aircraft, or intend to do so?	<input type="checkbox"/>	<input type="checkbox"/>
c. had any license to drive suspended or revoked?	<input type="checkbox"/>	<input type="checkbox"/>

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?
 No Yes (If Yes, circle any applicable condition; provide details in item C below.)
 - (1) cancer, tumor or malignancy; diabetes; heart or circulatory disease or disorder; high blood pressure; kidney or genitourinary disease or disorder; lung or respiratory disease or disorder; epilepsy; mental or nervous disease or disorder; stroke; use of alcohol or non-prescription drugs; any disease or disorder of the stomach, intestines, gallbladder, liver; or rectum? No Yes
 - (2) any deformity; disease or disorder not listed above or any surgical operation scheduled or contemplated? No Yes
- b. Has a 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)? [Please note this question is not referring to, or asking any information about, HIV status.] No Yes
- c. Details; Any Yes answer in question a. or b. above. Show: condition; dates; name(s) and address(es) of physician(s) and medical care facilities:

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

d. Family Doctor Name: _____

Address: _____ Phone # _____

7. Fraud Warning:

Any person who knowingly 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.

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 authorizes any of the following, who may have any records or information regarding the Proposed Insured (except for HIV test information): 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 and its reinsurer; or, except for the MIB, its legal representative. The National Slovak Society of the United States of America or its reinsurer may release any such records or information: to the MIB; 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.

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.

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

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:

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

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.)



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

