

Disability Insurance Claim for Children

Use this form to file a premium waiver/disability waiver claim on your Life insurance contract. Please complete it after four/six consecutive months of total disability.

Total disability exists when a child is at least age five and, due to accidental bodily injury or disease, is unable to attend a regular school or a special education facility. Under some contracts the disability must begin after age five. Please refer to the contract for specific requirements.

Instructions - Page 1

Read and follow the instructions listed below for each portion of the disability claim form.

Claimant's Disability Statement - Pages 2, 3 and 4

Answer questions 1-7 on the Claimant's Statement.

If a question does not apply, write "NA."

Be sure to sign and date the Claimant's Statement on page 3 and the authorization on page 4.

Attending Physician's Statement - Page 5 and 6

Complete, sign and date Section 1 of the Attending Physician's Statement; then have your doctor complete Section 2. Any charge made by the doctor to complete this form is not reimbursed by Thrivent Financial. Your doctor should mail the completed statement to Thrivent Financial.

Mail the completed form to:
Life Waiver Claims
Thrivent Financial for Lutherans
4321 N. Ballard Road
Appleton, WI 54919-0001

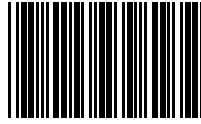
or fax it to us at 1-800-225-2264

Properly completed forms will help avoid unnecessary delays.

If you have any questions, call 800-847-4836.

Claimant's Statement

Check box if address is changed



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For your protection, state laws require the following to appear on this form: Any person who knowingly and with intent to defraud or deceive any insurance company or other person, files or facilitates the filing of a statement of claim containing any materially false information, or conceals information concerning any fact material to the statement is guilty of insurance fraud, which may be a felony crime, subject to civil penalties or criminal prosecution, including substantial fines and/or confinement in prison.

1. Name of child		Birthdate		Phone
Address	City	State	ZIP code	Contract number(s)

2a. Give nature and details of sickness or injury.	Date symptoms began or injury occurred
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b. Name, address and phone number of doctor first seen and dates treated

Name		Phone	
Address	City	State	ZIP code
Dates treated			

3. If treated for this sickness or injury by anyone other than doctor completing this form, give name(s), address(es), phone number(s) and date(s) of treatment. Attach a separate sheet of paper if necessary.

Name		Phone	
Address	City	State	ZIP code
Dates treated			

Name		Phone	
Address	City	State	ZIP code
Dates treated			

4. If hospitalized, name, address and phone number of hospitals, including birth hospital

Name		Phone	
Address	City	State	ZIP code
Date admitted (mm/dd/yyyy)		Date discharged (mm/dd/yyyy)	
Name		Phone	
Address	City	State	ZIP code
Date admitted (mm/dd/yyyy)		Date discharged (mm/dd/yyyy)	

5. If child attends or has attended a special and/or regular school, complete the following:

Name of special school		Phone	
Address of special school	City	State	ZIP code
Type of program	Hours per day	Dates attended	
Name of regular school		Phone	
Address of regular school	City	State	ZIP code
Type of program	Hours per day	Dates attended	

6. Indicate month, day and year child was unable to attend school outside of the home: From _____ to _____

The claimant must sign and date this form. Failing to sign or altering the authorization may limit Thrivent Financial's ability to review your claim or pay claim benefits.

I certify that, to the best of my knowledge, the answers I have given to each of the above questions are complete and accurate.

Signature of claimant (otherwise parent or authorized representative)	Date
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Relationship, if other than claimant



4321 N. Ballard Road, Appleton, WI 54919-0001
800-THRIVENT (800-847-4836) • www.thrivent.com

Health and Other Personal Information Authorization

(This authorization complies with the HIPAA Privacy Rule.)

Name (print title, first, middle, last name and suffix, as applicable)

Date of birth (mm/dd/yyyy)

Contract number

This authorization applies to Thrivent Financial for Lutherans, Thrivent Life Insurance Company and Field Agents' Brokerage Company, their employees, representatives, agents, reinsurers and any other persons performing business, legal, medical or insurance services for them or on their behalf, hereafter called "You" or "Your."

For the purpose of determining my eligibility for insurance, You may need to obtain, use or disclose any and all information about my physical and mental health, including but not limited to services for preventive, diagnostic and therapeutic care, tests, counseling and medical prescriptions; and non-health information about me including but not limited to financial, insurance, credit, occupational, avocational and driving history.

I authorize any health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearinghouse, other insurer, insurance broker, Your affiliate, health care component of Your company, Department of Motor Vehicles, consumer reporting agency, Medical Information Bureau (MIB), employer, family member and acquaintance to provide information about me, including my entire medical record, to You. **By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.**

I authorize You to disclose information about me to any insurance broker and other insurer approved by You for the purpose of securing insurance for me. Information about my health may be released as required or permitted by law such as to the Medical Information Bureau (MIB) in an effort to deter fraud, misrepresentation or criminal activity. Health information about me, which is used or disclosed pursuant to this authorization, may be subject to redisclosure by the recipient, and may no longer be protected under federal law.

This authorization is valid for 24 months following the date of my signature shown below. A copy, image or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing as outlined in the Privacy of Information about Your Health notice. I acknowledge that such a revocation is not effective to the extent You have relied on the use or disclosure of my health information or You have a legal right to contest the insurance contract or a claim under the insurance contract.

I understand that the application which holds personally identifiable health information and financial information will be attached to the contract for purposes of contract issuance. I understand that if this contract is owned by someone other than me a copy of the contract which contains the application will be provided to the owner.

I understand You may not be able to determine my eligibility for insurance if I do not agree to the terms of this authorization. I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below.

I am entitled to receive a copy of this authorization.

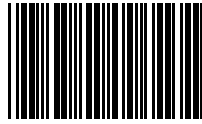
Signature of proposed insured or personal representative

Date signed (mm/dd/yyyy)

Description of personal representative's authority to act



4321 N. Ballard Road, Appleton, WI 54919-0001



Attending Physician's Statement

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or fax to 1-800-225-2264

Any cost for completion of the claim form is the responsibility of the patient.

Section 1 - To be Completed and Signed by the Patient

Name Contract number

I hereby authorize my physician to release any information acquired in the course of my examination(s) or treatment.

Signature of parent or guardian Date Date of birth

Section 2 - To be Completed and Signed by the Attending Physician

1. History

- A. Date symptoms first appeared or date accident happened
B. If patient has ever had same or similar conditions, state when and describe.

C. Name, address and phone number of physician who referred patient to you.

Name Phone
Address City State ZIP code

D. If hospitalized, give dates of confinement. Admitted Discharged

Name of hospital Phone
Address of hospital City State ZIP code

2. Diagnosis and Treatment

- A. Primary ICD-9 Diagnosis
Secondary ICD-9 Diagnosis

B. Objective findings (include results of x-rays, ECG's, laboratory data and any clinical findings).

C. Nature of treatment (include surgery, physical therapy and medication prescribed, if any).

D. What are the patient's present limitations?

3. Dates of Treatment	Date of first visit (mm/dd/yyyy)	Date of last visit (mm/dd/yyyy)	Date of next visit (mm/dd/yyyy)	Frequency of visits:
				<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other (specify)

4. Extent of Disability

How long was or will child be totally disabled from attending school outside the home?

From _____ to _____
(mm/dd/yyyy) (mm/dd/yyyy)

5. Remarks

Name of attending physician, degree (please print)			Phone
Street address			Tax ID number
City	State	ZIP code	Fax number
Signature of physician			Date