Thrivent Financial for Lutherans®

800-THRIVENT (800-847-4836) • www.thrivent.com

Life Premium Waiver/Disability Waiver Claim

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

Do not use this form if your **only** claim is for Disability Income Insurance contract, or both Life Premium Waiver/Disability Waiver and Disability Income insurance. Instead, complete the Disability Income Insurance Claim. Contact Thrivent Financial for Lutherans if you need this form.

Instructions - Page 1

Read and follow the instructions listed below for each portion of the Life Premium Waiver/Disability Waiver Claim form.

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

Answer questions 1-14 on the Claimant's Disability Statement.
If a question does not apply, write "NA."
Be sure to sign and date the Claimant's Disability Statement on page 3 and the authorization on page 4.

Attending Physician's Statement - Pages 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 54912-8075

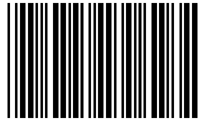
or fax it to us at 1-800-225-2264

Properly completed forms will help avoid unnecessary delays.

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

Claimant's Disability 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, may be 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 | Birthdate | Phone

Address | City | State | ZIP code | Contract number(s)

2. What date did sickness or accident occur? | Give nature of sickness or describe how and what injury occurred.

3. Date medically unable to perform regular occupation beginning (mm/dd/yyyy)

4. Date able to return to regular occupation, part time, beginning (mm/dd/yyyy)

5. Date able to return to regular occupation, full time, beginning (mm/dd/yyyy)

6. Name, address, and phone number of employer when disability began. I was ☐ employed ☐ self-employed ☐ a homemaker ☐ unemployed ☐ retired when disability began.

Name | Phone | Date last worked

Address | City | State | ZIP code

7. Occupational title | Avg hrs/week | Years in occupation

8. Occupational description - List the primary duties/responsibilities required in the occupation you were performing before your disability began. Please attach a copy of your job description, if available. If homemaker, unemployed or retired, list daily activities before disability began.	Hours spent each week

9. Date able to perform another occupation ☐ part time, ☐ full time from ____________ (mm/dd/yyyy) to ____________ (mm/dd/yyyy).

List duties performed, and name, address and phone number of employer.

Duties performed

Name | Phone

Address | City | State | ZIP code

10. Do you have secondary or part-time employment? ☐ Yes. Provide the following. ☐ No

List job duties, and name, address and phone number of employer.

Job duties	Income $
	Hours per week

Dates worked: From - ____________ To - ____________

Name			Phone
Address	City	State	ZIP code

11. Name, address and phone number of your workman's compensation carrier if you applied for benefits.

Name			Phone
Address	City	State	ZIP code

12. Have you applied for or are you receiving the following benefits:

- ☐ Social Security Disability Benefits effective ____________ (mm/dd/yyyy)
- ☐ Social Security Retirement Benefits effective ____________ (mm/dd/yyyy)
- ☐ Workers' Compensation Benefits effective ____________ (mm/dd/yyyy)

13. If treated for this disability 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				
Address			Phone	
City	State	ZIP code	Date of first treatment	Date of last treatment

14. List name(s), address(es), phone number(s) and date(s) of treatment of doctor(s) seen in last five years. Attach a separate sheet of paper if necessary.

Name				
Address			Phone	
City	State	ZIP code	Date of first treatment	Date of last treatment

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	**Date**

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.

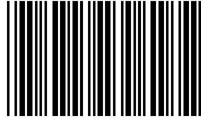
I understand that the application which holds personally identifiable health information and financial information will be attached to the contract for purposes of contract issuance. I understand that if this contract is owned by someone other than me a copy of the contract which contains the application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

Mail completed form to:
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4321 N. Ballard Road
Appleton, WI 54912-8075
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(s)

Occupation and primary work duties

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

Signature of the patient	Date	Date of birth

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

This report assists us in making a disability determination. Your patient is depending on your prompt and detailed information.

1. History

A. Date symptoms first appeared ______________ or date accident happened ______________

B. Is condition work-related? ☐ Yes ☐ No

C. If patient has ever had same or similar conditions, state when and describe.

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

Name			Phone
Address	City	State	ZIP code

E. If hospitalized, give dates of confinement. Admitted ______________ (mm/dd/yyyy) Discharged ______________ (mm/dd/yyyy)

Name of hospital			
Address of hospital	City	State	ZIP code

2. Diagnosis and Treatment

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

B. Treatment (include current and any anticipated surgery and medication prescribed)

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)	Is patient still under your care for this condition? ☐ Yes ☐ No

4. Extent of Disability - Refer to patient's Occupational Description, question 8 on Page 2.*

A. Patient was medically unable to perform regular job from __________ (mm/dd/yyyy) to __________ (mm/dd/yyyy).

If not released to return to work, when will patient be able to return to regular job?

☐ 1-3 mo. ☐ 4-6 mo. ☐ 7-12 mo. ☐ Over 12 mo.

B. Is patient capable of doing other work? ☐ Yes ☐ No Part time __________ (mm/dd/yyyy) Full time __________ (mm/dd/yyyy)

C. Please explain specific restrictions placed on your patient.

* If the patient is unemployed, retired or a homemaker, when was the patient unable to perform the duties of an unemployed, retired person or homemaker? From __________ (mm/dd/yyyy) to __________ (mm/dd/yyyy).

5. Is the patient competent to endorse checks and direct use of the proceeds? ☐ Yes ☐ No

6. Rehab - Do you suggest that the patient become involved in any of the following? Check all that apply.
If so, was this discussed with the patient? ☐ Yes ☐ No

☐ Physical Therapy ☐ Pain Management Program ☐ Vocational Rehabilitation
☐ Occupational Therapy ☐ Work Hardening Program ☐ Psychological Counseling
☐ Cardiac Rehabilitation ☐ Job Modification ☐ Other __________

Attending physician information (please print)

Name of attending physician			Physician's degree	
Physician's speciality	Phone	Fax number	Tax ID number	
Street address	City		State	ZIP code
Signature of physician			Date	