

## Disability Income Insurance Claim

**Use this form to file a claim under your Disability Income Insurance contract.  
Complete it immediately upon disability.**

Use this form when claiming benefits under both Disability Income Insurance and Life Premium Waiver/Disability Waiver. It is not necessary to complete a separate form for each benefit.

Do not use this form if your **only** claim is for Life Premium Waiver/Disability Waiver on a Life contract. Instead, complete the Life Premium Waiver/Disability Waiver Insurance Claim (LF259A).

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### Instructions - Page 1

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

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### Employment Statement - Page 2

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If you are an employee, complete, sign and date Section 1 of the Employment Statement; then have your employer(s) complete Section 2. Your employer should mail the completed statement to Thrivent Financial for Lutherans.

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### Claimant's Disability Statement - Pages 3, 4, 5 and 6

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Answer questions 1-11 on the Claimant's Disability Statement.

Note that question 11 is divided into three sections:

- If you are an employee, complete Section A.
- If you are self-employed, complete Section B.
- If you are a homemaker, unemployed or retired, complete Section C.

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

Be sure to sign and date the Claimant's Disability Statement on page 5 and the authorization on page 6.

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### Attending Physician's Statement - Pages 7 and 8

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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:

Disability Income Claims  
Thrivent Financial for Lutherans  
4321 N. Ballard Road  
Appleton, WI 54912-8075

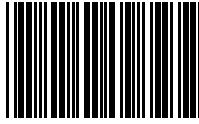
or fax it to us at 1-800-225-2264

Properly completed forms will help avoid unnecessary delays.

If you have any questions, call 1-800-847-4836.

# Employment Statement

Any cost for completion of the Employment Statement is the responsibility of the employee.



Mail completed form to:  
 Disability Income Claims  
 Thrivent Financial for Lutherans  
 4321 N. Ballard Road  
 Appleton, WI 54912-8075  
 or fax to 1-800-225-2264

## Section 1 - To be Completed and Signed by the Employee

Name of employee	Contract number	H
I hereby authorize my employer to release any information acquired in the course of my employment.		
Signature of employee	Date signed	Date of birth

## Section 2 - To be Completed and Signed by the Employer

Date of hire (mm/dd/yyyy)	Last day worked prior to disability (mm/dd/yyyy)	Has our insured returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, on what date (mm/dd/yyyy)? <input type="checkbox"/> Full time <input type="checkbox"/> Part time
Insured has returned to: <input type="checkbox"/> regular occupation <input type="checkbox"/> a different occupation		If our insured has not returned to work, what is the expected return to work date (mm/dd/yyyy)?	Are you holding the job open? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has our insured retired or resigned? <input type="checkbox"/> Yes, effective date <input type="checkbox"/> No		Do you pay any portion of the insured's Thrivent Financial disability insurance premium? <input type="checkbox"/> Yes % <input type="checkbox"/> No	

## Work History and Earnings for the Last Two Years - List Most Current Position First

Job Title	From	To	Avg Hrs Per Wk	Gross Monthly Income	Job Duties/Physical Requirements (Attach Job Description)
				\$	
				\$	
				\$	
				\$	

Other Insurance Coverage	Group Disability	Worker's Compensation
Claim filed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Policy number		
Name of carrier		
Phone number of carrier		
Monthly benefit	\$	\$
Date benefits began (mm/dd/yyyy)		
Effective date of coverage (mm/dd/yyyy)		

Waiting period: accident \_\_\_\_\_ sickness \_\_\_\_\_  
 Maximum period: accident \_\_\_\_\_ sickness \_\_\_\_\_

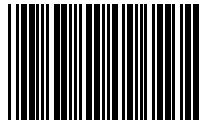
Is our insured receiving salary continuation or sick pay? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, amount \$	Date benefits started (mm/dd/yyyy)	Length of time benefits will continue
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**I swear that the statements and answers given to each of the questions on this form are true and complete to the best of my knowledge.**

Signature	Title	Phone	Date
Print name	Company name	Fax number	

# Claimant's Disability Statement

Check box if address has changed



Mail completed form to:  
 Disability Income Claims  
 Thrivent Financial for Lutherans  
 4321 N. Ballard Road  
 Appleton, WI 54912-8075  
 or fax to 1-800-225-2264

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.

Name		Date of birth	Phone		Contract #(s)
Address		City	State	ZIP code	H _____ H _____ H _____

<b>1. Nature of impairment</b>	<b>Beginning (mm/dd/yyyy)</b>	<b>Work related?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
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This claim is the result of: <input type="checkbox"/> Accident <input type="checkbox"/> Sickness	Describe accident/sickness
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If accident, describe how accident occurred

## 2. First physician seen and/or hospital where treatment was received for this condition(s).

Name of physician		Phone	Treatment dates (mm/dd/yyyy) to	
Address	City	State	ZIP code	
Name of hospital		Phone	Treatment dates (mm/dd/yyyy) to	
Address	City	State	ZIP code	

## 3. Other physicians seen for this condition(s). Attach additional sheet if necessary.

Name of physician		Phone	Treatment dates (mm/dd/yyyy) to	
Address	City	State	ZIP code	
Name of physician		Phone	Treatment dates (mm/dd/yyyy) to	
Address	City	State	ZIP code	

## 4. If your claim was incurred within two years from the date the contract was issued, complete the information below for all medical providers you have seen in the last 10 years. Attach additional sheet if necessary.

Name of physician		Phone	Treatment dates (mm/dd/yyyy) to	
Address	City	State	ZIP code	
Name of physician		Phone	Treatment dates (mm/dd/yyyy) to	
Address	City	State	ZIP code	

<b>5. Social Security benefits being received (check all that apply):</b> <input type="checkbox"/> Disability <input type="checkbox"/> Retirement <input type="checkbox"/> Supplemental Income			Monthly amount \$	Effective date (mm/dd/yyyy)
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**6. Check all benefits you have applied for; complete the following if you are receiving or may receive payment.**

<input type="checkbox"/> None	Monthly Amount	Date Benefits Began (mm/dd/yyyy)	Name, Address and Phone Number of Payor
<input type="checkbox"/> Disability Income Policy(ies)	\$		
<input type="checkbox"/> Group Disability Coverage	\$		
<input type="checkbox"/> Sick Pay <input type="checkbox"/> Vacation Pay	\$		
<input type="checkbox"/> Salary Continuation	\$		
<input type="checkbox"/> Workers' Compensation	\$		
<input type="checkbox"/> Railroad Retirement	\$		
<input type="checkbox"/> Government Disability	\$		
<input type="checkbox"/> Automobile/Liability	\$		

**7. Do you have a secondary occupation?**     Yes     No

Occupational title	Average monthly earned income \$	Employment dates (mm/dd/yyyy) to	
Employer name	Contact person	Phone	
Address	City	State	ZIP code

**8. How does this condition limit your ability to work (if you are a homemaker, unemployed and/or retired, perform your daily activities)?**

<b>9. Date medically unable to perform regular occupation/activities (mm/dd/yyyy)</b>	Date returned to regular occupation/activities (mm/dd/yyyy) <input type="checkbox"/> Full time <input type="checkbox"/> Part time
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If you are able to partially perform regular occupational duties/daily activities, list them below.

**10. Were you able to perform another occupation during the time you were unable to perform your regular occupation/activities?**     Yes. Date(s) employed (mm/dd/yyyy) \_\_\_\_\_ to \_\_\_\_\_     No

Explain occupation/activities:

**11. Employment Information**

**Section A - Employed**

Occupation and duties	Employment dates (mm/dd/yyyy) to		
Name of employer when disability began	Contact person		
Address	City	State	ZIP code
Phone	Average monthly earned income prior to disability (gross): \$		

**Section B - Self-Employed**

Business name		Phone	
Address	City	State	ZIP code
Nature of your business (be specific)			How long have you owned this business?

How is your business organized?  S Corporation  Partnership \_\_\_\_\_ %  
 Sole Owner/Proprietor  C Corporation  Limited Liability Corporation

Does your business pay any portion of your Thrivent Financial premium?  Yes \_\_\_\_\_ %  No

How are you compensated for your work? (check all that apply)  W2 wages  1099 earnings  \_\_\_\_\_ % of profits

Based on your last federal tax return prior to disability, what was the business:  
 Net profit: \$ \_\_\_\_\_ Gross income: \$ \_\_\_\_\_ What was your total earned income for the year? \$ \_\_\_\_\_

Thrivent Financial may require financial records to verify earned income.

List the primary duties/responsibilities you were performing before disability began. Include hours spent doing these tasks each week. \* Type: **S** = Supervisory; **C** = Clerical; **P** = Physical; **O** = Other

Duties/Responsibilities	*Type	Hrs/Wk	Duties/Responsibilities	*Type	Hrs/Wk

Do your duties vary throughout the year?  Yes (explain below)  No

**Section C - Homemaker/Unemployed/Retired**

List your activities/responsibilities, number of hours per day, and days per week you typically performed these activities/responsibilities just prior to the time you are claiming disability benefits.

Activity/Responsibility	Hrs Per Day	Days Per Week

Who is currently performing the activities you are unable to do?

If retired: Date of retirement	If unemployed: Date last worked	Reason for unemployment
If unemployment began within the last 24 months, name of last employer		Phone number of last employer

**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
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Relationship, if other than claimant	If a cognitive impairment exists and a durable power of attorney for finances has been appointed, send copy of document.
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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.

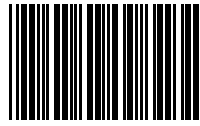
Signature of proposed insured or personal representative

Date signed (mm/dd/yyyy)

Description of personal representative's authority to act

**Attending Physician's Statement**

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



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Appleton, WI 54912-8075  
or fax to 1-800-225-2264

**Section 1 - To be Completed and Signed by the Patient**

Name	Contract number
Occupation and primary work duties	H

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
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**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.

**Diagnosis and Prognosis**

Primary diagnosis	Primary ICD-9
Secondary diagnosis	Secondary ICD-9

Date patient became medically unable to work (mm/dd/yyyy)	Did you treat the patient on this date? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Initial date of treatment for this condition(s) at your clinic or by you (mm/dd/yyyy)	Most recent date of treatment for this condition(s) (mm/dd/yyyy)
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Next date of treatment for this condition(s) (mm/dd/yyyy)	Is patient still under your care for this condition(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Is patient medically able to return to the above noted occupation?

Yes. Date (mm/dd/yyyy) \_\_\_\_\_  Full time  Part time

No. Probable return to work timeframe should not exceed (in months):

1  2  3  4  5  6  12

Permanently unable to work

Do you feel the patient is medically able to perform another occupation?

Yes. Date (mm/dd/yyyy) \_\_\_\_\_  Full time  Part time

No. Anticipated date the patient will be medically able to perform another occupation (mm/dd/yyyy) \_\_\_\_\_

**Current** limitations/restrictions:  
Please be as specific and quantitative as possible (i.e. lifting = how many lbs.).

Lifting/Carrying \_\_\_\_\_ Standing \_\_\_\_\_ Driving \_\_\_\_\_ Squatting \_\_\_\_\_

Bending/Twisting \_\_\_\_\_ Climbing \_\_\_\_\_ Sitting \_\_\_\_\_ Overhead \_\_\_\_\_

Walking \_\_\_\_\_ Psychological \_\_\_\_\_ Other \_\_\_\_\_

**Treatment**

Current and recommended treatment plans

Date surgery performed/anticipated

Medications (names and dosages)

Objective findings

**History**Symptoms are result of:  Accident  Sickness

Date accident happened or symptoms appeared (mm/dd/yyyy)

Has patient ever had the same or similar condition?  Yes. Date (mm/dd/yyyy) \_\_\_\_\_ Explain below.  No

Is condition work-related?

 Yes  No

Has patient been hospitalized?

 Yes: Dates confined (mm/dd/yyyy)

to

 No

Name of hospital

Phone

Address of hospital

City

State

ZIP code

Name of physician that referred patient to you

Physician's phone number

Name(s) of other health care providers the patient has been referred to

Provider's phone number

Do you believe the patient is competent to endorse checks and direct the use of proceeds thereof?  Yes  No

Have you completed claim forms for other disability income or workers' compensation insurance carriers?

 Yes, complete information below. No**Company Name****Address**

Name of attending physician (please print)

Phone

Fax number

Speciality

Degree

Tax ID number

Street address

City

State

ZIP code

**I swear that the statements and answers given to each of the questions on this form are true and complete to the best of my knowledge.****Signature of physician****Date**

Contact person for any questions regarding the information provided on this form.

Name

Phone