

Request For Waiver Of Surrender Charges For Health Care Facilities Confinement

Name of annuitant	Contract/Agreement number
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Thrivent will waive withdrawal or surrender charges if the annuitant or the annuitant's spouse* is confined as an inpatient of a licensed hospital, nursing home, and/or hospice facility for at least 30 consecutive days, the withdrawal or surrender occurs during the period of confinement or within 90 days after discharge from the facility, and written proof satisfactory to Thrivent is received at Thrivent. The 30 day confinement period will be considered satisfied even if interrupted by periods of non-confinement, provided reconfinement is due to the same or related condition, and within six months of a previous confinement. A new 30 day confinement period will be applied when confinement is for a new or non-related cause. A hospital, nursing home, or hospice facility is required to be licensed only if the jurisdiction in which the facility is located requires the licensing of such facility.

* **New Jersey** - The Waiver Of Charges For Health Care Facilities Confinement provision can only be exercised when the **annuitant** is confined, not the annuitant's spouse.

New York - The Waiver Of Charges For Health Care Facilities Confinement provision is subject to availability.

If the waiver of charges is denied, proceeds will not be disbursed until you are notified of such denial and provided with the opportunity to reapply for or reject the surrender or withdrawal proceeds.

Name of facility	Date of initial confinement	Date of discharge (if applicable)
Street address	City	
	State	ZIP code

I certify that the initial confinement date and discharge date (if applicable) indicated on this form are correct.

Signature of annuitant and date signed (mm/dd/yyyy)

I certify, under penalties of perjury, that the above named individual / individual's spouse has been confined as an inpatient of a licensed hospital, nursing home, or a hospice for at least 30 consecutive days and that the initial confinement date and discharge date (if applicable) indicated on this form are correct.

Signature of licensed medical doctor/hospital, nursing home facility, or hospice facility representative (**Required**) and date signed (mm/dd/yyyy)

Title
