

Attention: Insurance Compliance
Member Dispute Resolution Program

Name of client _____

Account/Contract number _____ Date _____

Statement explaining the dispute (attach additional pages, if necessary). Please submit any documents or evidence that supports your position.

In detail, describe the remedy you are requesting to resolve this dispute (list the amount of damages claimed, if any).

Name of party requesting appeal _____

Address _____

City _____ State _____ ZIP code _____

Phone _____ Fax _____

Email address _____

Name of legal representative/attorney, if applicable _____

Name of firm, if applicable _____

Address _____

City _____ State _____ ZIP code _____

Phone _____ Fax _____

Email address _____

The undersigned person requests appeal as part of the Member Dispute Resolution Program provided for in Section 11 of the Bylaws of Thrivent Financial for Lutherans.

Signature of party/legal representative/attorney _____

Send completed form to:

Thrivent
Member Dispute Resolution Program
4321 N Ballard Road
Appleton WI 54919-0001