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The Virtual Advice Team is a team of licensed financial advisors and professionals available to assist you during designated business hours. Our team offers a full variety of products and services. If you prefer to meet with a local financial advisor or professional, our team can connect you with someone in your area. Whether you work with the Virtual Advice Team, or with a local Thrivent financial advisor or professional, there will generally be no difference in the fees and expenses you will incur.

Insurance products, securities and investment advisory services are provided by appropriately appointed and licensed financial advisors and professionals. Only individuals who are financial advisors are credentialed to provide investment advisory services. Visit Thrivent.com or FINRA's Broker Check for more information about our financial advisors.

How the information is used

Once your assessment is complete, your results will be forwarded to an underwriter, who will use it to make a decision about your insurability. Based on the underwriter's evaluation, your coverage may be:

- Approved at the rate your financial professional quoted you.
- Approved, but at a rate different from the one originally quoted by your financial professional.
  - –Thrivent will explain its decision, and your financial professional may contact you to discuss the underwriting decision, as well as any additional requirements and available options.
- Denied. In this case, you will receive a letter from Thrivent explaining the reason(s) you were denied.

In certain circumstances, you may be reconsidered at a future date. If any special workups or tests are required as part of the reconsideration, they will be done at your expense.

Your financial professional may contact you to discuss additional or alternative options for your extended-care strategy.



Thrivent is the marketing name for Thrivent Financial for Lutherans. Insurance products issued by Thrivent. Not available in all states. Licensed agent/producer of Thrivent. Thrivent.com/disclosures.

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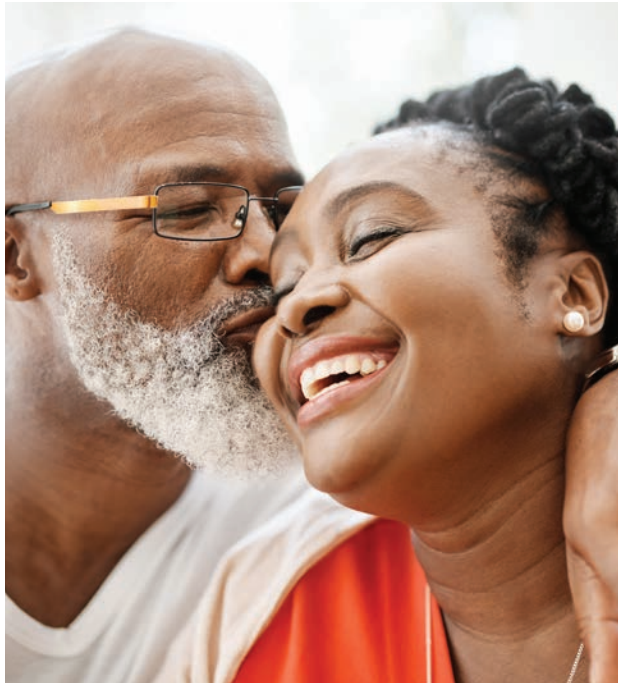
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Your Underwriting Process–

Long-term care insurance



What to expect next

You deserve a financial plan that you feel confident about—Thrivent is here to help with the necessary steps to take on the road to your retirement. Once you apply for Thrivent Long-Term Care Insurance, your underwriting process will begin. Take a deeper look, so you know what to expect from us and what the underwriting process will entail.

Your financial professional will gather your medical information during the application process, or it will be taken during a phone interview. Typically, assessments are ordered based on your age (see below). However, the underwriter can order an assessment for applicants of any age on a discretionary basis.

Your physician may require special authorization before releasing your medical records. Please respond to any requests as soon as possible to ensure the timely processing of your application.

The telephone assessment

The telephone assessment is conducted by a nurse, who will gather, validate or clarify your medical and nonmedical information. If your medical information wasn't gathered when you completed your application process, the nurse will ask questions about medical conditions you may or may not have had within the past 10 years, including:

- Names of conditions and dates of diagnoses.
- Names and addresses of the doctors seen for the conditions.
- Names and dates of medications prescribed or taken for the conditions.
- Names, dates and results of treatments and tests performed.
- Names, addresses and phone numbers of any treatment facilities used.

To minimize your time, it is helpful to have this information available during the assessment. Depending on your age and medical status, you also may be asked to participate in a cognitive acuity screen.

The in-home face-to-face assessment

If you are required to participate in an in-home face-to-face assessment, a nurse will call you to schedule an appointment at your convenience. During the assessment, you'll be asked to provide identification and answer standard questions about your medical history. The nurse will also take your blood pressure and record your height and weight. (No blood work or urinalysis is needed.) You also may be asked to participate in a cognitive acuity screen.

The cognitive acuity screen

Some people must also participate in a cognitive acuity screen in addition to the telephone or face-to-face assessment. Thrivent uses the Minnesota Cognitive Acuity Screen, a standardized assessment used by many long-term care insurance providers. You will be asked questions to assess your:

- Orientation
- Repetition
- Attention
- Naming computation
- Word recall
- Judgment
- Comprehension
- Verbal fluency

To help ensure your comfort and the best results, you'll want to select a time and place free from distraction. If family or friends are present during the screening, they will need to be in a separate room.

What's needed*		
If your age is	And you **have** consulted with a physician in the last 24 months	And you **have not** consulted with a physician in the last 24 months
18 to 59	• A telephone assessment and prescription check will be needed unless your physician is asked to provide medical records for certain medical conditions.	• A telephone assessment will be needed. • A prescription check will be ordered.
60 to 69	• A telephone assessment with a cognitive acuity screen will be needed. • Medical records from your physician will be requested.	• An in-home face-to-face assessment with a cognitive acuity screen will be needed. • A prescription check will be ordered.
70 or older	• An in-home face-to-face assessment with a cognitive acuity screen will be needed. • Medical records from your physician will be requested.	• An in-home face-to-face assessment with a cognitive acuity screen will be needed. • A prescription check will be ordered.
California applicants	• Medical records will be requested, and a prescription check will be ordered for all proposed insureds from California, regardless of their age and their last consultation with a physician. • Proposed insureds aged 18 to 59 will undergo a face-to-face assessment without a cognitive acuity screen if they have not consulted a physician in the last 24 months. • Proposed insureds aged 60 and older should refer to the guidelines in the columns above.	

*A typical telephone assessment takes approximately 15 minutes, a telephone assessment with a cognitive acuity screen takes approximately 30 minutes and an in-home face-to-face assessment takes approximately 40 minutes.

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Qualified Long-Term Care Insurance
Outline of Coverage

Form H-HX-LTC (13)

CAUTION:
The issuance of this long-term care insurance contract is based upon your responses to the questions on your application. A copy of your application will be attached to any issued contract. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your contract. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at 4321 North Ballard Road, Appleton, Wisconsin 54919-0001.

NOTICE TO BUYER
This contract may not cover all of the costs associated with long-term care which may be incurred by the buyer during the period of coverage. The buyer is advised to periodically review this contract in relation to the changes in the cost of long-term care.

1. This contract is an individual contract of insurance which has been issued and approved in the state of Florida as a long-term care insurance contract meeting the requirements of Florida law.

2. **PURPOSE OF THE OUTLINE OF COVERAGE.**
This outline of coverage provides a very brief description of the important features of the contract. You should compare this outline of coverage to outlines of coverage for other contracts available to you. This is not an insurance contract but only a summary of coverage. Only the individual contract contains governing contractual provisions. This means that the contract sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR CONTRACT CAREFULLY!

3. **FEDERAL TAX CONSEQUENCES.**
This contract is intended to be a qualified long-term care insurance contract under Section 7702B (b) of the Internal Revenue Code of 1986, as amended.

4. **TERMS UNDER WHICH THE CONTRACT MAY BE CONTINUED IN FORCE OR DISCONTINUED.**

RENEWABILITY: THIS CONTRACT IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your contract, to continue this contract as long as you pay your premiums on time. Thrivent Financial for Lutherans cannot change any of the terms of your contract on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

WAIVER OF PREMIUM BENEFIT.
We will waive any premiums that come due while you incur expenses for Qualified Long-Term Care Services for which long-term care benefits are payable. When such expenses are no longer incurred, premiums will cease to be waived and you must resume paying premiums in order to keep your contract in force. Expenses eligible for Ancillary Benefits will not trigger Waiver of Premiums.

5. **TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.**
We may change the premium for the contract based on premium class, but not more frequently than once a year. Any change will apply to all contracts issued in your state on this contract form. We will not change the premium due to changes in your health or due to any claims on your contract. We will give you at least 60 days notice of any change in premium. You will be given the right to reduce coverage in the event of a substantial premium increase.

6. **TERMS UNDER WHICH THE CONTRACT MAY BE RETURNED AND PREMIUM REFUNDED.**
Right to Return; Free Look. You have the right to return this contract within 30 days after its delivery and to have the premium refunded if, after examination of the contract, you are not satisfied for any reason. If you exercise this right, we will refund all premiums paid directly to the payer and this contract will be deemed void from the beginning.

Unearned Premium Refunds:
The contract provides for a refund of unearned premium upon termination due to death or cancellation. If you return your contract after 30 days of first receiving it, the portion of any premium paid beyond the date of cancellation will be refunded. If your contract terminates due to your death or because your Available Benefit has been reduced to zero, the portion of any premium paid beyond the date of termination will be refunded.

7. **THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.**
If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from us. Neither Thrivent Financial for Lutherans, nor its agents represent Medicare, the federal government, or any state government.

8. **LONG-TERM CARE COVERAGE.**
Contracts of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.

This contract provides coverage in the form of reimbursement for expenses that you incur for Qualified Long-Term Care Services when Eligibility for Benefits is met. Payment is subject to the Elimination Period, Maximum Monthly Benefit, Available Benefit, Exceptions and Limitations and all other terms and conditions of the contract.

9. **BENEFITS PROVIDED BY THIS CONTRACT.**

a) Contract Benefit Limits:

A. Maximum Monthly Benefit: $ _____ (enter amount)

B. Benefit Multiplier:
☐ 24 months ☐ 36 months ☐ 48 months ☐ 60 months ☐ 96 months

C. Available Benefit (A. x B. = C.): $ _____ (enter amount)

Elimination Period: ☐ 30 days ☐ 90 days ☐ 180 days

Increase Benefit Riders: ☐ Compound 1% ☐ Compound 2% ☐ Compound 3%
☐ Compound 5% ☐ Flexible 5%

☐ Cash Benefit Rider

☐ Nonforfeiture Benefit Rider

☐ Return of Premium upon Death Rider

☐ Shared Care Rider

☐ Survivorship Rider

☐ Waiver of Elimination Period for Home Care and Adult Day Care Rider

b) **Institutional Benefits:**

Residential Care Facility Benefit.
Residential Care Facility Benefit pays for Qualified Long-Term Care Services while you are confined in a nursing home, assisted living facility or hospice.

Bed Reservation Feature.
Bed Reservation Feature provides that the Residential Care Facility Benefit will not be interrupted by a temporary absence from the facility where you are a resident.

c) **Non-Institutional Benefits:**
Your contract includes benefits for Qualified Long-Term Care Services that are provided in an Adult Day Care Facility or in your home as Home Care Services.

Adult Day Care Benefit.
Adult Day Care Benefit provides social and health-related Qualified Long-Term Care Services in a community group setting to Chronically Ill people.

Home Care Services.
Home Care Services are Qualified Long-Term Care Services that are necessary to enable you to continue to live safely in your home. Home Care Services include homemaker services, home health aide services, skilled nursing services, physical therapy, occupational therapy, speech therapy, respiratory therapy, nutritional and dietary services and hospice care services.

d) **Eligibility for the Payment of Benefits:**
Your contract covers only Qualified Long-Term Care Services.

Qualified Long-Term Care Services are necessary diagnostic, preventive, curing, treating, mitigating and rehabilitative services and maintenance or personal care services that are:

- Required by a Chronically Ill individual; and
- Provided pursuant to a Plan of Care, prescribed by a licensed health care practitioner.

To be eligible for benefits under this contract, all of the following **Conditions on Eligibility for Benefits** must be met:

- You are Chronically Ill and receive Qualified Long-Term Care Services specified in a Plan of Care;
- The Elimination Period has been met, when applicable; and
- Coverage is not excluded.

Chronically Ill means that a licensed health care practitioner has certified that you:

- Are unable to perform without Substantial Assistance from another individual at least two Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity; or

- Require substantial supervision for protection from threats to health and safety due to severe Cognitive Impairment.

The **Activities of Daily Living** are:

a) **Bathing.** Washing oneself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower.
b) **Continence.** The ability to maintain control of bowel and bladder function; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for a catheter or colostomy bag.
c) **Dressing.** Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
d) **Eating.** Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by feeding tube or intravenously.
e) **Transferring**. Moving into or out of a bed, chair or wheelchair.
f) **Toileting.** Getting to and from the toilet, on or off the toilet, and performing the associated personal hygiene.

Cognitive Impairment means a deficiency in a person's short-term or long-term memory, orientation as to person, place, and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

A **Plan of Care** is a written document that prescribes Qualified Long-Term Care Services that are consistent with an assessment of your impairment. The Plan of Care must be prepared and signed by a licensed health care practitioner and must include services or treatment that could not be omitted without adversely affecting your health.

Care Coordinator Services.
A care coordinator can help develop your Plan of Care. Care Coordinator Services are optional and are offered to assist in identifying care needs and community resources available to deliver care while you are Chronically Ill. If you contact us and use a care coordinator referred to you by us, these services are provided at no cost to you and are not subject to the Elimination Period.

Contingent Nonforfeiture Benefit.
Your contract includes a Contingent Nonforfeiture Benefit provision. This benefit provides you the option to reduce your coverage or convert to a reduced paid-up contract in the event of a substantial premium increase.

The paid-up coverage will have an Available Benefit equal to the lesser of the Nonforfeiture Credit and the Available Benefit in effect immediately before the date paid-up coverage becomes effective. The Nonforfeiture Credit is equal to the greater of the total of all premiums paid by you and applied to your contract and the Maximum Monthly Benefit in effect on the date paid-up coverage becomes effective.

Benefits will be paid subject to all of the conditions and limitations of your contract. All optional benefit riders on your contract will terminate on the date paid-up coverage becomes effective. Paid-up coverage will terminate on the date the Available Benefit reaches zero.

Limited Premium Payment Period Contingent Nonforfeiture Benefit.
Contracts with a limited premium payment period include a Limited Premium Payment Period Contingent Nonforfeiture Benefit rider. This benefit provides you the option to reduce your coverage or convert to a reduced paid-up contract in the event of a premium increase after you have paid premiums for a specified portion of the premium payment period.

The paid-up coverage will have an Available Benefit, a Monthly Benefit, and Ancillary Benefit Limits reduced from the amounts in effect immediately before the date paid-up coverage becomes effective. The reduced amounts will be determined using the number of years (and partial years) you have paid premiums and the number of years in the premium payment period.

Benefits will be paid subject to all of the conditions and limitations of your contract. All optional benefit riders on your contract will terminate on the date paid-up coverage becomes effective. Paid-up coverage will terminate on the date the Available Benefit reaches zero.

10. **LIMITATIONS AND EXCLUSIONS.**

a) **Pre-existing Conditions Coverage:** Your contract does not exclude pre-existing conditions.

b) **Non-eligible Facilities/Providers:** Your contract does not cover services provided by a facility or agency that does not meet the contract definition for such facility or agency, except as provided under the Alternate Care Benefit. This contract does not cover services provided in a clinic, hospital, sanatorium, or a home or facility for the treatment of mental or nervous disorders, alcoholism or drug addiction.

c) **Non-eligible Levels of Care**: Your contract does not cover services that are not Qualified Long-Term Care Services as defined in the contract.

d) **Exclusions/Exceptions and Limitations:** Your contract does not pay benefits for:

- Charges billed by a doctor;
- Charges for prescription drugs;
- Services outside the United States, its territories and possessions except under the International Care Benefit;
- Services provided due to an attempt at suicide, while sane or insane, or an intentionally self-inflicted injury;
- Services provided for the treatment of alcoholism or drug addiction.
- Care or services provided by an immediate family member.
- Which benefits are payable under any governmental program (except Medicaid) state or federal workers' compensation, employer's liability or occupational disease law;
- Expenses which are reimbursable under Medicare or would be reimbursable under Medicare but for the application of a deductible or coinsurance amount.

THIS CONTRACT MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

11. **RELATIONSHIP OF COST OF CARE AND BENEFITS.**

Because the cost of long-term care services will likely increase over time, you should consider whether and how the benefits under this contract may be adjusted. For this purpose, you may add an Annual Increase Benefit rider or a Flexible Increase Benefit rider for an additional cost.

An optional **Compound Annual Increase Benefit rider** increases your Maximum Monthly Benefit, Available Benefit and Ancillary Benefit Limits on each rider anniversary by either 5%, 3%, 2% or 1% (depending on which rider your select) of the corresponding amounts in effect immediately before the increase. Premiums for this rider are set at the time of issue. Increases in coverage under this rider will not cause an increase in your contract's premium.

An optional **Flexible Increase Benefit rider** increases your Maximum Monthly Benefit, Available Benefit and Ancillary Benefit Limits on each rider anniversary by 5% of the corresponding amounts in effect immediately before the increase. You may decline the increase. If you decline three consecutive increases, automatic annual increases will cease and future increases will be provided only on rider anniversaries occurring while premiums are being waived under the Waiver of Premium provision of the contract. Premiums for this rider are set at the time of issue. Your contract's premium will increase with each option elected and will be based on your age at the time of the increase.

At the end of this outline is a graphic comparison of the benefit levels of a contract that includes the increase benefit over the coverage period with a contract that does not include the increase benefit. A relative cost comparison chart illustrates long-term care contract premiums with and without the increase benefit.

12. **ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.**
This contract includes benefits for persons who are clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses and meet the qualifying for benefits requirements described in the contract.

13. **PREMIUM.**
The total annual premium for your contract including the optional benefits is listed below.

Base Contract	$ _____
Cash Benefit Rider	$ _____
Compound Annual Increase Benefit Rider (5%, 3%, 2% or 1%)	$ _____
Flexible Increase Benefit Rider	$ _____
Nonforfeiture Benefit Rider	$ _____
Return of Premium upon Death Rider	$ _____
Shared Care Rider	$ _____
Survivorship Rider	$ _____
Waiver of Elimination Period for Home Care and Adult Day Care Rider	$ _____

Total Annual Premium $ _____

Your premium will be _____ on a _____ basis.

14. **ADDITIONAL FEATURES.**

The issuance of the contract is subject to medical underwriting.

The contract also includes the following benefits:

Alternate Care Benefit.
If your Plan of Care prescribes Qualified Long-Term Care Services that are not covered by the contract, we may pay benefits for such services if (1) the services are a cost-effective alternative to services covered by the contract and (2) you and we agree to a written alternate care benefit agreement.

Ancillary Benefits.
Ancillary Benefits are provided for Qualified Long-Term Care Services under Respite Care, Equipment/Home Modification, Caregiver Training and International Care. These benefits are not subject to the Elimination Period or the Maximum Monthly Benefit. Each benefit is subject to its own separate benefit limit and the Available Benefit.

- **Respite Care.**
  Respite Care is designed to relieve an informal caregiver on a short-term basis and is provided in a residential care facility, adult day care facility, or a person's home as Home Care Services.

- **Equipment/Home Modification.**
  Equipment/Home Modification provides coverage for special equipment such as a hospital bed, wheelchair, crutches or walker or safety-related equipment such as a medical alert system or any other medical equipment as specified in your Plan of Care.

  Home modifications are accessibility changes such as a ramp, chair-lift or alterations to accommodate a wheelchair or safety-related changes such as installation of grab bars or railings or other changes to your home that are specified in your Plan of Care.

- **Caregiver Training.**
  Caregiver Training means training that is (1) specified in your Plan of Care and (2) provided to your informal caregiver by a person who is licensed, certified or otherwise qualified to provide the training.

- **International Care.**
  International Care provides limited coverage for Qualified Long-Term Care Services received outside of the United States.

For an additional cost, you may elect any of the optional benefit riders listed below:

Nonforfeiture Benefit.
After your contract has been in force for three years, the Nonforfeiture Benefit rider provides paid-up coverage if you give us notice to cancel your contract or your contract terminates for nonpayment of premium.

The paid-up coverage will have an Available Benefit equal to the lesser of the Nonforfeiture Credit and the Available Benefit in effect immediately before the date paid-up coverage becomes effective. The Nonforfeiture Credit is equal to the greater of the total of all premiums paid by you and applied to your contract and the Maximum Monthly Benefit in effect on the date paid-up coverage becomes effective.

Benefits will be paid subject to all of the conditions and limitations of your contract. All optional benefit riders on your contract will terminate on the date paid-up coverage becomes effective. Paid-up coverage will terminate on the date the Available Benefit reaches zero.

Shared Care Benefit.
The Shared Care Benefit rider allows you and your benefit partner to share each other's Available Benefit if one of you exhausts his or her own Available Benefit. You and your benefit partner must each own a Thrivent Financial for Lutherans long-term care insurance contract with identical coverage issued on the same date that includes this rider and names each other as a benefit partner.

Survivorship Benefit.
The Survivorship Benefit rider will waive your premiums for life if after ten years from the date of issue of the rider your benefit partner dies. This benefit will not be paid if either you or your benefit partner was Chronically Ill within the first ten years from the date of issue of the contract. You and your benefit partner must each own a Thrivent Financial for Lutherans long-term care insurance contract with the same date of issue that includes this rider and names each other as a benefit partner.

Waiver of Elimination Period for Home Care and Adult Day Care.
The Waiver of Elimination Period for Home Care and Adult Day Care rider will waive the Elimination Period requirement when receiving benefits for Home Care or Adult Day Care. The days of care you receive will still help you satisfy the Elimination Period for other types of care that may be needed in the future.

Return of Premium upon Death.
The Return of Premium upon Death rider will return premiums paid (less any benefits paid and accumulated dividends paid upon death) to your estate if you die and your rider has been in force for at least ten years. Benefits paid under this rider will reduce your Available Benefit. This benefit may have tax implications for your estate. You are advised to consult a tax advisor.

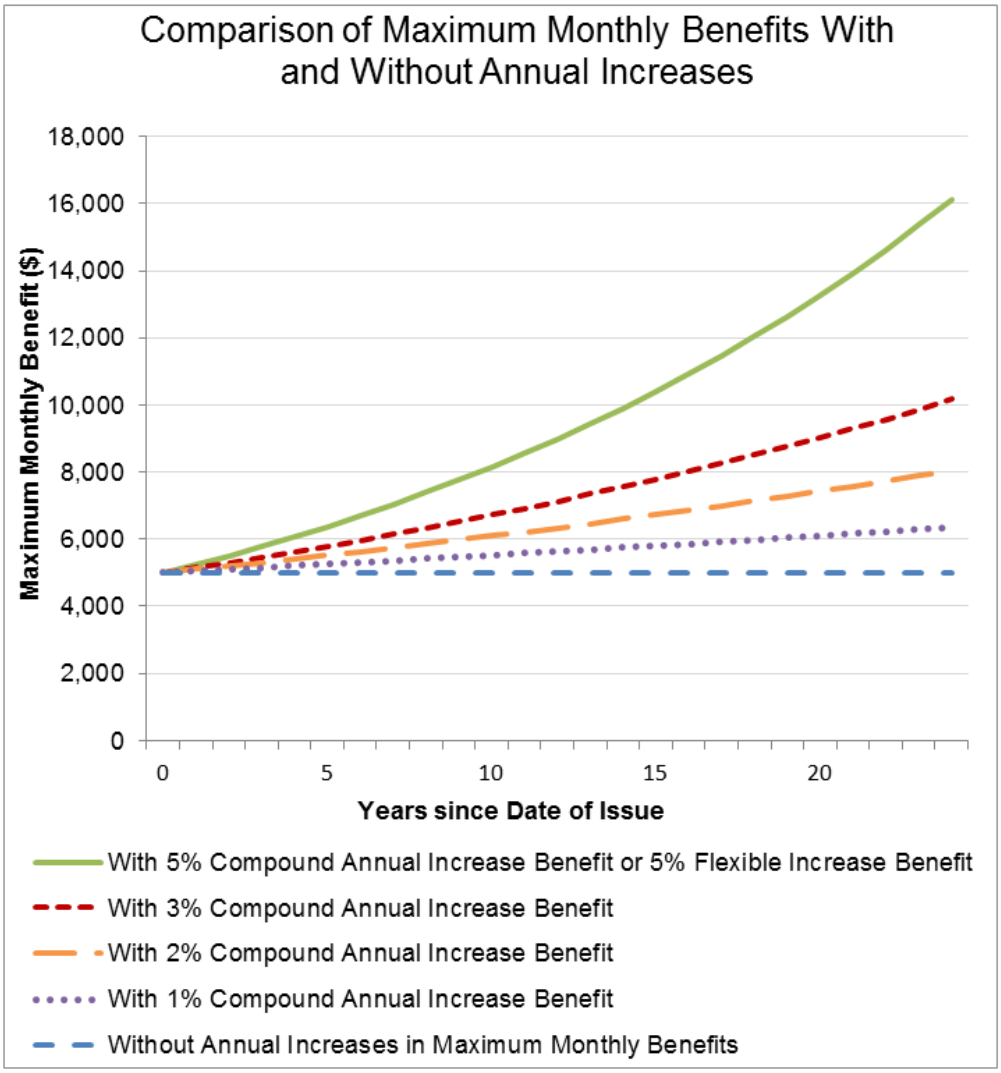
Cash Benefit.
In any calendar month in which you receive Long-Term Care Benefits for expenses incurred on at least five separate days and your Elimination Period has ended, the Cash Benefit rider pays you a benefit equal to:

- 15% of your Maximum Monthly Benefit in effect on the last day of the calendar month if on any of those days you receive Adult Day Care or Home Care Benefits; otherwise
- 10% of your Maximum Monthly Benefit in effect on the last day of the calendar month.

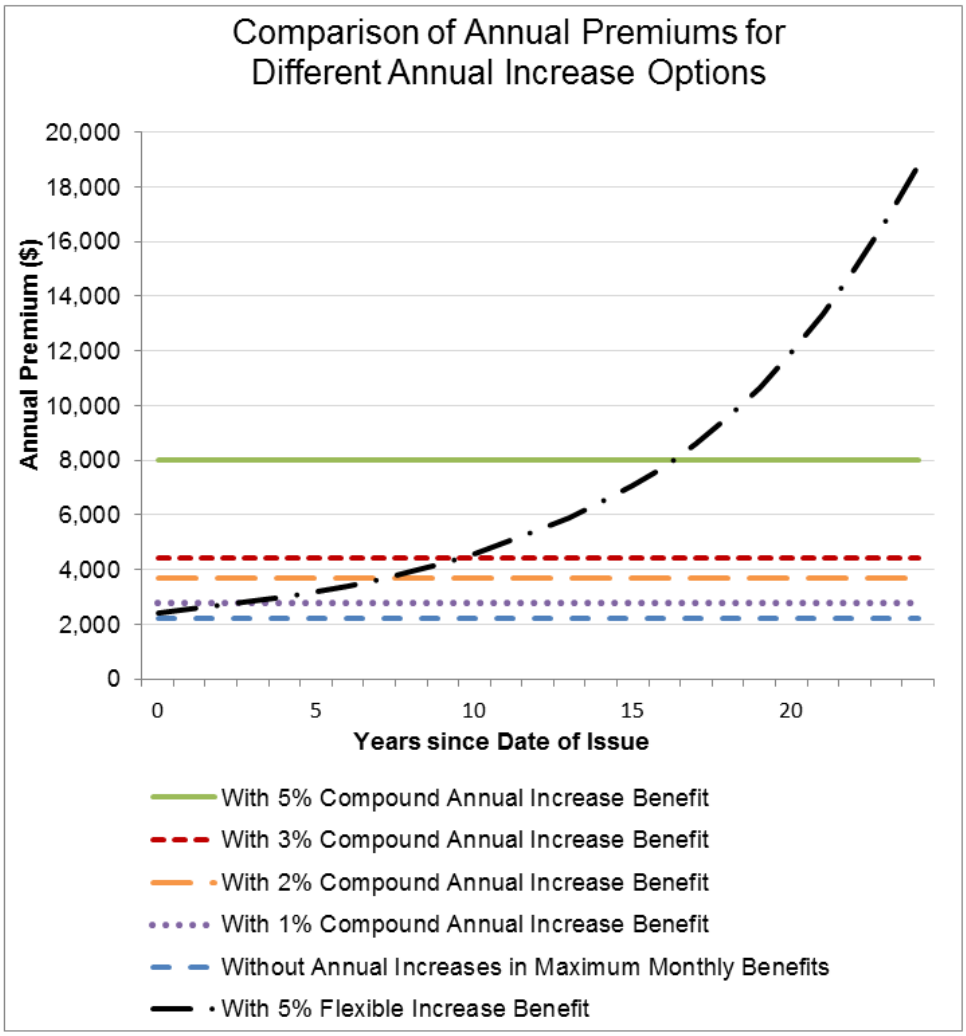
Benefits paid under this rider will not reduce your Available Benefit. This rider may have tax implications. You are advised to consult a tax advisor.

15. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE CONTRACT.

Comparisons of Maximum Monthly Benefits with and without the Annual Increases (Graph 1) and Comparison of Annual Premiums for Different Annual Increase Options (Graph 2)



This data is shown for a 55 year old female with a $5,000 Maximum Monthly Benefit and Benefit Multiplier of 4 years. There is a 90 day Elimination Period and premiums are made annually for the life of the insured. There are no marital or underwriting discounts applied and no additional riders selected. For the Flexible Increase Benefit this assumes no increases are declined by the insured.


Comparison of Annual Premiums for Different Annual Increase Options
Annual Premium ($)
20,000
18,000
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
0
5
10
15
20
Years since Date of Issue
With 5% Compound Annual Increase Benefit
With 3% Compound Annual Increase Benefit
With 2% Compound Annual Increase Benefit
With 1% Compound Annual Increase Benefit
Without Annual Increases in Maximum Monthly Benefits
With 5% Flexible Increase Benefit

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Application for Individual Long-Term Care Insurance

☐ New Business
☐ Contract Change - contract number - _____

Section 1 - Proposed Insured

Name of proposed insured (print first, middle, last name and suffix, as applicable)

Date of birth	Sex ☐ Male ☐ Female	Residence state
Driver's license number		Driver's license state

☐ Yes ☐ No Are you a citizen of the United States of America (USA)?
☐ Yes ☐ No If no, are you a permanent resident of the USA?

☐ Yes ☐ No Are you married or do you have a state recognized partner?
☐ Yes ☐ No Are you one of two individuals in a committed relationship who have been living together for at least three consecutive years as partners or family members, and are committed to sharing expenses, and if related, belong to the same generation?

If yes to either of the above two questions, answer the following:

☐ Yes ☐ No Is spouse/partner/family member applying for Long-Term Care Insurance or Long-Term Care Insurance Rider with Thrivent Financial?

If yes, spouse/partner/family member's name - _____

☐ Yes ☐ No If no, does spouse/partner/family member have a long-term care or nursing home contract with Thrivent Financial?

If yes, contract number - _____

Section 2 - Replacement and Other Coverage

☐ Yes ☐ No 1. Are you covered by Medicaid?
☐ Yes ☐ No 2. Do you have another long-term care insurance policy, contract or certificate in force (including health care service contract, health maintenance organization contract)? If yes, provide details.

Company			Contract number
Address	City		
	State	ZIP code	Phone

Type of coverage	Benefit/contract amount	Maximum period	Annual premium

☐ Yes ☐ No Do you intend to replace any of your medical or health insurance coverage with this contract?

Reason for replacement

☐ Yes ☐ No 3. Do you have any life insurance or annuity contracts currently in force which provide similar long-term care coverage? If yes, provide details.

Company			Contract number
Address	City		
	State	ZIP code	Phone

Type of coverage	Benefit/contract amount	Maximum period	Annual premium

☐ Yes ☐ No Will coverage be discontinued if this Long-Term Care Insurance contract is issued?

☐ Yes ☐ No If yes, is this a 1035 exchange?

Reason for replacement

☐ Yes ☐ No 4. Did you have another long-term care, nursing home policy, certificate, contract or rider in force during the last twelve (12) months? If yes, provide details.

Company

Contract number	Coverage end date or date of lapse

Section 3 - Long-Term Care Insurance New Business Benefit Information

Benefit Multiplier ☐ 24 months ☐ 36 months ☐ 48 months ☐ 60 months ☐ 96 months

Elimination Period ☐ 30 day ☐ 90 day ☐ 180 day

Maximum Monthly Benefit Amount $ _____

Contract Pay Type ☐ Lifetime Pay ☐ 10-Pay

Benefit Increase Options

☐ Annual Increase Benefit - 1% Compound
☐ Annual Increase Benefit - 2% Compound
☐ Annual Increase Benefit - 3% Compound
☐ Annual Increase Benefit - 5% Compound

Check if rejecting Annual Increase Benefit

☐ I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this contract with and without annual increase benefit, and I reject annual increase benefit.

Signature of proposed insured and date signed

X

☐ Flexible Increase Benefit
☐ None

Optional Riders

☐ Cash Benefit
☐ Nonforfeiture Benefit
☐ Return of Premium Upon Death
☐ Shared Care Benefit
☐ Survivorship Benefit
☐ Waiver of Elimination Period for Home Care and Adult Day Care

Section 4 - Long-Term Care Insurance Contract Change

☐ Increase Benefit Multiplier to ☐ 36 months ☐ 48 months ☐ 60 months ☐ 96 months

☐ Decrease Benefit Multiplier to ☐ 24 months ☐ 36 months ☐ 48 months ☐ 60 months

☐ Increase Elimination Period to ☐ 90 day ☐ 180 day

☐ Decrease Elimination Period to ☐ 30 day ☐ 90 day

☐ Increase ☐ Decrease Maximum Monthly Benefit Amount to $ _____

Optional Rider(s)

Add	Delete	
☐	☐	Annual Increase Benefit - 1% Compound Increases
☐	☐	Annual Increase Benefit - 2% Compound Increases
☐	☐	Annual Increase Benefit - 3% Compound Increases
☐	☐	Annual Increase Benefit - 5% Compound Increases
☐	☐	Cash Benefit
☐	☐	Flexible Increase Benefit
	☐	Nonforfeiture Benefit
	☐	Return of Premium Upon Death
	☐	Shared Care Benefit
	☐	Survivorship Benefit
☐	☐	Waiver of Elimination Period for Home Care and Adult Day Care

☐ Change Contract Pay Type to Lifetime Pay

☐ Add Spouse/Partner/Family Member discount - contract number - _____

Section 5 - Premium Payment Information

☐ Total initial premium $ _____ ☐ No premium with application

Premium billing amount $ _____

Frequency ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly ☐ _____

Section 6 - Protection Against Unintended Lapse

Protection against unintended lapse - I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance contract for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid.

☐ I elect not to designate any person to receive such notice.

I request that you notify the following person. I will provide any change in address of the person I designate.

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

Address	City		
	State	ZIP code	Phone

Section 7 - Special Requests

Section 8 - Agreement and Authorization

I understand and agree that:

1. I have read all statements and answers recorded on this application. They are given to obtain this insurance and are, to the best of my knowledge and belief, true, complete and correctly recorded.
2. The entire application consists of this Application for Individual Long-Term Care Insurance and all supplemental application forms required for the contract or change applied for as defined by the company. The entire application will become part of any contract issued or the contract for which a requested change has been approved.
3. No Representative of the company has the authority to change or waive any question contained in the application or to modify the application in any way.
4. No Representative of the company has the authority to accept risks or determine insurability for the company.
5. The date of the application is the latest of the following dates:
   a) The date shown on the Application for Individual Long-Term Care Insurance;
   b) The date shown on any required supplemental application forms;
   c) The date shown on the Declaration of Insurability.
6. Any change in this application that will result in any change in plan of insurance, amount, age at issue, sex, class or benefits shall require my written consent.
7. Thrivent Financial may require an attending physician's statement, medical records, an underwriting assessment, a medical exam, a motor vehicle report, a prescription drug or medication report or other questionnaire or test.
8. I have received the following:
   • Outline of Coverage • Long-Term Care Insurance Personal Worksheet • Potential Rate Increase Disclosure Form
   • Things You Should Know Before You Buy Long-Term Care Insurance • Shopper's Guide to Long-Term Care Insurance

In addition, for New Business:

No insurance will take effect unless and until:

a. A contract of insurance is issued and delivered;
b. The first full premium is paid during the lifetime of the person to be covered; and
c. The health of the person to be insured remains as stated in this application.

In addition, for Contract Change:

1. I agree that the requested change in my contract shall not become effective unless and until the required premium has been paid and the requested change has been approved by the company.
2. With regard to statements made in this application, the Time Limit on Certain Defenses provision will apply from the effective date of the contract change.

The signature below applies to all sections and statements on this application.

Signed at state - _____

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Caution: If your answers on this application are incorrect or untrue, Thrivent Financial for Lutherans may deny benefits or rescind your contract.

Signature of proposed insured and date signed

X

List any other health insurance contracts that you have sold to the insured that are still in force.

List any other health insurance contracts that you have sold to the insured in the past five years that are no longer in force.

I certify that I have asked all questions and recorded all answers as they were given to me and reviewed these with the proposed insured.

To the best of my knowledge, the contract applied for ☐ is ☐ is not intended to replace any part of, or all of, another contract.

Signature of agent and date signed

X

Print name of licensed agent	Code number and FL licensed ID number of agent

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Important Privacy Choices for Consumers

Rev. 2/25

Facts	What does Thrivent do with your personal information?
Why?	Financial services and insurance companies choose how they share your personal information. Federal and state law gives consumers the right to limit some but not all sharing. Federal and state law also requires us to tell you how we collect, share and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: • Identifying information, such as name and contact information. • Social Security number. • Financial factors, including income, assets, credit history, transaction history and risk tolerance. • Health indicators, such as medical records, prescription history and claims' statuses. We may share any/all of the information we collect depending on what is needed for the stated purpose.
How?	All companies need to share clients' personal information to run their everyday business. In the section below, we list the reasons companies may share their clients' personal information; the specific reasons Thrivent chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	Does Thrivent share?	Can you limit this sharing?
For our everyday business purposes Such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, report to credit and medical bureaus, or engage with third parties, such as insurance agents, financial advisors and service providers who act on our behalf to support our operations.	YES	NO
For our marketing purposes To offer our products and services to you.	YES	YES
For joint marketing with other financial companies	YES	YES
For our affiliates' everyday business purposes Information about your transactions and experiences with Thrivent.	YES	NO
For our affiliates' everyday business purposes Information about your creditworthiness.	NO	NO
For nonaffiliates to market to you This includes nonprofit organizations such as churches or partner organizations.	YES	YES*

To limit our sharing

- Log in to your thrivent.com account and go to **Profile and Settings**.
- Call 800-847-4836 between 7 a.m. and 6 p.m. Central time, Monday through Friday.
- Mail to: Thrivent
  4321 N. Ballard Rd.
  Appleton WI, 54919-0001

Please note:
If you are a new client, we can begin sharing your information 30 days from the date we provide you this notice. If you have previously provided us with your sharing preferences, your preferences have not been changed; they will remain as is, unless we receive instruction to change them. For all others, including former clients, we will continue to share your information as described in this notice; however, you can contact us at any time to limit our sharing.

Who we are	
Who is providing this notice?	This notice describes the privacy practices of "Thrivent," which includes Thrivent Financial for Lutherans, Thrivent Investment Management Inc. (TIMI), Thrivent Financial Investor Services Inc., Thrivent Insurance Agency Inc., Thrivent Asset Management, LLC, Thrivent Distributors, LLC, Thrivent Mutual Funds, Thrivent Series Fund, Inc., Thrivent Core Funds, Thrivent Cash Management Trust, Thrivent Education Funding, LLC, and Thrivent ETF Trust.

What we do	
How does Thrivent collect my personal information?	We collect your personal information in a few ways: • Directly from you, such as when you use a service, apply for a product, or file a claim. • From other third parties, such as credit reporting agencies or your doctor. • Through your transactions and interactions with us.

How does Thrivent protect my personal information?	To safeguard your personal information from unauthorized access and use, we maintain physical, procedural and electronic security measures. These strategies include: • Frequent internal and external reviews to ensure our technology and protocols are up-to-date. • Limited access to your personal information; only those with a "need to know" are authorized. • Anyone who uses your data must follow established policies, procedures and laws.
Why can't I limit all sharing?	Federal law gives you the right to limit sharing only in certain situations: •To affiliates: • If we share information about your creditworthiness. • If affiliates use your information to market to you. At Thrivent, if you opt out of marketing, identified in the chart above as "for our marketing purposes," that choice applies to any/all Thrivent affiliates. •To nonaffiliates: • If they wish to obtain your information to market to you. *In addition, residents of CA, MA, MN, NM, ND and VT are opted out of nonaffiliate sharing, per state law. Clients in these states may choose to opt in for this sharing.
What if I am a joint contract owner or joint account owner?	You may be receiving this notice on behalf of all owners. As a joint owner, you may choose one or more of the sharing options that apply in your home state on behalf of all joint owners or only on your own behalf.
How do I access and update the information Thrivent has about me?	Accurate information helps us to provide you better customer service, increase the efficiency of our operations, and comply with laws. You may request access to and correction of your personal information by writing to us at the address above. Registered users of thrivent.com or Thrivent's mobile application may also update some personal information through their online personal profile. Information collected is retained according to Thrivent's record retention policy and applicable laws and regulations.

Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. Thrivent affiliates include lines of business such as life insurance, long-term care insurance, brokerage, investments, trust, banking, mutual funds and distribution partners.
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. Thrivent nonaffiliates include financial institutions, such as consumer banking, and other non-profit entities.
Joint marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. Thrivent has joint marketing agreements with other financial institutions, such as consumer banking, and non-profit foundations.

Other important information

If applicable, when your financial advisor leaves, he/she may be able to take your personal information and share it with his/her new firm. If you live in CA, MA, MN, NM, ND, or VT, state law requires you to opt in before this sharing can occur. In all other states, you have the right to opt out of such sharing. To exercise your right to opt in or opt out, please contact us at the address listed above.

Please note that if your insurance agent or financial advisor is part of a team, your information may also be shared amongst team members.

For information about our collection and use of your health information, be sure to review our Health Information Privacy Notice available at thrivent.com/privacy. You can request a copy of any of our notices at any time by writing to us at the address above.

Complaints can be sent to us at the address provided above. Depending on where you live, you may also be able to contact local or state agencies to report specific concerns.

Questions? Call 800-847-4836 or go to thrivent.com.

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Privacy of Information About Your Health

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Protecting the privacy of information about your medical conditions and health is a responsibility we take very seriously. We understand that medical information about you and your health is personal, and it is important to you that we keep it confidential. We are committed to the practices and procedures we established to protect the confidential nature of information about your health.

This notice describes the ways in which we may use and disclose information about your health to carry out treatment, payment and health care operations, and for other purposes as permitted or required by law. It also describes your rights and our duties regarding the use and disclosure of health information.

Uses and disclosures of information about your health without your authorization

The following categories describe ways that we may use and disclose information about your health without your written authorization. For each category, we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information without written authorization fall within one of the categories.

Treatment: We do not use information about your health to provide you with medical treatment or related services.

Payment: Generally, we use and disclose information about your health so we can administer claims, which includes reimbursing incurred expenses for treatment and services you receive from a health care provider. For example, we may disclose this information to your health care provider to verify insurance coverage for medical treatment or service expenses.

Health care operations: We use and disclose information about your health for our insurance operations. These uses and disclosures are necessary for our business and to make sure our members are receiving quality service. Some examples of how we may use and disclose information about your health include: underwriting insurance, processing transactions, resolving grievances and conducting business planning.

We may also disclose information about your health to our business associates to enable them to perform services for us or on our behalf relating to our operations. At the time you apply for insurance, we may disclose information about your health in encoded form to the Medical Information Bureau (MIB) in an effort to deter fraud, misrepresentation or criminal activity.

Public health risks: As required by law, we may disclose information about your health to public health authorities that receive information to: prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; and notify a person who may be at risk for contracting or spreading a disease or condition.

Health oversight activities: We may disclose information about your health to a health oversight agency for activities authorized by law. Examples of these oversight activities include: audits, investigations and inspections. These activities are necessary for the government to monitor the health care system, government programs and entities subject to civil rights laws.

Lawsuits and disputes: If you are involved in a lawsuit or a dispute, we may disclose information about your health in response to a court or administrative order. We may also disclose this information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute. We will make reasonable efforts to tell you about the request.

Law enforcement: We may release information about your health if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process; and about a death that may be the result of criminal conduct.

We may also release information about your health to law enforcement or other governmental authorities to protect us against perpetration of fraud or other illegal activities.

Coroners, medical examiners and funeral directors: We may release information about your health to a coroner or medical examiner. We also may release information about your health to funeral directors as necessary to carry out their duties.

Research: Under certain circumstances, we may use information about your health for insurance research purposes. We may also disclose information about your health to organizations conducting actuarial or insurance research studies.

To avert a serious threat to health or safety: Although it is not our practice, we may use and disclose information about your health when necessary to help prevent a serious threat to the health and safety of you or others.

Any disclosure, however, would only be to someone able to help prevent the threat.

Military and veterans: If you are a member of the armed forces, we may release information about your health as required by military command authorities.

Workers' compensation: We may release information about your health to comply with laws relating to workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Uses and disclosures of information about your health with your authorization

The following use and disclosures will only be made with authorization from you:

- Uses and disclosures of health information for marketing purposes.
- Uses and disclosures of psychotherapy notes, unless permitted by law.
- Disclosures that constitute the sale of personal health information.

Other uses and disclosures of information about your health that are not described in this notice or are not otherwise permitted by law will be made only with your written authorization. You may revoke such authorization as described in this notice.

Your rights regarding information about your health

You have the following rights regarding the health information we maintain about you, which you may exercise by submitting your request in writing to:

Thrivent
Attention: Privacy Office
4321 N. Ballard Road
Appleton, WI 54919-0001

Right to revoke authorization: You may revoke your authorization that allows us to use or disclose health information that is not otherwise covered by this notice or applicable law in writing at any time except: when the authorization was obtained as a condition of obtaining insurance; during the contestable period; or to the extent that we have taken action in reliance on your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization and that we may retain documents that may contain information about your health.

Right to request restrictions: You have a right to request a restriction on the information about your health that we use or disclose for treatment, payment or health care operations. You also have the right to request a limit on the information we disclose about your health to someone who is involved in your care or the payment for your care, such as a family member.

In your request, you must tell us the information you want to limit; whether you want to limit our use, disclosure or both; and to whom you want the limits to apply (for example, disclosures to your spouse).

We are not required to agree to your requested restriction or limitation, unless the protected health information pertains solely to health care for which you, not a health plan, have paid us or your provider in full.

Right to request confidential communications: If you could be endangered by our normal communication channels, you have the right to request that we communicate information about your health to you by alternative means or at an alternative location. We will ask you the reason for your request, and we will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to inspect and copy: You have a right to inspect and copy information about your health that we maintain. Usually, this includes medical and billing records. Under federal law, this right does not include psychotherapy notes or information about your health compiled in reasonable anticipation of litigation, administrative action or administrative proceeding. If you request a copy of this information, we may charge a standard fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain limited circumstances, such as where disclosure would reasonably endanger the life or physical safety of you or another person. If you are denied access to information about your health, you may request that the denial be reviewed.

Right to amend: If you believe the information we have about your health is incorrect or incomplete, you may ask us to amend the information. You must provide a reason that supports your request. You have the right to request an amendment for as long as the information is kept by or for us.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment.
- Is not part of the information about your health kept by or for us.
- Is not part of the information about your health that you would be permitted to inspect and copy.
- Is accurate and complete.

Right to request an accounting: You have the right to receive an accounting of certain disclosures of information about your health that we made, if any. This right applies to disclosures for purposes other than treatment, payment, health care operations, or as otherwise permitted or required by law. You have a right to receive specific information about these disclosures that occur after Nov. 1, 2002. The right to receive this information is subject to certain exceptions, restrictions and limitations.

Right to a copy of this notice: You have the right to obtain a copy of this notice at any time.

Our duties regarding information about your health

We are required by law to:

- Maintain the privacy of your protected health information.
- Notify you following a breach of your unsecured protected health information.
- Provide you with this notice of our legal duties and health information privacy practices.
- Not use or disclose protected health information that is genetic information to underwrite for Medicare Supplement Insurance.
- Abide by the terms of this notice.

Changes to this notice

We reserve our right to change the terms of this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. If we make a material change to the terms of this notice, we will mail a revised notice to you. Please be aware this notice is also provided on Thrivent.com for you to review.

For more information or to file a complaint

If you have questions or would like additional information, you may contact us at 800-847-4836.

If you believe your privacy rights have been violated, you may file a written complaint with our privacy office and with the Secretary of the Department of Health & Human Services. You will not be retaliated against for filing a complaint.

This notice was published and became effective on Sept. 24, 2013.

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4321 N. Ballard Road, Appleton, WI 54919-0001
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Authorization to Release Underwriting information to Insurance Agent/Agency

Proposed Insured's Name: _____

Do not mark up this form outside of the fillable field areas. Any changes to the form will not be honored.

By signing below, I, the proposed insured named above or their personal representative, authorize Thrivent Financial for Lutherans, its employees, representatives, agents, and any other persons performing services for it (collectively, "Thrivent") to release personal and medical information about me to _____, my insurance agent/agency. This is limited to information Thrivent collected about me to determine my eligibility for Thrivent long term care insurance (collectively, "underwriting information"), described below.

The underwriting information Thrivent may disclose to my agent/agency includes personal and medical information related to actions Thrivent may have taken. For example, these actions include charging me a higher insurance premium, changing insurance benefits to something other than I applied for, or declining my insurance application.

I authorize my insurance agent/agency to use Thrivent's underwriting information to assist me in the insurance application process, or to find insurance coverage through another insurance carrier.

I authorize Thrivent to disclose to my insurance agent/agency underwriting information including protected health information about my physical health (e.g., services for preventive, diagnostic and therapeutic care, testing, counseling, and medical prescriptions), as well as non-health information about me (e.g., financial, insurance, credit, occupational, avocational, and driving history). Pursuant to this authorization, Thrivent may release underwriting information when such disclosure is allowed under applicable state and federal laws and regulations. If Thrivent's underwriting information contains information specifically protected under state or federal law (e.g., information on the diagnosis and treatment of mental illness, alcohol, and drug use, information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, and genetic testing information), I understand and agree that such information is excluded from the scope of this authorization and it will not be provided by Thrivent to my insurance agent/agency.

This authorization is valid for 24 months following the date of my signature below. A copy, image or facsimile of this authorization is as valid as the original. I authorize the release of this information in any format including but not limited to paper and/or electronic form.

I understand I may refuse to sign this authorization. If I refuse to sign, it will not affect the issuance of the insurance I applied for.

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. Health information about me, which is used or disclosed pursuant to authorization, may be subject to redisclosure by my insurance agent/agency, and may no longer be protected under federal law.

I have the right to revoke this authorization by writing to Thrivent at:
Attention: Privacy Office, Thrivent, 4321 N. Ballard Rd., Appleton, WI 54919-0001

I understand and agree that revocation of this authorization is effective prospectively, not retroactively, and is not effective to the extent Thrivent has previously relied on it.

Advisors: Please leave a completed copy of this form with the client.

I have read this authorization and agree to its terms as indicated by my signature below.

Signature of proposed insured or personal representative _____

Date signed _____

Description of personal representative's authority to act: _____

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Things You Should Know Before You Buy Long-Term Care Insurance

Long-Term Care Insurance

- A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
- You should **not** buy this insurance policy unless you can afford to pay the premiums every year. Remember that the insurer can increase premiums in the future.
- The personal worksheet includes questions designed to help you and the insurer determine whether this policy is suitable for your needs.

Medicare

- Medicare does **not** pay for most long-term care.

Medicaid

- Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid.
- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide

- Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

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Membership Application

Welcome to Membership

For some of us, personal finances aren't just personal—they impact more than ourselves. Loved ones. Neighbors. The communities we call home, and the causes we hold in our hearts.

At Thrivent, we help you look at your financial picture with the bigger picture in mind. Our unique combination of financial services and generosity programs unlock opportunities to make an impact where it matters most.

Thrivent is member-owned. This means when you become a member, you become part of something bigger: our collective ownership. Thrivent members share a commitment to help strengthen the communities where they live, work and worship.

After more than 120 years, we've grown to become a Fortune 500 financial organization serving 2.4 million clients nationwide who seek to make a difference with their money.

What unites Thrivent Members

Thrivent is a unique type of membership organization that is required to maintain a common bond among its membership. Thrivent's members share the common bond of Christianity. We welcome and serve all Christians.

Our service to Christians is based on three core beliefs:

- Everything we have is a gift from God.
- We are called to be good stewards of those gifts.
- Generosity is an expression of our faith.

If you share these beliefs, we invite you to join Thrivent's membership.

Membership Application

Select one of the following:

☐ I am age 16 or older and applying for membership with Thrivent and a Thrivent Member Network; or

☐ I am age 18 or older and applying for membership on behalf of a youth under age 16

Proposed Member Information

Name of Proposed Member _____

Address _____

City _____ State _____ ZIP code _____

Phone _____ Date of birth _____

Email Address _____

Statement of Common Bond. Please select the option that best fits:

☐ I am a Christian; or

☐ I am the spouse of a Christian; or

☐ I am the parent/guardian of the youth, under age 16, identified above. I confirm they are being raised in the Christian faith.

I agree to support and further Thrivent's shared goal of helping people plan their finances for the people, causes and communities they love. I verify that the information I provided is true and correct.

Signature of proposed member (age 16 or older) or parent/guardian of youth (age 0-15)

_____ _____

Signature Date Signed

Get answers to questions we receive about membership at Thrivent: www.thrivent.com/membershipFAQ.

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Preliminary Declaration of Insurability Long-Term Care Insurance

Section 1 - Proposed Insured Information

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

Section 2 - Preliminary Insurability

☐ Yes ☐ No 1. Within the past five years have you had, been diagnosed, taken medication or been treated by a licensed health care practitioner for:

- ☐ Alcohol or controlled substance dependency
- ☐ Alzheimer's disease, dementia, senility, organic brain syndrome, or frequent or persistent forgetfulness or memory loss
- ☐ Amyotrophic Lateral Sclerosis (ALS, Lou Gehrig's disease)
- ☐ Bone marrow, Hodgkin's disease, leukemia or lymphoma disorder
- ☐ Cancer of the bone, brain, esophagus, liver, lung, kidney, ovary, pancreas, stomach, or any metastatic cancer
- ☐ Cirrhosis of the liver
- ☐ Cystic Fibrosis
- ☐ Down's syndrome
- ☐ Emphysema or other lung disorder requiring the use of oxygen
- ☐ Huntington's Chorea
- ☐ Multiple Sclerosis or post-polio syndrome
- ☐ Muscular Dystrophy
- ☐ Myasthenia Gravis
- ☐ Organ transplant other than cornea
- ☐ Paralysis (excluding Bell's palsy), paraplegia or quadriplegia
- ☐ Parkinson's disease
- ☐ Renal failure, chronic kidney disease, not including kidney stones
- ☐ Schizophrenia or other forms of psychosis
- ☐ Stroke
- ☐ Transient Ischemic Attack (TIA)

☐ Yes ☐ No 2. Have you tested positive for exposure to the Human Immunodeficiency Virus (HIV) infection, been diagnosed as having AIDS-related complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by the HIV infection or other sickness or condition derived from such infection?

☐ Yes ☐ No 3. During the last 12 months, have you used or been advised by a licensed health care practitioner to use:

- ☐ Catheter
- ☐ Chairlift
- ☐ Dialysis
- ☐ Hospital bed
- ☐ Motorized scooter
- ☐ Oxygen equipment
- ☐ Quad cane
- ☐ Respirator
- ☐ Stair lift
- ☐ Walker
- ☐ Wheelchair

☐ Yes ☐ No 4. Do you currently or within the past 12 months have you ever required assistance or supervision of any kind to perform any of the following activities:

- ☐ Bathing
- ☐ Bowel or Bladder Control
- ☐ Dressing
- ☐ Eating
- ☐ Moving in or out of bed or chair
- ☐ Taking your medication
- ☐ Toileting
- ☐ Walking

☐ Yes ☐ No 5. Do you currently or within the past 12 months have you resided in, been medically advised by a licensed health care practitioner to enter or are you planning to enter a:

- ☐ Assisted Care Living Facility
- ☐ Nursing Home
- ☐ Other Custodial Facility

☐ Yes ☐ No 6. Are you currently receiving, within the past 12 months have you received, have you been medically advised by a licensed health care practitioner to receive or are you planning to receive:

- ☐ Home Health Care Services
- ☐ Adult Day Care Services

If a "Yes" response is provided to any of questions 1-6, we recommend not continuing the application process.

Section 3 - Agreement and Signature

I have read the statements and answers recorded on this Preliminary Declaration of Insurability. To the best of my knowledge and belief, they are true, complete and correctly recorded and shall be a basis of any contract issued or for which a change has been requested. My signature applies to all sections and statements on this Preliminary Declaration of Insurability.

Signed at _____ _____
City State

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Signature of proposed insured and date signed (mm/dd/yyyy)

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

Print name of licensed agent	Code number and FL licensed ID number of agent

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Declaration of Insurability Long-Term Care Insurance

Section 1 - Proposed Insured Information

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

Section 2 - Declaration of Insurability

Height - ___ Ft ___ In Weight - _____ Lbs To the best of your knowledge weight 1 year ago - _____ Lbs

Name of primary health care provider for the past two years - Indicate if none.

Date last consulted	Reason last consulted	
Type of treatment	Medication prescribed	Recovery date

Place details for all "Yes" answers for questions 1-6 in Section 3.

1. Within the past 10 years have you been diagnosed or been treated by a licensed health care practitioner, physician or other member of the medical profession, chiropractor, counselor or any other health care provider for any of the following:

☐ Yes ☐ No (a) disease or disorder of the heart, circulatory, blood or immune system (excluding Human Immunodeficiency Virus (HIV))?
If high blood pressure:
Last blood pressure reading - _____ /_____ Date of last blood pressure reading - _____

☐ Yes ☐ No (b) abnormal growth, cyst, tumor or cancer?

☐ Yes ☐ No (c) disease or disorder of the respiratory system?

☐ Yes ☐ No (d) disease or disorder of the digestive system (e.g., stomach, intestines, rectum, liver, gallbladder, esophagus)?

☐ Yes ☐ No (e) disease or disorder of the urinary system, (e.g., kidneys, bladder)?

☐ Yes ☐ No (f) disease or disorder of the endocrine/hormone system (e.g., diabetes)?

☐ Yes ☐ No (g) disease or disorder of the nervous system, including psychological and psychiatric care?

☐ Yes ☐ No (h) disease or disorder of the muscle, skin, bone or joint?

☐ Yes ☐ No (i) disease or disorder of the reproductive system?

☐ Yes ☐ No (j) disease or disorder of the eyes, ears, nose or throat?

☐ Yes ☐ No 2. Within the past 10 years have you received medical treatment or counseling for, or been advised by a licensed health care practitioner, physician or other member of the medical profession, chiropractor, counselor or any other health care provider to discontinue the use of alcohol or controlled substances or been a member of Alcoholics Anonymous, Narcotics Anonymous, or other support organization?

☐ Yes ☐ No 3. Within the past 10 years, have you used or are you currently using, except as prescribed by a licensed health care practitioner or physician, controlled substances such as cocaine, marijuana, amphetamines or narcotics?

4. Other than reported above, within the past five years, have you:

☐ Yes ☐ No (a) consulted or been advised to consult a licensed health care practitioner, physician or other member of the medical profession, chiropractor, psychiatrist, psychologist, or counselor for any reason?

☐ Yes ☐ No (b) been advised to have surgery, medical evaluation or other diagnostic test(s) other than an AIDs related test that has not yet been completed?

☐ Yes ☐ No (c) been advised by a licensed health care practitioner, physician, or other member of the medical profession, chiropractor or medical therapist to restrict or avoid normal activities due to illness or injury?

☐ Yes ☐ No (d) taken any other prescription drugs?

Prescription Drug Used	Date Last Used	Reason for Use

☐ Yes ☐ No 5. Within the past five years have you been diagnosed or treated by a licensed health care practitioner, physician or other member of the medical profession, chiropractor, counselor, or any other health care provider for multiple falls or any fall that resulted in a fracture?

☐ Yes ☐ No 6. Other than reported above, within the past five years, have you been under the care of a licensed health care practitioner, physician or other member of the medical profession or are you scheduled to see a licensed health care practitioner, physician or other member of the medical profession?

☐ Yes ☐ No 7. Do you currently use, or within the past 10 years have you used, tobacco or other nicotine products?

Type of Tobacco/Nicotine Product	Date Last Used

☐ Yes ☐ No 8. Within the past two years have you been required or advised by a licensed health care practitioner, physician or other member of the medical profession, chiropractor, counselor or any other health care provider to have nursing home care or home health care?

Reason Care Needed	Date Began	Date Ended

☐ Yes ☐ No 9. To the best of your knowledge have your biological parents, brothers, or sisters been diagnosed or treated by a physician or other member of the medical profession, chiropractor, counselor or any other health care provider for Alzheimer's disease, cancer (internal or melanoma), coronary artery disease, diabetes, or Huntington's disease?

Disease or Disorder	Relationship to Proposed Insured	Age at Onset	Current Age	Age at Death

☐ Yes ☐ No 10. Do you currently drive? If yes, miles per year - _____

☐ Yes ☐ No 11. Within the past five years, have you had a driver's license suspended or had a moving traffic violation?

Type of Violation	MPH Over	Date

☐ Yes ☐ No 12. To the best of my knowledge, within the past seven years, have you had a life, disability income or long-term care insurance application declined, postponed, rated, modified, or withdrawn?

Application Action	Company Name	Date	Reason

13. Occupation status

☐ Employed
☐ Employed - unable to work, disabled
☐ Retired
☐ Other (describe) - _____
☐ Retired due to disability
☐ Unemployed
☐ Unemployed due to disability

Current occupation

14. Type of dwelling

☐ Home, condominium, apartment
☐ Nursing home
☐ Other (describe) - _____
☐ Assisted living facility
☐ Retirement home

☐ Yes ☐ No 15. Within the past two years have you been required or been advised by a licensed health care practitioner, physician or other member of the medical profession, chiropractor, counselor or any other health care provider to use any of the following aids or appliances or have assistance with any of the following:

☐ Brace
☐ Climbing stairs
☐ Crutches
☐ Grab bars
☐ Handicap license plate, place card permit or sticker
☐ Housework
☐ Laundry
☐ Meal preparation
☐ Mobility outside the residence
☐ Prosthetic device
☐ Shopping
☐ Single footed cane
☐ Other (describe) - _____

Aid, appliance or assistance needed

Reason needed

Date began	Current use ☐ Yes ☐ No	Date ended

Aid, appliance or assistance needed

Reason needed

Date began	Current use ☐ Yes ☐ No	Date ended

Aid, appliance or assistance needed

Reason needed

Date began	Current use ☐ Yes ☐ No	Date ended

☐ Yes ☐ No 16. Within the past five years, have you made a claim for or received benefits, compensation or pension for any injury, sickness, disability or impaired condition? If yes:

Type of injury, sickness, disability, or impaired condition

Claim begin date (mm/yyyy)	Claim end date (mm/yyyy)

Name of treating health care provider

Section 3 - Details for questions answered "Yes"

Question: No/Ltr	Type of disease, disorder, injury, test, care, controlled substance			Date of diagnosis
Date of onset	Number of occurrences	Treatment		Number of times treated
Last occurrence date	Time lost from work/school	Recovered ☐ Yes ☐ No	Recovery date	Date substance last used
Last consultation date	Date of last hospitalization	Surgery date	Medication(s) currently taking	
Residuals		Care provider/Facility with records if other than primary care provider		

Question: No/Ltr	Type of disease, disorder, injury, test, care, controlled substance			Date of diagnosis
Date of onset	Number of occurrences	Treatment		Number of times treated
Last occurrence date	Time lost from work/school	Recovered ☐ Yes ☐ No	Recovery date	Date substance last used
Last consultation date	Date of last hospitalization	Surgery date	Medication(s) currently taking	
Residuals		Care provider/Facility with records if other than primary care provider		

Question: No/Ltr	Type of disease, disorder, injury, test, care, controlled substance		Date of diagnosis
Date of onset	Number of occurrences	Treatment	Number of times treated
Last occurrence date	Time lost from work/school	Recovered ☐ Yes ☐ No / Recovery date	Date substance last used
Last consultation date	Date of last hospitalization	Surgery date	Medication(s) currently taking
Residuals		Care provider/Facility with records if other than primary care provider	

Question: No/Ltr	Type of disease, disorder, injury, test, care, controlled substance		Date of diagnosis
Date of onset	Number of occurrences	Treatment	Number of times treated
Last occurrence date	Time lost from work/school	Recovered ☐ Yes ☐ No / Recovery date	Date substance last used
Last consultation date	Date of last hospitalization	Surgery date	Medication(s) currently taking
Residuals		Care provider/Facility with records if other than primary care provider	

Question: No/Ltr	Type of disease, disorder, injury, test, care, controlled substance		Date of diagnosis
Date of onset	Number of occurrences	Treatment	Number of times treated
Last occurrence date	Time lost from work/school	Recovered ☐ Yes ☐ No / Recovery date	Date substance last used
Last consultation date	Date of last hospitalization	Surgery date	Medication(s) currently taking
Residuals		Care provider/Facility with records if other than primary care provider	

Section 4 - Agreement and Signature

I have read the statements and answers recorded on this Declaration of Insurability. To the best of my knowledge and belief, they are true, complete and correctly recorded and shall be a basis of any contract issued or for which a change has been requested. My signature applies to all sections and statements on this Declaration of Insurability.

Signed at _____ _____
City State

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Signature of proposed insured and date signed (mm/dd/yyyy)

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

Print name of licensed agent	Code number and FL licensed ID number of agent

thrivent

Thrivent Financial for Lutherans
4321 N. Ballard Road, Appleton, WI 54919-0001
thrivent.com • 800-847-4836

Health and Other Personal Information Authorization

(This authorization complies with the HIPAA Privacy Rule.)

Name _____

Date of birth _____ Contract number _____

To determine my eligibility for insurance, payment, or health care, or for any other use, collection or disclosure permitted by law, I authorize Thrivent Financial for Lutherans, Thrivent Insurance Agency Inc. and third-party administrator illumifin, their employees, representatives, agents, reinsurers and any other persons performing business, legal, medical or insurance services for them or on their behalf (hereafter "You" or "Your") 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. This medical or health information includes information on the diagnosis and treatment of mental illness, alcohol, drug use, and information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law.

Any health care professional, medical facility, pharmacy, pharmacy benefit manager, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearinghouse, other insurer, insurance broker, health plan, Your affiliate, health care component of Your company, Department of Motor Vehicles, government agency, consumer reporting agency, employer, family member and acquaintance may provide information about me, including my entire medical record, which may contain DNA or genetic testing analysis results, to You. This information may be released in any format including but not limited to paper and/or electronic format, including through a Health Information Exchange or My Provider's electronic health record system. I authorize MIB, LLC to give to You, or Your reinsurers, any records of me or my health. **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.**

You may disclose information about me, including any DNA or genetic testing analysis results contained within my medical history to any insurance broker and other insurer approved by You for the purpose of securing insurance for me. You may disclose health information I provide to You to the writing agent or agency. Information about my health may be released as required or permitted by law such as to MIB, LLC to deter fraud, misrepresentation, or criminal activity, or to my indicated physician where state law requires notification. 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. The application holding my personally identifiable health information and financial information will be attached to the contract for purposes of contract issuance. If I do not own the contract, a copy of the contract and application will be provided to the owner.

I authorize You to procure or prepare an investigative consumer report to determine my eligibility for insurance. This inquiry may include information as to my character, general reputation, personal characteristics, and mode of living, as applicable. Upon my written request, You will inform me whether an investigative consumer report was requested, and if so, You will provide the name and address of the consumer reporting agency to whom the request was made so I may contact the agency to inspect and receive a copy of such report.

This authorization is valid for 24 months following the date signed below. For health insurance benefit claims it is valid for the coverage of the policy, or for all other claims for the duration of the claim. A copy, image or facsimile is as valid as the original. I may revoke this authorization by writing to You at the address above. I acknowledge that such revocation is not effective to the extent You previously relied on it, or You had a legal right to contest the insurance contract or a claim under the insurance contract. Failure to sign or subsequent revocation of this authorization may impair Your ability to process my application or evaluate claims and may be a basis for denying my application or claim for benefits.

MIB Disclosure: I authorize You and Your reinsurers to make a brief report of my personal health information to MIB, LLC.

I have read this authorization and am entitled to receive a copy of it. By my signature below, I agree to this authorization and the MIB Disclosure.

Signature of proposed insured or personal representative _____ Date _____

Description of personal representative's authority to act _____

MIB Pre-Notice

Information regarding your insurability will be treated as confidential. Thrivent Financial for Lutherans (“Thrivent”), or its reinsurers may, however, make a brief report thereon to MIB, LLC, which operates an information exchange on behalf of insurance companies that are members of MIB Group Inc. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 or go to its website at www.mib.com to request disclosure online. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400 Braintree, MA 02184-8734.

Thrivent, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Form **W-9**
(Rev. March 2024)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give form to the requester. Do not send to the IRS.

Before you begin. For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

Print or type. See ***Specific Instructions*** on page 3.

1 Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)

2 Business name/disregarded entity name, if different from above.

3a Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor ☐ C corporation ☐ S corporation ☐ Partnership ☐ Trust/estate

☐ LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) . . . . .

Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner.

☐ Other (see instructions)

3b If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions . . . . . ☐

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any)

Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any)

(Applies to accounts maintained outside the United States.)

5 Address (number, street, and apt. or suite no.). See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. See also *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–		–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and, generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	**Signature of U.S. person**	**Date**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3. See the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they

must obtain your correct taxpayer identification number (TIN), which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

• Form 1099-INT (interest earned or paid).

• Form 1099-DIV (dividends, including those from stocks or mutual funds).

• Form 1099-MISC (various types of income, prizes, awards, or gross proceeds).

• Form 1099-NEC (nonemployee compensation).

• Form 1099-B (stock or mutual fund sales and certain other transactions by brokers).

• Form 1099-S (proceeds from real estate transactions).

• Form 1099-K (merchant card and third-party network transactions).

• Form 1098 (home mortgage interest), 1098-E (student loan interest), and 1098-T (tuition).

• Form 1099-C (canceled debt).

• Form 1099-A (acquisition or abandonment of secured property).

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

Caution: If you don't return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding*, later.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued);

2. Certify that you are not subject to backup withholding; or

3. Claim exemption from backup withholding if you are a U.S. exempt payee; and

4. Certify to your non-foreign status for purposes of withholding under chapter 3 or 4 of the Code (if applicable); and

5. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting is correct. See *What Is FATCA Reporting*, later, for further information.

Note: If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

• An individual who is a U.S. citizen or U.S. resident alien;

• A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;

• An estate (other than a foreign estate); or

• A domestic trust (as defined in Regulations section 301.7701-7).

Establishing U.S. status for purposes of chapter 3 and chapter 4 withholding. Payments made to foreign persons, including certain distributions, allocations of income, or transfers of sales proceeds, may be subject to withholding under chapter 3 or chapter 4 of the Code (sections 1441–1474). Under those rules, if a Form W-9 or other certification of non-foreign status has not been received, a withholding agent, transferee, or partnership (payor) generally applies presumption rules that may require the payor to withhold applicable tax from the recipient, owner, transferor, or partner (payee). See Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities.

The following persons must provide Form W-9 to the payor for purposes of establishing its non-foreign status.

• In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the disregarded entity.

• In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the grantor trust.

• In the case of a U.S. trust (other than a grantor trust), the U.S. trust and not the beneficiaries of the trust.

See Pub. 515 for more information on providing a Form W-9 or a certification of non-foreign status to avoid withholding.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person (under Regulations section 1.1441-1(b)(2)(iv) or other applicable section for chapter 3 or 4 purposes), do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Pub. 515). If you are a qualified foreign pension fund under Regulations section 1.897(l)-1(d), or a partnership that is wholly owned by qualified foreign pension funds, that is treated as a non-foreign person for purposes of section 1445 withholding, do not use Form W-9. Instead, use Form W-8EXP (or other certification of non-foreign status).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a saving clause. Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items.

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if their stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first Protocol) and is relying on this exception to claim an exemption from tax on their scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 24% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include, but are not limited to, interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third-party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester;

2. You do not certify your TIN when required (see the instructions for Part II for details);

3. The IRS tells the requester that you furnished an incorrect TIN;

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only); or

5. You do not certify to the requester that you are not subject to backup withholding, as described in item 4 under "*By signing the filled-out form*" above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code*, later, and the separate Instructions for the Requester of Form W-9 for more information.

See also *Establishing U.S. status for purposes of chapter 3 and chapter 4 withholding*, earlier.

What Is FATCA Reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all U.S. account holders that are specified U.S. persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code*, later, and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you are no longer tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account, for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account (other than an account maintained by a foreign financial institution (FFI)), list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9. If you are providing Form W-9 to an FFI to document a joint account, each holder of the account that is a U.S. person must provide a Form W-9.

• **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note for ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040 you filed with your application.

• **Sole proprietor.** Enter your individual name as shown on your Form 1040 on line 1. Enter your business, trade, or "doing business as" (DBA) name on line 2.

• **Partnership, C corporation, S corporation, or LLC, other than a disregarded entity.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

• **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. Enter any business, trade, or DBA name on line 2.

• **Disregarded entity.** In general, a business entity that has a single owner, including an LLC, and is not a corporation, is disregarded as an entity separate from its owner (a disregarded entity). See Regulations section 301.7701-2(c)(2). A disregarded entity should check the appropriate box for the tax classification of its owner. Enter the owner's name on line 1. The name of the owner entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2. If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, enter it on line 2.

Line 3a

Check the appropriate box on line 3a for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box on line 3a.

IF the entity/individual on line 1 is a(n) . . .	THEN check the box for . . .
• Corporation	Corporation.
• Individual or • Sole proprietorship	Individual/sole proprietor.
• LLC classified as a partnership for U.S. federal tax purposes or • LLC that has filed Form 8832 or 2553 electing to be taxed as a corporation	Limited liability company and enter the appropriate tax classification: P = Partnership, C = C corporation, or S = S corporation.
• Partnership	Partnership.
• Trust/estate	Trust/estate.

Line 3b

Check this box if you are a partnership (including an LLC classified as a partnership for U.S. federal tax purposes), trust, or estate that has any foreign partners, owners, or beneficiaries, and you are providing this form to a partnership, trust, or estate, in which you have an ownership interest. You must check the box on line 3b if you receive a Form W-8 (or documentary evidence) from any partner, owner, or beneficiary establishing foreign status or if you receive a Form W-9 from any partner, owner, or beneficiary that has checked the box on line 3b.

Note: A partnership that provides a Form W-9 and checks box 3b may be required to complete Schedules K-2 and K-3 (Form 1065). For more information, see the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

If you are required to complete line 3b but fail to do so, you may not receive the information necessary to file a correct information return with the IRS or furnish a correct payee statement to your partners or beneficiaries. See, for example, sections 6698, 6722, and 6724 for penalties that may apply.

Line 4 Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space on line 4 any code(s) that may apply to you.

Exempt payee code.

• Generally, individuals (including sole proprietors) are not exempt from backup withholding.

• Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.

• Corporations are not exempt from backup withholding for payments made in settlement of payment card or third-party network transactions.

• Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space on line 4.

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2).

2—The United States or any of its agencies or instrumentalities.

3—A state, the District of Columbia, a U.S. commonwealth or territory, or any of their political subdivisions or instrumentalities.

4—A foreign government or any of its political subdivisions, agencies, or instrumentalities.

5—A corporation.

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or territory.

7—A futures commission merchant registered with the Commodity Futures Trading Commission.

8—A real estate investment trust.

9—An entity registered at all times during the tax year under the Investment Company Act of 1940.

10—A common trust fund operated by a bank under section 584(a).

11—A financial institution as defined under section 581.

12—A middleman known in the investment community as a nominee or custodian.

13—A trust exempt from tax under section 664 or described in section 4947.

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
• Interest and dividend payments	All exempt payees except for 7.
• Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
• Barter exchange transactions and patronage dividends	Exempt payees 1 through 4.
• Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 5.[2]
• Payments made in settlement of payment card or third-party network transactions	Exempt payees 1 through 4.

[1] See Form 1099-MISC, Miscellaneous Information, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) entered on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37).

B—The United States or any of its agencies or instrumentalities.

C—A state, the District of Columbia, a U.S. commonwealth or territory, or any of their political subdivisions or instrumentalities.

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i).

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i).

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state.

G—A real estate investment trust.

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940.

I—A common trust fund as defined in section 584(a).

J—A bank as defined in section 581.

K—A broker.

L—A trust exempt from tax under section 664 or described in section 4947(a)(1).

M—A tax-exempt trust under a section 403(b) plan or section 457(g) plan.

Note: You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns. If this address differs from the one the requester already has on file, enter "NEW" at the top. If a new address is provided, there is still a chance the old address will be used until the payor changes your address in their records.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have, and are not eligible to get, an SSN, your TIN is your IRS ITIN. Enter it in the entry space for the Social security number. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN.

If you are a single-member LLC that is disregarded as an entity separate from its owner, enter the owner's SSN (or EIN, if the owner has one). If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note: See *What Name and Number To Give the Requester*, later, for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at *www.SSA.gov*. You may also get this form by calling 800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/EIN*. Go to *www.irs.gov/Forms* to view, download, or print Form W-7 and/or Form SS-4. Or, you can go to *www.irs.gov/OrderForms* to place an order and have Form W-7 and/or Form SS-4 mailed to you within 15 business days.

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and enter "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, you will generally have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon. See also *Establishing U.S. status for purposes of chapter 3 and chapter 4 withholding*, earlier, for when you may instead be subject to withholding under chapter 3 or 4 of the Code.

Caution: A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, 4, or 5 below indicates otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code*, earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third-party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), ABLE accounts (under section 529A), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account) other than an account maintained by an FFI	The actual owner of the account or, if combined funds, the first individual on the account[1]
3. Two or more U.S. persons (joint account maintained by an FFI)	Each holder of the account
4. Custodial account of a minor (Uniform Gift to Minors Act)	The minor[2]
5. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee[1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner[1]
6. Sole proprietorship or disregarded entity owned by an individual	The owner[3]
7. Grantor trust filing under Optional Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))**	The grantor*
8. Disregarded entity not owned by an individual	The owner
9. A valid trust, estate, or pension trust	Legal entity[4]
10. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
11. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
12. Partnership or multi-member LLC	The partnership
13. A broker or registered nominee	The broker or nominee
14. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
15. Grantor trust filing Form 1041 or under the Optional Filing Method 2, requiring Form 1099 (see Regulations section 1.671-4(b)(2)(i)(B))**	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name on line 1, and enter your business or DBA name, if any, on line 2. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

* **Note:** The grantor must also provide a Form W-9 to the trustee of the trust.

** For more information on optional filing methods for grantor trusts, see the Instructions for Form 1041.

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records From Identity Theft

Identity theft occurs when someone uses your personal information, such as your name, SSN, or other identifying information, without your permission to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax return preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity, or a questionable credit report, contact the IRS Identity Theft Hotline at 800-908-4490 or submit Form 14039.

For more information, see Pub. 5027, Identity Theft Information for Taxpayers.

Victims of identity theft who are experiencing economic harm or a systemic problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 877-777-4778 or TTY/TDD 800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov*. You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 800-366-4484. You can forward suspicious emails to the Federal Trade Commission at *spam@uce.gov* or report them at *www.ftc.gov/complaint*. You can contact the FTC at *www.ftc.gov/idtheft* or 877-IDTHEFT (877-438-4338). If you have been the victim of identity theft, see *www.IdentityTheft.gov* and Pub. 5027.

Go to *www.irs.gov/IdentityTheft* to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their laws. The information may also be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payors must generally withhold a percentage of taxable interest, dividends, and certain other payments to a payee who does not give a TIN to the payor. Certain penalties may also apply for providing false or fraudulent information.

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4321 N. Ballard Road, Appleton, WI 54919-0001
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Additional Client Information

Please print. This form is required when completing a paper application.

Name of annuitant/insured (print title, first, middle, last name and suffix, as applicable)

Sex ☐ Male ☐ Female	State of birth	Country of citizenship if not U.S.		
Marital status	Residential phone	Best time to call (CST)	Business phone	Best time to call (CST)
Residential address		Mailing address		
City / State / ZIP code		City / State / ZIP code		

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

Sex ☐ Male ☐ Female	State of birth	Country of citizenship if not U.S.		
Marital status	Residential phone	Best time to call (CST)	Business phone	Best time to call (CST)
Residential address		Mailing address		
City / State / ZIP code		City / State / ZIP code		

Name of applicant controller/owner (print title, first, middle, last name and suffix, as applicable) — Living trust? ☐ Yes ☐ No

Sex ☐ Male ☐ Female	State of birth	Country of citizenship if not U.S.		
Marital status	Residential phone	Best time to call (CST)	Business phone	Best time to call (CST)
Residential address		Mailing address		
City / State / ZIP code		City / State / ZIP code		

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Application for Individual Long-Term Care Insurance

☐ New Business
☐ Contract Change - contract number - _____

Section 1 - Proposed Insured

Name of proposed insured (print first, middle, last name and suffix, as applicable)

Date of birth	Sex ☐ Male ☐ Female	Residence state
Driver's license number		Driver's license state

☐ Yes ☐ No Are you a citizen of the United States of America (USA)?
☐ Yes ☐ No If no, are you a permanent resident of the USA?
☐ Yes ☐ No Are you married or do you have a state recognized partner?
☐ Yes ☐ No Are you one of two individuals in a committed relationship who have been living together for at least three consecutive years as partners or family members, and are committed to sharing expenses, and if related, belong to the same generation?

If yes to either of the above two questions, answer the following:

☐ Yes ☐ No Is spouse/partner/family member applying for Long-Term Care Insurance or Long-Term Care Insurance Rider with Thrivent Financial?

If yes, spouse/partner/family member's name - _____

☐ Yes ☐ No If no, does spouse/partner/family member have a long-term care or nursing home contract with Thrivent Financial?

If yes, contract number - _____

Section 2 - Replacement and Other Coverage

☐ Yes ☐ No 1. Are you covered by a state assistance program (e.g. Medicaid)?
☐ Yes ☐ No 2. Do you have another long-term care insurance policy or contract in force (including health care service contract, health maintenance organization contract)? If yes, provide details.

Company			Contract number
Address	City		
	State	ZIP code	Phone

Type of coverage	Benefit/contract amount	Maximum period	Annual premium

☐ Yes ☐ No Will coverage be discontinued if this Long-Term Care Insurance contract is issued?

Reason for replacement

☐ Yes ☐ No 3. Do you have any life insurance or annuity contracts currently in force which provide similar long-term care coverage? If yes, provide details.

Company			Contract number
Address	City		
	State	ZIP code	Phone

Type of coverage	Benefit/contract amount	Maximum period	Annual premium

☐ Yes ☐ No Will coverage be discontinued if this Long-Term Care Insurance contract is issued?

☐ Yes ☐ No If yes, is this a 1035 exchange?

Reason for replacement

☐ Yes ☐ No 4. Did you have another long-term care, nursing home policy, contract or rider in force during the last twelve (12) months? If yes, provide details.

Company	Contract number	Coverage end date

Section 3 - Long-Term Care Insurance New Business Benefit Information

Benefit Multiplier ☐ 24 months ☐ 36 months ☐ 48 months ☐ 60 months ☐ 96 months

Elimination Period ☐ 30 day ☐ 90 day ☐ 180 day

Maximum Monthly Benefit Amount $ _____

Contract Pay Type ☐ Lifetime Pay ☐ 10-Pay

Benefit Increase Options

☐ Annual Increase Benefit - 1% Compound
☐ Annual Increase Benefit - 2% Compound
☐ Annual Increase Benefit - 3% Compound
☐ Annual Increase Benefit - 5% Compound

Check if rejecting Annual Increase Benefit

☐ I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this contract with and without annual increase benefit, and I reject annual increase benefit.

Signature of proposed insured and date signed

X

☐ Flexible Increase Benefit
☐ None

Optional Riders

☐ Cash Benefit
☐ Nonforfeiture Benefit
☐ Return of Premium Upon Death
☐ Shared Care Benefit
☐ Survivorship Benefit
☐ Waiver of Elimination Period for Home Care and Adult Day Care

Section 4 - Long-Term Care Insurance Contract Change

☐ Increase Benefit Multiplier to ☐ 36 months ☐ 48 months ☐ 60 months ☐ 96 months

☐ Decrease Benefit Multiplier to ☐ 24 months ☐ 36 months ☐ 48 months ☐ 60 months

☐ Increase Elimination Period to ☐ 90 day ☐ 180 day

☐ Decrease Elimination Period to ☐ 30 day ☐ 90 day

☐ Increase ☐ Decrease Maximum Monthly Benefit Amount to $ _____

Optional Rider(s)

Add	Delete	
☐	☐	Annual Increase Benefit - 1% Compound Increases
☐	☐	Annual Increase Benefit - 2% Compound Increases
☐	☐	Annual Increase Benefit - 3% Compound Increases
☐	☐	Annual Increase Benefit - 5% Compound Increases
☐	☐	Cash Benefit
☐	☐	Flexible Increase Benefit
	☐	Nonforfeiture Benefit
	☐	Return of Premium Upon Death
	☐	Shared Care Benefit
	☐	Survivorship Benefit
☐	☐	Waiver of Elimination Period for Home Care and Adult Day Care

☐ Change Contract Pay Type to Lifetime Pay

☐ Add Spouse/Partner/Family Member discount - contract number - _____

Section 5 - Premium Payment Information

☐ Total initial premium $ _____ ☐ No premium with application

Premium billing amount $ _____

Frequency: ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly ☐ _____

Section 6 - Protection Against Unintended Lapse

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance contract for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid.

☐ I elect not to designate any person to receive such notice.

I request that you notify the following person:

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

Address	City		
	State	ZIP code	Phone

Section 7 - Special Requests

Section 8 - Agreement and Authorization

I understand and agree that:

1. I have read all statements and answers recorded on this application. They are given to obtain this insurance and are, to the best of my knowledge and belief, true, complete and correctly recorded.
2. The entire application consists of this Application for Individual Long-Term Care Insurance and all supplemental application forms required for the contract or change applied for as defined by the company. The entire application will become part of any contract issued or the contract for which a requested change has been approved.
3. No Representative of the company has the authority to change or waive any question contained in the application or to modify the application in any way.
4. No Representative of the company has the authority to accept risks or determine insurability for the company.
5. The date of the application is the latest of the following dates:
   a) The date shown on the Application for Individual Long-Term Care Insurance;
   b) The date shown on any required supplemental application forms;
   c) The date shown on the Declaration of Insurability.
6. Any change in this application that will result in any change in plan of insurance, amount, age at issue, sex, class or benefits shall require my written consent.
7. Thrivent Financial may require an attending physician's statement, medical records, an underwriting assessment, a medical exam, a motor vehicle report, a prescription drug or medication report or other questionnaire or test.
8. I have received the following:
   • Outline of Coverage • Long-Term Care Insurance Personal Worksheet • Potential Rate Increase Disclosure Form
   • Things You Should Know Before You Buy Long-Term Care Insurance • Shopper's Guide to Long-Term Care Insurance

In addition, for New Business:

No insurance will take effect unless and until:

a. A contract of insurance is issued and delivered;
b. The first full premium is paid during the lifetime of the person to be covered; and
c. The health of the person to be insured remains as stated in this application.

In addition, for Contract Change:

1. I agree that the requested change in my contract shall not become effective unless and until the required premium has been paid and the requested change has been approved by the company.
2. With regard to statements made in this application, the Time Limit on Certain Defenses provision will apply from the effective date of the contract change.

The signature below applies to all sections and statements on this application.

Signed at state - _____

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Caution: If your answers on this application are incorrect or untrue, Thrivent Financial for Lutherans may deny benefits or rescind your contract.

Signature of proposed insured and date signed

X

List any other health insurance contracts that you have sold to the insured that are still in force.

List any other health insurance contracts that you have sold to the insured in the past five years that are no longer in force.

I certify that I have asked all questions and recorded all answers as they were given to me and reviewed these with the proposed insured.

To the best of my knowledge, the contract applied for ☐ is ☐ is not intended to replace any part of, or all of, another contract.

Signature of representative and date signed

X

Name and code number of representative

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Supplement to Representative's Information

Care Provider Addresses

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

Primary Care Provider Address

Question: No / Ltr	Name			
	Address	City		
		State	ZIP Code	Phone number

Care Provider Addresses

Question: No / Ltr	Name			
	Address	City		
		State	ZIP Code	Phone number
Question: No / Ltr	Name			
	Address	City		
		State	ZIP Code	Phone number
Question: No / Ltr	Name			
	Address	City		
		State	ZIP Code	Phone number
Question: No / Ltr	Name			
	Address	City		
		State	ZIP Code	Phone number
Question: No / Ltr	Name			
	Address	City		
		State	ZIP Code	Phone number

Question: No / Ltr	Name			
	Address	City		
		State	ZIP Code	Phone number
Question: No / Ltr	Name			
	Address	City		
		State	ZIP Code	Phone number
Question: No / Ltr	Name			
	Address	City		
		State	ZIP Code	Phone number
Question: No / Ltr	Name			
	Address	City		
		State	ZIP Code	Phone number
Question: No / Ltr	Name			
	Address	City		
		State	ZIP Code	Phone number
Question: No / Ltr	Name			
	Address	City		
		State	ZIP Code	Phone number
Question: No / Ltr	Name			
	Address	City		
		State	ZIP Code	Phone number

Signature of representative and date signed

X

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Long-Term Care Insurance Personal Worksheet

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.
By state law, the insurance company must fill out part of the information on this worksheet and **ask** you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy form numbers	The premium for the coverage you are considering will be $ _____ per month, or $ _____ semiannually or $ _____ per quarter, or $ _____ year.	**Type of policy** (noncancellable/guaranteed renewable)
H-HX-LTC FL (13)		**Guaranteed Renewable**

The Company's Right to Increase Premiums:
The company has a right to increase the premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.

Rate Increase History
The company has sold long-term care insurance since 1987 and has sold this policy since 2012.

The company has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increases.

Florida Rate Increase History

Thrivent Policy Series	Years Available for Sale	Calendar Year of Increase	Percentages of Increase
12105 FL, 12106 FL	1997-2002	2007	Range: 1% to 39%
H2-LN-LTC-1 FL, H2-LH-LTCH-1 FL	1990-1998	2007	Range: 6% to 59%
H3-NN-LTCN-1 FL (97), H3-NC-LTCC-1 FL (97)	1997-2002	2007	Range: 1% to 59%

Nationwide Rate Increase History

Thrivent Policy Series[1]	Years Available for Sale	Calendar Year of Increase	Percentages of Increase[3]
12105, 12106	1997-2003	2004[2]	Range: 0% to 39% Average = 20%
H2-LN-LTC-1, H2-LH-LTCH-1	1990-1998	2004[2]	Range: -19% to 59% Average = 13%
H2-LA-LTC-1	1992-1997	2004[2]	Range: -22% to 59% Average = 16%
H3-NN-LTCN-1(97), H3-NC-LTCC-1(97)	1997-2003	2004[2]	Range: 0% to 59% Average = 37%

[1] Not every policy series was available in every state.

[2] The increase was implemented over the years 2004 to 2009 as the filing process was completed for each state.

[3] Percentage of increase varies by state, issue age and plan of insurance. Includes all rates, those that increased, decreased and stayed the same. Florida table only shows rates that increased.

Questions Related to Your Income

How will you pay each year's premium?

☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

☐ Yes ☐ No Have you considered whether you could afford to keep this policy if the premium schedule you were initially shown went up, for example, by 20%?

What is your annual income? (check one)

☐ Under $10,000 ☐ $20,000-$29,999 ☐ Over $50,000
☐ $10,000-$19,999 ☐ $30,000-$49,999

How do you expect your income to change over the next 10 years? (check one)

☐ No change ☐ Increase ☐ Decrease

Explain if increase or decrease is expected

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) ☐ Yes ☐ No

If not, have you considered how you will pay for the difference between future costs and your monthly benefit amount?

☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

The national average annual cost of care in 2018 was $92,724, but this figure varies across the country. In 10 years the national average annual cost would be about $151,038 if costs increase 5% annually.

What elimination period are you considering?

Number of days ____. Approximate cost $ _____ for that period for care.

How are you planning to pay for your care during the elimination period?

☐ From my income ☐ From my savings/investments ☐ My family will pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

☐ Under $20,000 ☐ $20,000-$29,999 ☐ $30,000-$49,999 ☐ $50,000 or over

How do you expect your assets to change over the next 10 years? (check one)

☐ Stay about the same ☐ Increase ☐ Decrease

Explain if increase or decrease is expected

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

Check one.

☐ The answers to the questions above describe my financial situation.

Or

☐ I choose not to complete this information.

This box must be checked.

☐ I acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. I understand the above disclosures. **I understand that the rates for this policy may increase in the future.**

Signatures

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

Print name of applicant

☐ I explained to the applicant the importance of completing this information.

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

Print name of agent

In order for us to process your application, please return this signed statement to Thrivent Financial for Lutherans, along with your application.

☐ My agent has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

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

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

The company may contact you to verify your answers.

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Representative's Information

Thrivent Financial for Lutherans
4321 N. Ballard Road, Appleton, WI 54919-0001
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Section 1 - Proposed Insured

Name of proposed insured (print first, middle, last name)

Section 2 - Requirements

☐ Yes ☐ No 1. Did you complete the application in person with the proposed insured? If no, explain.

☐ Yes ☐ No 2. Did the proposed insured or their family member contact you for this coverage?

☐ Yes ☐ No 3. Did you see the proposed insured walk?

☐ Yes ☐ No 4. Did you observe any physical impairment in the ability to sit in or get up from a chair, walk, or talk? If yes, explain.

☐ Yes ☐ No 5. Did you observe any form of tremor? If yes, explain.

☐ Yes ☐ No 6. Did you observe any confusion or deficiency in the ability of deductive or abstract reasoning, short or long term memory, orientation as to people, places, or times? If yes, explain.

☐ Yes ☐ No 7. Did you observe any other impairments? If yes, explain.

☐ Yes ☐ No 8. Have you observed the proposed insured participating in activities outside his/her residence? If yes, list activities observed.

Date last observed -

☐ Yes ☐ No 9. Do you believe that the proposed insured is house confined?

Additional details

Section 3 - Agreements and Signatures

To the best of my knowledge and belief, I know nothing about the proposed insured's health, habits, or lifestyle affecting insurability which has not been stated in this application.

Signature of financial professional	Date signed
X	

Mail contract to: ☐ Financial Professional ☐ Owner

If no premium is submitted with application, or no box selected, the contract will be mailed to the financial professional for delivery.

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Supplement to Application for Insurance

Medical Details - Continuation

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

Question: No/Ltr	Type of disease, disorder, injury, test, care, controlled substance			Date of diagnosis
Date of onset	Number of occurrences	Treatment		Number of times treated
Last occurrence date	Time lost from work / school	Recovered ☐ Yes ☐ No	Recovery date	Date substance last used
Last consultation date	Date of last hospitalization	Surgery date	Medication(s) currently taking	
Residuals		Care provider / Facility with records if other than primary care provider		

Question: No/Ltr	Type of disease, disorder, injury, test, care, controlled substance			Date of diagnosis
Date of onset	Number of occurrences	Treatment		Number of times treated
Last occurrence date	Time lost from work / school	Recovered ☐ Yes ☐ No	Recovery date	Date substance last used
Last consultation date	Date of last hospitalization	Surgery date	Medication(s) currently taking	
Residuals		Care provider / Facility with records if other than primary care provider		

Question: No/Ltr	Type of disease, disorder, injury, test, care, controlled substance			Date of diagnosis
Date of onset	Number of occurrences	Treatment		Number of times treated
Last occurrence date	Time lost from work / school	Recovered ☐ Yes ☐ No	Recovery date	Date substance last used
Last consultation date	Date of last hospitalization	Surgery date	Medication(s) currently taking	
Residuals		Care provider / Facility with records if other than primary care provider		

Question: No/Ltr	Type of disease, disorder, injury, test, care, controlled substance			Date of diagnosis
Date of onset	Number of occurrences	Treatment		Number of times treated
Last occurrence date	Time lost from work / school	Recovered ☐ Yes ☐ No	Recovery date	Date substance last used
Last consultation date	Date of last hospitalization	Surgery date	Medication(s) currently taking	
Residuals		Care provider / Facility with records if other than primary care provider		

Question: No/Ltr	Type of disease, disorder, injury, test, care, controlled substance			Date of diagnosis
Date of onset	Number of occurrences	Treatment		Number of times treated
Last occurrence date	Time lost from work / school	Recovered ☐ Yes ☐ No	Recovery date	Date substance last used
Last consultation date	Date of last hospitalization	Surgery date	Medication(s) currently taking	
Residuals		Care provider / Facility with records if other than primary care provider		

Question: No/Ltr	Type of disease, disorder, injury, test, care, controlled substance			Date of diagnosis
Date of onset	Number of occurrences	Treatment		Number of times treated
Last occurrence date	Time lost from work / school	Recovered ☐ Yes ☐ No	Recovery date	Date substance last used
Last consultation date	Date of last hospitalization	Surgery date	Medication(s) currently taking	
Residuals		Care provider / Facility with records if other than primary care provider		

I have read (or have had read to me) the statements and answers recorded on this Supplement to Application for Insurance. To the best of my knowledge and belief, they are true, complete and correctly recorded and shall be a basis of any contract issued or for which a change has been requested. My signature applies to all sections and statements on this Supplement to Application for Insurance.

Signed at _____ _____
City State

Signature of proposed insured (parent or guardian if proposed insured is age 0-15) / Date signed (mm/dd/yyyy)	Signature of representative / Date signed (mm/dd/yyyy)

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Supplement to Application for Insurance

Application Action - Continuation

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

Application Action	Company Name	Date	Reason

I have read (or have had read to me) the statements and answers recorded on this Supplement to Application for Insurance. To the best of my knowledge and belief, they are true, complete and correctly recorded and shall be a basis of any contract issued or for which a change has been requested. My signature applies to all sections and statements on this Supplement to Application for Insurance.

Signed at _____ _____
City State

Signature of proposed insured / Date signed (mm/dd/yyyy)	Signature of representative / Date signed (mm/dd/yyyy)

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Supplement to Application for Insurance

Prescription Drugs - Continuation

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

Prescription Drug Used	Date Last Used	Reason for Use

I have read (or have had read to me) the statements and answers recorded on this Supplement to Application for Insurance. To the best of my knowledge and belief, they are true, complete and correctly recorded and shall be a basis of any contract issued or for which a change has been requested. My signature applies to all sections and statements on this Supplement to Application for Insurance.

Signed at _____ _____
City State

Signature of proposed insured (parent or guardian if proposed insured is age 0-15) / Date signed (mm/dd/yyyy)	Signature of representative / Date signed (mm/dd/yyyy)

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Supplement to Application for Insurance

Moving Traffic Violations - Continuation

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

Type of Violation	MPH Over	Date

I have read the statements and answers recorded on this Supplement to Application for Insurance. To the best of my knowledge and belief, they are true, complete and correctly recorded and shall be a basis of any contract issued or for which a change has been requested. My signature applies to all sections and statements on this Supplement to Application for Insurance.

Signed at _____ _____
City State

Signature of proposed insured and date signed (mm/dd/yyyy)	Signature of representative and date signed (mm/dd/yyyy)

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Automatic Payment Authorization

1. Bank Account Owner Information

Thrivent ID _____ Phone number _____

Bank Account Owner email _____

2. Type of Request

Recurring Automatic Payment

- ☐ Establish a new automatic payment (complete sections 3 & 4)
- ☐ Update bank on an existing automatic payment authorization (complete sections 3 & 4)
  - ☐ Existing/Old bank account is closed ☐ Existing/Old bank account is open
- ☐ Change, Cancel or Add contracts/agreements to my existing Automatic Payment Plan (complete section 4)

One-Time Payment

- ☐ One-Time Payment (complete sections 3 & 5)

3. Bank Information

Name of account owner _____

Address of account owner _____

City _____ State ____ ZIP code _____

Account type ☐ Checking ☐ Savings ☐ Business

Full name of bank _____

Routing number _____ Account number _____

Name of joint account owner _____

Address of joint account owner _____

City _____ State ____ ZIP code _____

For Dedicated Planning Services only - non-qualified mutual fund accounts can be used.

When providing bank information on this form, you authorize Thrivent to use a Third-Party Service Provider to verify account and account owner information. Account and/or account owner information that cannot be verified may result in a delay in processing. This Third-Party Service Provider is a consumer reporting agency under the Fair Credit Reporting Act. By signing this form, you understand and agree that a consumer report, including credit reports, criminal records and driving records, among other forms of information obtained from private and public record sources, may be obtained on you as part of this transaction.

4. Recurring Automatic Payment Information

Change	Cancel	Add	Name of Insured/ Annuitant/Owner	Contract/Agreement Number	Draw Date	Frequency	Payment Amount	Loan Repayment Amount*
☐	☐	☐						
☐	☐	☐						
☐	☐	☐						
☐	☐	☐						
☐	☐	☐						

*Not applicable for all products and services

5. One-Time Payment Information

Name of Insured/ Annuitant/Owner	Contract/Agreement Number	Payment Amount	Loan Repayment Amount*	Tax Year*

*Not applicable for all products and services

The withdrawal will be processed from your bank account within 3 business days of Thrivent receiving this form.

6. Agreements and Signatures

Agreements: Automatic Payment

I authorize Thrivent to 1) make an immediate electronic withdrawal from the bank account listed upon receipt of this form for new business initial payments and policy reinstatements; 2) to withdraw my payment from my bank account in accordance with section 4 of this form; if no frequency or amount is listed, to establish monthly automatic payment; (3) make electronic deposits, withdrawals, and corrections to my bank account that comply with U.S. law; 4) act on this authorization until I revoke it by contacting Thrivent or Thrivent Investment Management Inc., as applicable; 5) apply this authorization to any future bank accounts I may designate; 6) make administrative changes to this authorization which I request such as date and amount changes, or adding or removing contracts for automatic payment; 7) release any and all information related to this authorization to the bank account owner(s); 8) act upon electronic deposit, withdrawal, and administrative instructions I provide to my financial advisor; 9) begin drawing on the next occurrence of the day of the month I have indicated above, my authorization may take effect in the following month; 10) make the draw on the 28th if I have selected my automatic payment to occur on day 29, 30, or 31, and if no date is selected it will be my monthaversary; and 11) use only the date indicated by by me or my financial advisor for future transactions I may request.

Agreements: One-Time Payment

I authorize Thrivent to 1) make an immediate electronic withdrawal from the bank account listed upon receipt of this form; and 2) to withdraw my payment from my bank account in accordance with Section 5 of this form unless I timely* revoke this authorization by calling Thrivent at 800-847-4836.

*Timely means I have given Thrivent a reasonable opportunity to act on the revocation instructions.

Signatures

I certify I have received, read, and agree to the Agreements and Disclosures (pages 2-3 of this form) for the Type of Request(s) I completed above and any other disclosures contained in this form.

If you are signing in any capacity other than the bank account owner, a title (attorney-in-fact, conservator, guardian, trustee, authorized person, etc.) must be provided.

Signature of bank account owner _____

Date signed _____

Title _____

Signature of joint bank account owner _____

Date signed _____

Title _____

Disclosures

Universal Life, Variable Universal Life, or Annuity Product Authorization

I understand my draw will be established monthly in an amount proportional to my payment mode (e.g., 1/3 of my quarterly billed premium, 1/12 of my annually billed premium), unless requested otherwise in section 4 of this form.

Variable Annuity Product Disclosure

I understand if I establish monthly electronic deposits on a variable annuity contract, the confirmation of these payments will be on my quarterly statement in place of immediate confirmation.

Term Life, Whole Life, Disability Income, Medicare Supplement, or Long-Term Care Product Authorization

I understand that my draw will be established at the monthly premium rate which will be higher than 1/12 of my annual premium. I understand that I can receive a quote of the exact monthly billing amount by contacting Thrivent.

Autopay Disclosure

I understand that by providing my email address, I consent to receive Courtesy Autopay Reminder Emails. You can opt out by contacting Thrivent.

Variable Product Disclosure

I understand my payments for Variable Products will be applied based on the most recent allocation instructions on record at Thrivent.

Dedicated Planning Services Fee

Refer to your Dedicated Planning Services Agreement Schedule with Thrivent Investment Management Inc. for the Dedicated Planning Fee, payment amount, withdrawal frequency, and withdrawal date, which could occur immediately upon receipt of this form.

Mutual Fund Accounts only: For Proceeds from Broker and Barter Exchange Transactions (IRS Form 1099-B) reportable accounts cost basis will be applied to the transaction and fees associated with expedited distribution methods.

Program Fees for AdvisorFlex Managed Variable Annuity Program

Refer to your AdvisorFlex Managed Variable Annuity Client Agreement with Thrivent Investment Management Inc. for specifics about your Program Fee including your Program Fee amount and frequency.
Because the exact amount and date of your Program Fee fluctuates, Thrivent will notify you in advance of withdrawing every Program Fee payment from your bank account. Thrivent will provide that notice at least 10 days prior to withdrawing your payment. You must notify Thrivent before the draw date indicated on that notice if you want to cancel the draw. If you do not notify Thrivent by that date, Thrivent will deem you to agree to the date and amount of the withdrawal.

Mail completed form to:
Thrivent
PO Box 8075
Appleton, WI 54912-8075

Fax:
800-225-2264

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Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-Term Care Insurance

Thrivent Financial for Lutherans, 4321 N. Ballard Road, Appleton, WI 54919

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by Thrivent Financial for Lutherans. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

Statement to Applicant by Agent (use additional sheets as necessary)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

Signatures

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

Print name of agent

Address of agent	City	
	State	ZIP code

The above "Notice to Applicant" was delivered to me on:

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

Print name of applicant

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

Print name of applicant

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Annuity/Settlement Option Surrender Service Request

1. Owner Information

Thrivent ID and email are optional in the state of California.

Thrivent ID _____ Contract number _____ Email _____

Name _____

2. Surrender Details

☐ Full surrender *(this will close the contract)*

☐ One-time partial surrender amount

- ☐ Amount $ _____
- ☐ Amount that is penalty free
- ☐ *For Retirement Choice VA only:* Withdraw total amount free of surrender charges (Higher of earnings or 10%)
- ☐ Maximum Partial Surrender

☐ Ongoing Automatic Payout Option (APO)

☐ New ☐ Change ☐ Cancel

Payout frequency

☐ Monthly ☐ Quarterly ☐ Semiannually ☐ Annually

Start date - _____

Automatic payout options (select one)

- ☐ Interest only
- ☐ Fixed amount $ _____
- ☐ Fixed percentage _____ %

3. Specific Subaccount Surrender

For Fixed Indexed products, the surrender will be taken from the Fixed Account first and will only be taken from the Indexed Account when the accumulated value in the Fixed Account is not sufficient.

For variable or Multi-Year Guarantee products, indicate account(s) from which payout should be made. If no amounts are indicated, surrenders will be taken proportionately from all subaccounts or allocation periods containing a value.

Subaccount Name or Allocation Period	Amount or Percent
_____	$ _____ _____ %
_____	$ _____ _____ %
_____	$ _____ _____ %

4. Delivery of Payment *(If no box is checked, the distribution will be sent via check.)*

☐ Check

☐ Direct Deposit

Complete bank information for direct deposit

Full name of bank account owner(s) _____

Full name of bank _____

Account type ☐ Checking ☐ Savings

Routing number _____ Account number _____

☐ Deposit into an existing Thrivent Mutual Fund account _____

☐ Deposit into a new Thrivent Mutual Fund account.

☐ Apply to another Thrivent contract/account. Only available for one-time partial or complete surrenders.

Contract number	Premium amount	Loan repayment
_____	$ _____	$ _____
_____	$ _____	$ _____

5. Request for Waiver of Surrender Charges (subject to availability)

Optional in the state of California.

- ☐ Confinement to health care facility still applicable. Information already on file at Thrivent.
- ☐ Request for Waiver of Surrender Charges for Health Care Facilities Confinement form will be sent to Thrivent separately.
- ☐ A letter from the nursing home concerning waiver of surrender charges will be sent to Thrivent separately.
- ☐ A letter from an attending physician or doctor indicating a life expectancy of less than 12 months will be sent to Thrivent separately. Attending physician cannot be a family member.
- ☐ A Claimant's Statement for Total Disability form and an Attending Physician's Statement of Disability form will be sent to Thrivent separately.
- ☐ Proof of state unemployment benefits will be sent to Thrivent separately.

6. Notification for Federal and State Income Tax Withholding and Surrender Charges

If no box is checked, 10% federal income tax will be withheld and state withholding will occur as required by your state of residence.

Federal Tax Withholding:

- ☐ Do not withhold federal income tax
- ☐ Withhold federal income tax amount of 10%
- ☐ Other federal withholding _____ %

For more details on federal withholding, please consult IRS Form W-4R, available on the IRS website. Failure to withhold enough or underpaying estimated taxes may lead to IRS penalties.

State Tax Withholding:

- ☐ Do not withhold state income tax
- ☐ Other state withholding _____ %

Select one *(If neither is checked, the default is NET Request.)*:

- ☐ **NET Request:** *You will receive the amount requested. Your account balance will be reduced by this amount plus any applicable surrender charges and tax withholding.*
- ☐ **GROSS Request:** *You will receive the amount requested less any applicable surrender charges and tax withholding.*

7. Additional Information

8. Plan Trustee Certification

For Qualified Retirement Plan Surrenders from Deferred Annuities

By signing in section 10, I certify that the participant (owner) named in section 1 has had a distributable event (age 59 1/2, termination of employment, financial hardship, etc.) and is able to receive a distribution in accordance with the terms and conditions of the plan owning the contract. I also acknowledge the trustee signature requirements have been satisfied in accordance with the terms of the plan.

Is this complete surrender a result of qualified retirement plan (401(k), profit sharing plan, etc) termination? (If no box is marked, Thrivent will assume this complete surrender is **not** the result of a plan termination.) ☐ Yes ☐ No

9. Validation (see validation requirements in disclosure section)

Medallion Signature Guarantee Seal or Notary Seal and authorized signature
For Medallion Signature Guarantee, seal and signature and original document must be mailed. Fax will not be accepted.

10. Agreements and Signatures

I authorize Thrivent to process the requested distribution and I certify: 1) I have received, read, and agree to the Disclosures (pages 4-6 of this form) and any other disclosures contained in this form; 2) I understand this transaction may be taxable and subject to surrender charges; 3) I understand I have the opportunity to request a quote of the taxable gain and surrender charges prior to requesting this transaction; and 4) I understand this transaction, including any distribution of taxable gain or assessment of surrender charges, cannot be reversed.

If you are signing in any capacity other than the owner/controller/assignee, a title (power-of-attorney, conservator, guardian, trustee, authorized person, etc.) must be provided.

Signature of owner/controller/assignee _____

Date signed _____

Title _____

Signature of owner/controller/assignee _____

Date signed _____

Title _____

Employer Certification ***Only*** *for 403(b) surrenders/APO from deferred annuities.*

By signing, I certify that the participant (owner) named in section 1 has had a distributable event (age 59 1/2, termination of employment, financial hardship, etc.) and is able to receive a distribution in accordance with the terms and conditions of the 403(b) plan sponsored by the employer named below. In addition, I certify that I am an authorized representative of the employer.

☐ Hardship surrender only (does not apply to APO) - By checking this box, I certify the distributable event is financial hardship.

Name of employer _____

Name of authorized representative of employer _____

Title of authorized representative of employer _____

Signature of authorized representative of employer _____

Date signed _____

Send completed form to:

Thrivent
PO Box 8075
Appleton WI 54912-8075

Fax: 800-225-2264

Disclosures

2. Surrender Details

I fully acknowledge and understand that by distributing the amount requested from my contract/agreement, the following may result:

Upon complete surrender, I understand that all insurance coverage provided by this contract and the rights of all beneficiaries under this contract cease as of the date this form is properly signed.

Taxable Gain - The distributions may result in the reporting of taxable gains to me.

Penalty Tax - An IRS premature distribution penalty may apply to the taxable portion of the surrender if I am under age 59 1/2 or if this is a SIMPLE IRA and I have participated for less than two years.

Surrender charges may apply.

A market value adjustment (MVA) may apply to distributions from a Fixed Period Allocation.

Surrenders removed from the Indexed Account will not receive any interest credited on the Interest Crediting Date.

Automatic Payout Option (APO) - Only available on Deferred Annuities and FPDAs. If we receive this form in good order after your selected start date, the start date shall be deemed the first business day (or Valuation Date for variable products) that occurs on or after the date of receipt. Subsequent transactions requested pursuant to this form shall be based upon your selected start date.

If 29-31 is chosen, the 28th will be used. If no date is entered, your distribution amount will be the 15th.

Allow 2-5 business days after date selected for funds to be available to you.

Interest only payment must be at least $25.00. Not available for FPDA or Advisor/Flex.

Fixed - Amount - FPDA only - payment amounts under $200 will require direct deposit or payment to another Thrivent product.

Fixed Percent - % of cash value to be distributed at the time of each surrender. i.e. .8% monthly = 9.6%, or approximately 10% annually. Not available for FPDA.

If the payment frequency is blank, illegible or invalid, you are deemed to have elected annual distribution. If annual distribution is elected, but the month is left blank, illegible or invalid, you are deemed to have elected December. If the date of the distribution is left blank, illegible or invalid, you are deemed to have elected the 15th and for distributions to begin when this date next occurs.

If funds are being removed from a specific subaccount, and the value of that subaccount drops below the requested distribution amount, the value in that subaccount will be depleted and the balance will be taken proportionately from the remaining subaccounts. Subsequent payouts will be removed proportionately from all the remaining subaccounts, unless otherwise instructed.

Impact of Withdrawal on Guaranteed Lifetime Withdrawal Benefit (GLWB) rider - If you have a GLWB rider and a withdrawal results in a GLWB Excess Surrender as defined by the GLWB rider, all GLWB guaranteed values will be reduced. Please see the prospectus for details.

For Income Builder GLWB Rider Only: Be advised that the first withdrawal will set your withdrawal percentage.

For an annuity with the Long-Term Care (LTC) Insurance Rider - If the reason for your surrender request is due to the need to pay for LTC costs, make a claim from your LTC benefits instead of taking a partial surrender from your annuity.

Impact of Surrender or Partial Surrender on LTC Insurance Benefits - I understand that if the LTC Insurance Rider is present, a request to surrender, or a request for a partial surrender which results in the Accumulated Value being less than the required minimum, the LTC Insurance Rider will terminate and all LTC benefits will cease (although nonforfeiture benefits may be available). I understand that if the LTC Insurance Rider is present, a request for a partial surrender will result in a reduction of my available LTC Insurance benefits. Partial surrenders may be subject to income taxation.

I understand that the distribution and any taxable gain resulting from this distribution cannot be reversed once the distribution is processed. Such taxable gain will be subject to federal and state income tax withholding, unless the federal and state tax withholding election is completed.

Transactions are processed as of market close on the day the form is received in good order. If the withdrawal amount requested will cause the value of the contract to fall below the required minimum balance due to market fluctuation, the maximum amount available will be withdrawn.

Disclosure and Important Information Regarding Qualified Charitable Distributions (QCD)

- Use only when IRA owner is 70 1/2 or older.
- The IRS defines QCD as an otherwise taxable distribution from an IRA (other than an ongoing SEP or SIMPLE IRA) owned by an individual who has attained the required age that is paid directly from the IRA to a qualified charity.
- The charity must qualify as a 501(c)(3) organization and be eligible to receive tax-deductible contributions. Certain charities do not qualify; such as, sponsoring charities of donor-advised funds, private foundations and supporting organizations.
- Consult a tax professional to discuss this option as it is your responsibility to ensure the distribution made with this form complies with the IRS rules.
- Thrivent will report this distribution to the IRS on IRS Form 1099-R.

3. Specific Subaccount Surrender

Minimum requirements may apply. Allocations of percentages are subject to availability. If a specific subaccount or allocation period is chosen, and the percentage field is entered, the percentage requested will be based on the specific subaccount or allocation period value, not the entire contract value. If more than 3 subaccounts, use section 7 - Additional Information.

4. Delivery of Payment

Direct Deposit - I authorize Thrivent to make this electronic deposit and, if necessary, corrections to my bank account. I further authorize Thrivent to act upon future electronic deposit instructions I provide to my representative or directly to Thrivent. My authorization is valid for electronic deposits and corrections that comply with U.S. law. This authorization shall remain in full force and effect until I revoke it by giving 10 day prior notice to Thrivent.

Checks - For contracts with multiple owners, disbursement checks may be made payable to only the primary owner. If only the primary owner's name appears as the payee on a disbursement check from a contract with multiple owners, it is the responsibility of the primary owner to obtain signatures of the other owners prior to cashing the check. If the disbursement results in taxable income, the tax information will be reported to all owners.

When providing bank information on this form, you authorize Thrivent to use a Third-Party Service Provider to verify account and account owner information. Account and/or account owner information that cannot be verified may result in a delay in processing. This Third-Party Service Provider is a consumer reporting agency under the Fair Credit Reporting Act. By signing this form, you understand and agree that a consumer report, including credit reports, criminal records and driving records, among other forms of information obtained from private and public record sources, may be obtained on you as part of this transaction.

For internal product-to-product transfers only - Only available for One-time Partial or Complete Surrenders. Unless otherwise indicated herein, I intend the requested transfer(s) from the distributing contract(s) to become effective only if and when:

- Thrivent (including its subsidiaries and affiliates) has approved the first application of the amount(s) requested to the receiving contract(s), as described above, or, if not, as I subsequently agree to accept; and
- with respect to any receiving contract(s) that I have applied for, as described above, Thrivent (including its subsidiaries and affiliates) has approved the issuance of the receiving contract(s), as applied for or, if not, as I subsequently agree to accept.

6. Notification for Federal and State Income Tax Withholding and Surrender Charges

Notification of Withholding and Surrender Charges (Not Applicable for FPDAs) - You are liable for federal and state income tax, where applicable, on the taxable portion of your distribution even if you elect no withholding. You may be subject to tax penalties under the estimated tax payment rules if your payments of estimated tax and withholding, if any, are not adequate. Check with your tax advisor to determine if withholding is necessary.

Form W-4R can be found on IRS website https://www.irs.gov/pub/irs-pdf/fw4r.pdf

State Withholding - If withholding is indicated and the dollar amount or percentage is less than the state minimum, or if amount or percentage is not completed, we will withhold at your state's minimum rate.

Residents of Connecticut - submit the Form CT-W4P to indicate your withholding election with this form. If you do not submit Form CT-W4P with this form, Thrivent will use your most recently-submitted CT-W4P, if one is on file. If you do not submit Form CT-W4P with this form and you have not previously submitted Form CT-W4P, the maximum rate will be withheld. You have the right to revoke or change your withholding election at least 10 days prior to the effective date of the distribution.

Mandatory Tax - Distributions from a 403(b) or qualified retirement plan that are eligible for rollover and are not directly rolled over are subject to mandatory 20% federal tax withholding. Refer to the 403(b) and Qualified Plan Distribution Disclosure (form 9972) for more information. If your distribution is subject to mandatory 20% federal tax withholding, your distribution may also be subject to mandatory state tax withholding.

Roth IRA Distributions - No tax withholding will be withheld from your Roth IRA.

Qualified Charitable Distribution - No tax withholding will be withheld from your qualified annuity.

8. Plan Trustee Certification

Notice to Qualified Plan Trustee(s) - Trustee(s) of Qualified Retirement Plans (such as Money Purchase Plans, Profit Sharing Plans, 401(k) Plans, Defined Benefit Plans, etc.) or 457(b) Plans must provide the Qualified Joint and Survivor Annuity Notice, when applicable, to plan participants. Your Thrivent representative will provide you with the required participant-specific benefit illustration to accompany the Qualified Joint and Survivor Annuity Notice. If a form of benefit other than the Qualified Joint and Survivor Annuity is elected, spousal consent must be obtained. Trustee(s) are also required to provide participants with a Distribution Disclosure Notice.

If you do not have the above referenced notices, Thrivent has generic notices for your use. These notices should be reviewed by your tax advisor to verify suitability for your plan. You are responsible for providing the applicable notices and obtaining any required signatures. Thrivent does not require a copy of these notices be sent to our office.

Generic Notices Available:

- Qualified Joint and Survivor Annuity Notice form
- Spousal Consent form
- 403(b) and Qualified Plan Distribution Disclosure form

9. Validation

For your protection, validation of your identity is requested for certain variable and non-variable contract transactions.
Surrender/disbursement transactions:

a. Greater than $499,999 will require a Medallion Signature Guarantee for variable contract transactions and a Notary Public for non-variable contract transactions.
b. Greater than $99,999 and up to $499,999 will require one of the following forms of validation:
   · Attestation by a Thrivent representative
   · A Notary Public
   · A Medallion Signature Guarantee (not available for fixed contracts)
c. Greater than $10,000, less than $99,999, and the address of record changed within the prior 15 days will require a Notary Public or attestation by a Thrivent representative.
d. Greater than $10,000, less than $99,999, and the bank information provided has been on record for less than 15 days will require a Notary Public or attestation by a Thrivent representative.
e. Requesting special distribution instructions will also require one of the three forms of validation listed in (b) above. Examples include: Request to send proceeds to an address other than the one listed on your contract and/or request to make proceeds payable to someone other than the current owner.
   A Notary Public or Medallion Signature Guarantee may generally be obtained at any national bank.

10. Agreements and Signatures

403(b) or Tax Sheltered Annuity Distribution Acknowledgement - I acknowledge that if this distribution is an eligible rollover distribution from a 403(b) and is not a direct rollover to a qualified retirement plan or IRA, the taxable amount of the distribution will be subject to 20% income tax withholding. I also acknowledge that I have received and read the 403(b) and Qualified Plan Distribution Disclosure (form 9972). I acknowledge that I have the right to delay making a decision regarding the distribution from the above plan for at least 30 days after receiving the 403(b) and Qualified Plan Distribution form and have been given this opportunity. I hereby elect to waive my right to the 30 day waiting period and request Thrivent to make this distribution as soon as administratively possible. Due to the tax consequences, I have been advised to seek competent tax advice pertaining to this distribution.

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Assignment and Agreement for 1035 Exchange

Thrivent ID

Section 1 - General Information

Name of insured/annuitant

Name of insured/annuitant

Name of owner	Social Security number
Name of additional owner	Social Security number

Section 2 - Contract to be exchanged ("Source Contract")

Full company name	Company phone
Company service address	City
	State / ZIP code

Contract number	Contract issue date	Type of contract	Approximate current value
			$

From "Source Contract"	Select One	To "Destination Contract"	Type of Exchange	Exchange Frequency
Life Insurance	☐	**New** Life Insurance	Full	
	☐	**New** Nonqualified Annuity	Full	
	☐	**Existing** Nonqualified Annuity Contract number - _____	Full	
	☐	**Existing** Long-Term Care Insurance Contract number - _____	Full	
	☐	**New** Long-Term Care Insurance	Full	
	☐	**New** Life Insurance with Long-Term Care	Full	

From "Source Contract"	Select One	To "Destination Contract"	Type of Exchange	Exchange Frequency
Life Insurance with Long-Term Care^	☐	**New** Life Insurance with Long-Term Care	Full Life Insurance Cash Value Amount $ _____ Long-Term Care Insurance Return of Premium Amount $ _____	Instructions: The life insurance cash value from the Source Contract will be allocated pro rata to both the life insurance and long-term care components of the Destination Contract. The Long-Term Care return of premium (ROP) value, if any, from the Source Contract will also be allocated pro rata to both the life insurance and long-term care components of the Destination Contract
Nonqualified Annuity	☐	**New** Nonqualified Annuity	☐ Partial $ _____ or ___ % ☐ Full	
	☐	**Existing** Nonqualified Annuity Contract number - _____	☐ Partial* $ _____ or ___ % ☐ Full	
	☐	**Existing** Long-Term Care Insurance Contract number - _____	☐ Partial $ _____ or ___ % ☐ Full	☐ One Time Exchange ☐ Recurring Exchanges *(Only available for internal exchanges on an annual frequency)*
	☐	**New** Long-Term Care Insurance	☐ Partial $ _____ or ___ % ☐ Full	☐ One Time Exchange ☐ Recurring Exchanges *(Only available for internal exchanges on an annual frequency)*

* Partial 1035 exchanges from an existing Thrivent nonqualified annuity to an existing Thrivent nonqualified annuity are limited to funds originating from Thrivent Multi-Year Guarantee fixed period allocation about to expire.

^ Any Long-Term Care return of premium monies exchanged to the life insurance portion of Thrivent's Life with Long-Term Care Insurance are not eligible for tax-free treatment under section 1035 and will be treated as "after tax" investment in the life insurance contract.

Section 3 - Assignment Provisions

1. I hereby assign my rights, title, and interest in my above designated Source Contract for the sole purpose of effectuating a 1035 exchange.
2. In exchange for assigning my Source Contract to Thrivent, Thrivent agrees to accept proceeds from my Source Contract, subject to any contract limitations. Upon receipt of proceeds from my source contract, Thrivent agrees to apply those proceeds to my Destination Contract. Thrivent agrees to release its ownership of my Source Contract to me upon receipt of proceeds from my source contract. Assignment of the Source Contract shall be void if Thrivent does not issue the **NEW** Destination Contract.
3. I represent and warranty that no other person or entity has an interest in my Source Contract or right to surrender my Source Contract such as an irrevocable beneficiary, assignee, or collateral assignee.
4. I have reviewed the effects of this 1035 exchange on my Source Contract, such as any surrender charge and/or loss of guarantees.
5. I agree to destroy my Source Contract if this request is for a full 1035 exchange.

Section 4 - Disclosures of Distribution request

If the taxable gain and surrender charge fields below are not completed or do not contain accurate amounts, this request may be delayed. If there is no taxable gain or surrender charge, enter zero in the fields below.
I understand that:

- **Taxable Gain -** An amount of approximately $ _____ will be reported to the IRS as being taxable as ordinary income in the year this distribution is processed.
- **Penalty Tax -** If the distribution results in a taxable gain, an IRS penalty tax may apply to the taxable gain if I am under age 59 1/2.
- **Surrender Charge -** A surrender charge of $ _____ will be levied.
- Any taxable gain resulting from this distribution cannot be reversed once the distribution is processed.
- I am responsible for any taxable gain resulting from this distribution.
- Neither Thrivent nor its representatives or agents, makes any representation or warranty concerning my tax treatment under Section 1035 of the Internal Revenue Code or otherwise.

Important Information

I understand that:

- Once I request this distribution, I may not be able to reverse ("free look") this request, even if Thrivent has not received the proceeds from my Source Contract.
- The company administering my Source Contract may require a different form or different type of signature. Thrivent may ask me to sign a new request in a form acceptable to the company administering my Source Contract.
- I am responsible for ensuring payment of any premium payment due on my Source Contract even after assignment of my Source Contract to Thrivent. If I have an agreement on file to pay premium on my Source Contract from another Thrivent product, Thrivent will continue to facilitate that premium payment.

Full Exchanges

I understand that:

- All coverage provided by my Source Contract and the rights of the beneficiaries under the contract cease.

Partial Exchanges to Annuities

I understand that:

- If I take a distribution from either contract (Source or Destination) within 180 days after the exchange, the IRS may treat this exchange as a way to avoid tax and I may be assessed with additional taxes, penalties and interest.
- Thrivent is unable to predict what regulations or tax requirements, if any, will be issued regarding partial exchanges and the effect those regulations or requirements will have on any contracts involved in a partial exchange.

Ad Hoc 1035 Exchanges

I understand that:

- I may request to distribute the amount from specific investment options/allocations.
- If I do not request to distribute the amount from specific investment options/allocations, distributions will occur as follows:
  - Variable and Multi-Year Guarantee Annuity - proportionately from each investment option/allocation,
  - Fixed Indexed Annuity amounts from the Fixed Account and will only be taken from the Indexed Account when the value in the Fixed Account is insufficient. Amounts removed from the Indexed Account will not receive any interest.

Market Value Adjustment (MVA)

I understand that:

- A market value adjustment may apply to the exchange amount from a Source Contract with a Fixed Period Allocation.

Impact for a Contract with Long-Term Care Insurance

I understand that:

- If a long-term care insurance benefit or rider is present on the Source Contract, an exchange request will result in the termination of my long-term care insurance.

Exchanges to a Long-Term Care Insurance or Life Insurance with Long-Term Care

I understand that:

- It is currently unclear what, if any, tax impact the exchange may have on long-term care benefit payments. I fully acknowledge and understand that Thrivent is unable to predict what regulation or tax requirements, if any will be issued regarding exchanges to long-term care insurance and the effect those regulations or requirements will have on any contract involved in the exchange.

Recurring 1035 Exchange Requests to Long-Term Care Insurance

I understand that:

- Subsequent exchange amounts may vary based on amounts billed for my long-term care insurance contract and authorize adjustment of the requested 1035 exchange amount to reflect the amount necessary in subsequent exchanges. Thrivent will provide notice of the necessary 1035 exchange amount taken each year.
- The payments to the long-term care insurance contract are withdrawals from my annuity contract and will reduce and possibly deplete the value of my annuity contract.
- Distributions will occur as follows:
  - Variable and Multi-Year Guarantee Annuity - proportionately from each investment option/allocation,
  - Fixed Indexed Annuity amounts from the Fixed Account and will only be taken from the Indexed Account when the value in the Fixed Account is insufficient. Amounts removed from the Indexed Account will not receive any interest.
- Requests are intended for exchanges between Thrivent products and exchanges from other companies may require completion of annual paperwork.

Guaranteed Living Withdrawal Benefit Rider

- Impact of withdrawal on Guaranteed Living Withdrawal Benefit (GLWB) Rider: If you have a GLWB rider and a withdrawal results in a GLWB Excess Surrender as defined by the GLWB rider, all GLWB guaranteed values will be reduced. Please see the prospectus for details.
- For Income Builder GLWB Rider Only: Be advised that the first withdrawal will set your withdrawal percentage.

Section 5 - Agreements and Signatures

I authorize Thrivent to process the requested **exchange** and I certify that I have read and agree to the disclosures contained in this form.

Signature of owner/trustee/authorized signer and date signed

X _____

Title (if applicable)

Signature of owner/trustee/authorized signer and date signed

X _____

Title (if applicable)

Signature of representative/witness and date signed

X _____

As used in this form "Thrivent" refers to Thrivent Financial for Lutherans and its subsidiaries without limitation.

Mail completed form to:
Thrivent
PO Box 8075
Appleton, WI 54912-8075

Fax:
800-225-2264

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1035 Annuity to Pay Long Term Care Disclosure

Thrivent ID

Section 1 - General Information

Annuity contract number	Long Term Care contract number
Name of annuitant(s)	Name of insured(s)
Name of owner(s)	Name of owner(s)

Section 2 - Disclosures

- The IRS has not issued any guidance as to exchanges where the annuitant(s) do not match the insured(s). As such, the law is unclear as to whether the IRS would recognize such an exchange as tax free.
- If the IRS determines this partial exchange was entered into for tax avoidance purposes, or otherwise will not recognize it as a tax free exchange, the IRS may impose income taxes, tax penalties, and interest on the distribution.
- Thrivent is unable to predict what regulations or tax requirements, if any, will be issued regarding exchanges from an annuity contract to a long term care contract where the annuitant(s) do not match the insured(s). Thrivent cannot predict the effect any such regulations or requirements will have on any contracts involved in a partial exchange.
- Thrivent will not be held responsible for any adverse tax consequences resulting from a partial exchange where the annuitant(s) on an annuity contract do not match the insured(s) on the long term care contract.
- Thrivent strongly suggests that you consult with a competent tax adviser before requesting a partial exchange from an annuity contract to pay a long term care premium where the annuitant(s) and insured(s) do not match.
- Thrivent does not provide tax advice.

Section 3 - Agreements and Signatures

By signing below, I acknowledge the disclosures provided by Thrivent regarding the transaction requested. I have had the opportunity (whether exercised or not) to discuss the transaction with a lawyer or tax advisor of my choosing. I agree not to hold responsible Thrivent, its officers, directors, agents, employees and affiliates for any and all claims, demands, proceedings, suits and actions and all liabilities, losses, expenses and costs (including any legal fees and expenses) arising out of or related to the transactions involving partial assignment of the annuity contract listed above and the partial exchange of premium from that annuity contract to the long term care insurance contract listed above.

Signature of annuity owner/trustee/authorized signer*	Date signed
X	

Title (if applicable)

Signature of annuity owner/trustee/authorized signer*	Date signed
X	

Title (if applicable)

*One authorized signer's signature is required if the contract is owned by a business entity. The Business Entity Authorization form must be on file.

Mail completed form to: Thrivent
PO Box 8075
Appleton WI 54912-8075

Fax: 800-225-2264

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Thrivent Financial for Lutherans
4321 N. Ballard Road, Appleton, WI 54919-0001
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Split Compensation Request

1. General Information

Name of client _____

Name of writing financial professional _____

TS number _____ Application date _____

2. Sales Compensation

Type of agreement on file ☐ None ☐ Blanket ☐ Revenue Sharing

For the Sales Compensation on this contract/account

☐ Do not split sales compensation - 100% of the sale will be paid to the writing representative.

☐ Use existing blanket or revenue sharing sales agreement on file.

☐ Create new sales split or override the blanket or revenue sharing sales split on file. Paper application complete below.

Split Information

Agent name _____ Agent code _____ Split % _____

Agent name _____ Agent code _____ Split % _____

Agent name _____ Agent code _____ Split % _____

Agent name _____ Agent code _____ Split % _____

Agent name _____ Agent code _____ Split % _____

Agent name _____ Agent code _____ Split % _____

Agent name _____ Agent code _____ Split % _____

Agent name _____ Agent code _____ Split % _____

3. Trail or Service Compensation

Type of agreement on file ☐ None ☐ Blanket ☐ Revenue Sharing

For the Trail or Service Compensation on this contract/account

☐ Do not split the trail or service - 100% of the trail or service compensation will be paid to the assigned representative.

☐ Match the trail or service to the sales split.

☐ Use existing blanket or revenue sharing trail or service split on file.

☐ Create a new trail or override the blanket or revenue share trail or service split on file. Paper application complete below.

Split Information

Agent name _____ Agent code _____ Split % _____

Agent name _____ Agent code _____ Split % _____

Agent name _____ Agent code _____ Split % _____

Agent name _____ Agent code _____ Split % _____

Agent name _____ Agent code _____ Split % _____

Agent name _____ Agent code _____ Split % _____

Agent name _____ Agent code _____ Split % _____

Agent name _____ Agent code _____ Split % _____

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eDelivery Consent Disclosures

Thrivent Financial for Lutherans
4321 N. Ballard Road, Appleton, WI 54919-0001
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Thrivent ID

Section 1 - General Information

Name

Email address

By consenting to eDelivery, you are consenting for Thrivent (as defined on page 2) to deliver electronic documents to you instead of mailing paper documents to your mailing address. Thrivent recommends you store your important documents in a secure electronic or paper format for your records. Thrivent is not responsible for any Internet Service Provider, electronic data provider, or hardware or software provider subscription or use fees.

Section 2 - Document Description and Method of Delivery

To receive, print, and view your documents, you must provide a valid email address and have internet access and portable document format (PDF) viewing software, such as Adobe Reader. Review Thrivent.com/faqs/#techsupport for information about browsers and browser settings most compatible with Thrivent's website.

Documents you do not log in to view

- You will receive an email notification containing a link to a publicly available electronic version of the document that can be viewed, printed or saved.
- The documents do not contain personal information.
- Examples of documents you do not log in to view include prospectuses, annual reports and the annual Privacy Notice.

Documents you must log in to view

- Documents you must log in to view contain personal information. You will receive an email notification containing a link. After clicking the link and verifying your identity, you will have electronic access to your document. The document can be viewed, printed or saved.
- Examples of documents you log in to view include activity confirmations, payment notices and statements.

Inserts

- Notification for any documents may include links to inserts that would otherwise be sent with the document if delivered via U.S. mail. You will not be required to log in if the insert is publicly available or if you do not have a log in. Examples of inserts include annual Privacy Notice, prospectus supplements, and other documents.

Section 3 - Document Availability

Your voluntary consent will apply to:

- any product with which you have a relationship now or while your consent is in effect; and
- any document Thrivent is legally permitted to send via eDelivery.

Examples of the documents you might receive are included in Section 2. Thrivent may, at its discretion, mail paper documents. Depending on the relationship you have with Thrivent, Thrivent may allow you to choose eDelivery of specific documents. Thrivent reserves the right to discontinue this type of offering in the future.

The length of time your electronic documents are available online may vary by product and document. The length of time will never be less than legally required.

Section 4 - Revoke eDelivery Preference or Request Paper Copies

Thrivent will act upon your voluntary eDelivery consent until you revoke it. You may revoke your eDelivery preference and receive documents by U.S. mail at any time without penalty. Thrivent accepts notification of revocation through any of the Contact Thrivent options listed. Revocations will be processed within 7 days or sooner as required by law. On some products, Thrivent may discontinue waiving certain contractual fees or charges if you revoke your eDelivery consent. However, you will not incur a separate charge or fee for receiving paper documents. Revocation does not change the effectiveness, validity, or enforceability of documents previously provided to you by eDelivery.

You may request paper copies of any document you previously received by eDelivery without revoking your eDelivery preference. Thrivent will provide these documents to you free of charge.

If Thrivent is unable to successfully eDeliver your documents, Thrivent will contact you by U.S. mail with further instructions. Thrivent may deem unsuccessful eDelivery of your documents as a revocation of consent for eDelivery.

Section 5 - Contact Thrivent

You must notify Thrivent when your contact information changes or you wish to revoke your consent. You may use any of the following methods to update your email address, residential address, or phone number(s), or to revoke your consent:

Thrivent.com

Log in to Thrivent.com and manage your profile

Call 800-847-4836

- A member service professional will be happy to update your contact information
- For details about the documents currently available by eDelivery
- To request a paper copy of a document you received by eDelivery

Send a Written Request

Thrivent
4321 N Ballard Rd
Appleton, WI 54919-0001

Section 6 - Changes to These eDelivery Consent Disclosures

Thrivent reserves the right to modify these eDelivery Consent Disclosures. You will receive an email notification prior to the effective date of any modified eDelivery Consent Disclosures. The email will include instructions to change your preferences if you prefer to receive any document(s) by U.S. mail or do not agree to the new eDelivery Consent Disclosures. Any modification of the eDelivery Consent Disclosures will apply from the effective date forward and not to documents you previously received.

Section 7 - Acceptance and Consent

By electronically signing this form and submitting it to Thrivent, I certify I have reviewed and accept these eDelivery Consent Disclosures. I am voluntarily consenting for Thrivent to act on my eDelivery preference(s) until revoked.

Signature and date signed

X

As used in this form, "Thrivent" refers to Thrivent Financial for Lutherans, Thrivent Life Insurance Company, Thrivent Investment Management Inc., and the Thrivent Series Fund. Thrivent's Privacy Notice also applies to Thrivent Mutual Funds, Thrivent Financial Investor Services Inc., Thrivent Insurance Agency Inc. and the Thrivent Asset Management, LLC.

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Advanced Premium Payment Long Term Care Insurance

Name of applicant	Payment $

- Your advanced premium payment must be at least one month's premium.

Why is an advance premium payment important?

By making an advance premium payment with your application, underwriting will not be affected by any change in health status that occurs after the later of:

- The date you make the advanced premium payment, or
- The date you sign your application, or
- The date you complete all tests or physical exams required by Thrivent, if applicable.

No coverage is effective until your application is approved and a contract is issued.

Completing this application or making an advanced premium payment does not guarantee that your application will be approved.

If a contract is issued, you must pay all premiums when due to keep your contract in force.

If a contract is not issued any advanced premium payment submitted with the application will be refunded without interest.

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Supplement to Application for Insurance

Application Action - Continuation

Thrivent Financial for Lutherans
4321 N. Ballard Road, Appleton, WI 54919-0001
thrivent.com • 800-847-4836

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

Application Action	Company Name	Date	Reason

I have read (or have had read to me) the statements and answers recorded on this Supplement to Application for Insurance. To the best of my knowledge and belief, they are true, complete and correctly recorded and shall be a basis of any contract issued or for which a change has been requested. My signature applies to all sections and statements on this Supplement to Application for Insurance.

Signed at _____ _____
City State

Signature of proposed insured / Date signed (mm/dd/yyyy)	Signature of representative / Date signed (mm/dd/yyyy)