THRIVENT FINANCIAL®

Appleton, Wisconsin · Minneapolis, Minnesota
Thrivent.com · 800-847-4836

Disability Insurance Claim for Children

Use this form to file a premium waiver/disability waiver claim on your life insurance contract, completing it after four or six consecutive months of total disability, depending on the contract.

Total disability exists when a child is at least five years of age and, due to accidental bodily injury or disease, is unable to attend a regular school or special education facility. Under some contracts the disability must begin after age five. Refer to the contract for specific requirements.

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

Claimant's Statement and Health Information Authorization (pages 2-4)
Complete all sections. If a question does not apply, indicate "N/A". If more information needs to be included than space allows, attach a separate sheet of paper with those details. Be sure to sign and date the Claimant's Statement on page 3 and the Health Information Authorization on page 4.

Attending Physician's Statement (pages 5-6)
Complete, sign, and date Section 1 of the Attending Physician's Statement; then have your doctor complete Section 2. Any charges made by the doctor to complete this are not reimbursed by Thrivent Financial. Your doctor should mail or fax the completed statement to Thrivent Financial.

Mail completed form to:
Attn Disability Income Claims
Thrivent Financial
PO Box 8075
Appleton WI 54912-8075

or fax it to 800-225-2264

Properly completed forms will help avoid unnecessary delays.
If you have any questions, call 800-847-4836.

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Claimant's Statement

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Section 1 - General Information

Name of child			Phone	
Address	City		State	ZIP code
Date of birth (mm/dd/yyyy)	Contract number(s)			

Section 2 - Sickness/Injury and Initial Treatment Information

Describe the nature and details of the child's sickness or injury			Date symptoms began or injury occurred	
Name of doctor first seen			Phone	
Address	City		State	ZIP code
Dates treated (mm/dd/yyyy)				

Section 3 - Additional Treatment Information

If the child has been treated for this sickness or injury by anyone other than the doctor completing the attached Attending Physician's Statement, provide name(s), address(es), phone number(s), and date(s) of treatment.

Name of additional physician providing treatment			Phone	
Address	City		State	ZIP code
Dates treated (mm/dd/yyyy)				

Name of additional physician providing treatment			Phone	
Address	City		State	ZIP code
Dates treated (mm/dd/yyyy)				

Section 4 - Hospital Information

If the child has been hospitalized, provide the name, address, and phone number of each hospital, including birth hospital.

Name of hospital			Phone	
Address	City		State	ZIP code
Date admitted (mm/dd/yyyy)	Date discharged (mm/dd/yyyy)			

Name of hospital		Phone	
Address	City	State	ZIP code
Date admitted (mm/dd/yyyy)	Date discharged (mm/dd/yyyy)		

Section 5 - School Attendance Information

If the child attends and/or has attended a special or regular school, provide the name, address, and phone number for each one.

Name of **special school**		Phone	
Address	City	State	ZIP code
Type of program		Hours per day	
Dates attended (mm/dd/yyyy)			

Name of **regular school**		Phone	
Address	City	State	ZIP code
Type of program		Hours per day	
Dates attended (mm/dd/yyyy)			

Indicate month, day, and year the child was unable to attend school outside of the home (mm/dd/yyyy):
from _____ to _____

Section 6 - Signature

The claimant must sign and date this form. Failing to sign or altering the authorization may limit Thrivent Financial's ability to review your claim or pay claim benefits.

For your protection, state laws require the following to appear on this form: Any person who, knowingly and with intent to defraud or deceive any insurance company or other person, files or facilitates the filing of a statement of claim containing any materially false information, or conceals information concerning any fact material to the statement, may be guilty of insurance fraud, which may be a felony crime, subject to civil penalties or criminal prosecution, including substantial fines and/or confinement in prison.

I swear that the statements and answers provided on this form are true and complete to the best of my knowledge.

Signature of claimant (or parent/authorized representative) and date signed (mm/dd/yyyy)

X

Relationship, if other than claimant

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4321 N. Ballard Road, Appleton, WI 54919-0001
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Health and Other Personal Information Authorization

(This authorization complies with the HIPAA Privacy Rule.)

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

Date of birth (mm/dd/yyyy)	Contract number

This authorization applies to Thrivent Financial for Lutherans, Thrivent Life Insurance Company, Thrivent Insurance Agency Inc. and third party administrator LTCG, their employees, representatives, agents, reinsurers and any other persons performing business, legal, medical or insurance services for them or on their behalf, hereafter called "You" or "Your."

For the purpose of determining my eligibility for insurance, payment, or health care, or for any other use, collection or disclosure permitted by law, You may need to obtain, use or disclose any and all information about my physical and mental health, including but not limited to services for preventive, diagnostic and therapeutic care, tests, counseling and medical prescriptions; and non-health information about me including but not limited to financial, insurance, credit, occupational, avocational and driving history.

I authorize any health care professional, medical facility, pharmacy benefit manager, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearinghouse, other insurer, insurance broker, Your affiliate, health care component of Your company, Department of Motor Vehicles, consumer reporting agency, MIB, Inc., employer, family member and acquaintance to provide information about me, including my entire medical record, to You. **By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.**

I authorize You to disclose information about me to any insurance broker and other insurer approved by You for the purpose of securing insurance for me. Information about my health may be released as required or permitted by law such as to MIB, Inc. in an effort to deter fraud, misrepresentation or criminal activity. Health information about me, which is used or disclosed pursuant to this authorization, may be subject to redisclosure by the recipient, and may no longer be protected under federal law.

I understand that to determine my eligibility for insurance, You may request an investigative consumer report. This inquiry may include information as to my character, general reputation, personal characteristics and mode of living, whichever is applicable. I further understand that upon my written request, I will be informed whether or not an investigative consumer report was requested, and if such report was requested, the name and address of the consumer reporting agency to whom the request was made so that I may inspect and receive a copy of such report by contacting such agency. I authorize you to procure or prepare such consumer report.

This authorization is valid for 24 months following the date of my signature shown below. However, for health insurance benefit claims this authorization is valid for the coverage of the policy, or for all other claims for the duration of the claim. A copy, image or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing as outlined in the Privacy of Information about Your Health notice. I acknowledge that such a revocation is not effective to the extent You have relied on the use or disclosure of my health information or You have a legal right to contest the insurance contract or a claim under the insurance contract.

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

I understand You may not be able to determine my eligibility for insurance if I do not agree to the terms of this authorization. I have read this authorization, and I agree to its terms as indicated by my signature below.

I am entitled to receive a copy of this authorization.

Signature of proposed insured or personal representative	Date signed (mm/dd/yyyy)	Description of personal representative's authority to act
X		

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Attending Physician's Statement

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

Section 1 - Patient Information (to be completed and signed by the patient or parent/authorized representative)

Name of patient

Date of birth (mm/dd/yyyy)	Contract number(s)

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

Signature of patient or parent/authorized representative and date signed (mm/dd/yyyy)

X

Section 2 - Medical History (to be completed and signed by the attending physician)

1. History

Date symptoms first appeared or date of accident (mm/dd/yyyy) -_____

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

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

Name of referring physician		Phone	
Address	City	State	ZIP code

If hospitalized, give dates of confinement (mm/dd/yyyy): Admitted -_____ Discharged -_____

Name of hospital		Phone	
Address	City	State	ZIP code

2. Diagnosis and Treatment

Primary ICD - _____ Diagnosis - _____

Secondary ICD - _____ Diagnosis - _____

Objective findings (include results of x-rays, ECGs, laboratory data, and any clinical findings

Nature of treatment (include surgery, physical therapy, and medication prescribed, if any)

Patient's present limitations

3. Dates of Treatment

Date of first visit (mm/dd/yyyy)	Date of last visit (mm/dd/yyyy)	Date of next visit (mm/dd/yyyy)	Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other, specify -

4. Extent of Disability

How long was or will the child be totally disabled from attending school outside of the home (mm/dd/yyyy)?
from _____ to _____

5. Remarks

I swear that the statements and answers provided on this form are true and complete to the best of my knowledge.

Name of attending physician (including specialty/degree)		Tax ID number	
Address	City	State	ZIP code
Phone	Fax		

For your protection, state laws require the following to appear on this form: Any person who, knowingly and with intent to defraud or deceive any insurance company or other person, files or facilitates the filing of a statement of claim containing any materially false information, or conceals information concerning any fact material to the statement, may be guilty of insurance fraud, which may be a felony crime, subject to civil penalties or criminal prosecution, including substantial fines and/or confinement in prison.

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

X

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