THRIVENT FINANCIAL®

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

Life Premium Waiver 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

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.

Attending Physician's Statement

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 Life Waiver Claims
Thrivent Financial
PO Box 8075
Appleton WI 54912-8075

Fax:
800-225-2264

Questions:
800-847-4836

Properly completed forms will help avoid unnecessary delays.

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Claimant's Statement

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Section 1 - General Information

Contract number	Contract number	Contract number	Contract number	Contract number	Contract number
Name of child					Date of birth
Address	City		State	ZIP code	Phone

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.

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

X

Relationship, if other than claimant

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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)

Contract number	Contract number	Contract number	Contract number	Contract number	Contract number

Name of patient	Date of birth

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

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

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