THRIVENT®

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Deceased Additional Health Information

The following information is needed as one of the below items pertains to your beneficiary claim:

- A life insurance contract has been in force for two years or less
- There is an accidental death benefit rider on the contract
- The situation involves unusual circumstances of death

1. Deceased Information

Name _____ Member ID _____

Date of Birth _____ Date of Death _____

Cause of death _____

Consulting physician(s) for last illness
Include name, address and phone number of physician(s). Provide date deceased first complained or gave indication of last illness, along with the date deceased first consulted a medical practitioner for last illness.

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Physician(s) the deceased was seen by and hospital(s) attended within the past three years.
Include name, address and phone number of physician(s) and hospital(s). Provide date of visit and disease or condition treated for.

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2. Authorization for Information Regarding a Deceased Person

This authorization complies with the HIPAA Privacy Rule.

This authorization applies to Thrivent Financial for Lutherans and Thrivent Insurance Agency Inc., 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 evaluating and processing my claim for insurance benefits, You may need to obtain, use or disclose any and all physical and mental health information, including but not limited to services for preventive, diagnostic and therapeutic care, tests, counseling and medical prescriptions; and non-health information, including but not limited to financial, insurance, credit, occupational, avocational and driving history about deceased.

I authorize any health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, pharmacy, medical records service, prescription history clearinghouse, other financial institution, Your affiliate, health care component of Your company, Department of Motor Vehicles, Social Security Administration, consumer reporting agency, Medical Information Bureau (MIB), Health Claim Index (HCI), employer, case manager, social worker, financial advisor, attorney, family member, and acquaintance to provide information about the above-named deceased person, including the entire medical record, to You.

Information about the health of the deceased person may be released as required or permitted by law, such as to the Medical Information Bureau (MIB) in an effort to deter fraud, misrepresentation or criminal activity. This health information, 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 authorize you to share any information concerning this claim with Your affiliates for purposes of processing a death claim or changing registration on accounts. I understand this information will not be disclosed to nonaffiliated third parties that are not conducting specific business activities for or on behalf of You.

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 health information or to the extent that You have a legal right to contest the insurance contract or my claim under the insurance contract.

I understand You may not be able to evaluate and/or process my claim for insurance benefits if I do not agree to the terms of this authorization. I have read (or have had read to me) 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 beneficiary _____

Name of beneficiary _____

Date signed _____