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Life Premium Waiver/ Disability Waiver Claim

This form is used to file a premium waiver/disability waiver claim on your life insurance contract, and is to be completed after four or six consecutive months of total disability, depending on the contract.

Do not use this form if your claim is for a disability income insurance contract **only**, or if your claim is for both a life premium waiver/disability waiver and disability income insurance. Instead, complete the Disability Income Insurance Claim (form DI259NY).

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:

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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Section 1 - General Information

Contract number 1	Contract number 2	Contract number 3	Contract number 4	Contract number 5	Contract number 6
Name of claimant					Date of birth
Email					Phone
Address			City	State	ZIP code

Section 2 - Sickness/Injury Information

Describe the nature and details of the sickness or injury _____ Date symptoms began or injury occurred _____

Date medically unable to perform regular occupation/activities (mm/dd/yyyy) - _____

Yes No Are you able to return to your regular occupation/activities?
 If yes, effective date (mm/dd/yyyy) - _____ Full time Part time

Yes No Were you able to perform another occupation during the time you were unable to perform your regular occupation/activities?
 If yes, what dates were you employed (mm/dd/yyyy)? _____ to _____
 If yes, explain occupation/activities performed - _____

Section 3 - Benefits Information

Select all of the following benefits that you have applied for or are receiving:

Social Security Disability Effective date (mm/dd/yyyy) - _____

Social Security Retirement Effective date (mm/dd/yyyy) - _____

Workers' Compensation Effective date (mm/dd/yyyy) - _____

Name of your workers' compensation carrier (if applicable)	Phone
Address	City
State	ZIP code

Section 4 - Employment Information (when disability began)

Employed Unemployed Self-employed Homemaker Retired

Reason for unemployment _____

Name of employer	Phone
Address	City
State	ZIP code
Occupational title	Years in occupation

Date last worked (mm/dd/yyyy) - _____

List the primary duties/responsibilities (or if homemaker, unemployed, or retired, the daily activities) you were performing before disability began, including number of hours spent doing these tasks each week. Attach a copy of your job description, if available.

Duties/Responsibilities	Hrs/Wk

Yes No Do you have a secondary occupation? If yes, complete the information below.

Name of employer	Employment dates (mm/dd/yyyy) _____ to _____
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Occupation and duties

Average monthly earned income	Hours per week
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Contact person	Phone
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Address	City	State	ZIP code
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Section 5 - Medical Provider Information

If you have been treated for this sickness/injury by anyone other than the doctor completing the attached Attending Physician's Statement, provide the following information.

Name of additional medical provider	Phone
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Address	City	State	ZIP code
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Dates treated (mm/dd/yyyy)

Complete the information below for all medical providers you have seen in the last five years.

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

Section 6 - Signature

The claimant must sign and date this form.

For your protection, any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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

Signature of claimant	Date signed
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X

Relationship, if other than claimant

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)

Contract number 1	Contract number 2	Contract number 3	Contract number 4	Contract number 5	Contract number 6
Name of patient					Date of birth
Occupation and primary work duties or homemaker/unemployed					

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

Signature of patient X	Date signed
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Section 2 - Medical History (to be completed and signed by the attending physician)

This report assists us in making a disability determination. Your patient is depending on your prompt and detailed information.

1. History

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

Yes No Has the patient ever had the same or similar condition?
If yes, explain - _____

Yes No Is the condition work-related?

Yes No Has the patient been hospitalized?

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

Name of hospital	Phone		
Address	City	State	ZIP code

Name of physician who referred patient to you	Phone
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Name(s) of other health care providers the patient has been referred to	Phone(s)
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2. Diagnosis and Prognosis

Primary ICD - _____ Diagnosis - _____

Secondary ICD - _____ Diagnosis - _____

Initial date of treatment at your clinic or by you (mm/dd/yyyy) - _____

Most recent date of treatment for this condition(s) (mm/dd/yyyy) - _____

Next date of treatment for this condition(s) (mm/dd/yyyy) - _____

Yes No Is the patient still under your care for this condition(s)?

Date patient became medically unable to work (mm/dd/yyyy) - _____

Yes No Did you treat patient that day?

3. Extent of Disability and Treatment

- Yes No Is the patient medically able to return to his/her occupation?
 If yes, provide return date (mm/dd/yyyy) - _____ Full time Part time
 If no, when will the patient be able to return to the above noted occupation (in months)?
 1-3 4-6 7-12 Over 12 Permanently unable to work
- Yes No Do you feel the patient is medically able to perform another occupation?
 If yes, provide return date (mm/dd/yyyy) - _____ Full time Part time
 If no, anticipated date patient will be medically able to perform another occupation (mm/dd/yyyy) - _____
- Yes No Is the patient medically able to return to homemaker or unemployed activities?
 If yes, provide return date (mm/dd/yyyy) - _____ Full time Part time
 If no, when will the patient be able to return to the above noted activities (in months)?
 1-3 4-6 7-12 Over 12 Permanently unable

Current and recommended treatment plans	Date surgery performed/anticipated (mm/dd/yyyy)
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Medications (names and dosages)

Explain any specific restrictions placed on the patient

- Treatment/Rehabilitation programs that you would suggest for the patient (select all that apply):
- Physical therapy Pain management program Vocational rehabilitation
 Occupational therapy Work hardening program Psychological counselling
 Cardiac rehabilitation Job modification Other, describe - _____
- Yes No Did you discuss these treatment/rehabilitation program selections with the patient?
 Yes No Do you believe the patient is competent enough to endorse checks and direct the use of proceeds thereof?

4. Physician Information

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

For your protection, any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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

Signature of physician	Date signed
X Name of contact person for any questions regarding the information provided on this form	Phone

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Fax: 800-225-2264