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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 DI259).

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. Your doctor should mail or fax the completed statement to Thrivent.

Mail completed form to:
Life Waiver Claims
Thrivent
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 Disability Statement

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 _____
Occupation and duties	

Average monthly earned income $	Hours per week

Contact person	Phone

Address	City	State	ZIP code

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

Address	City	State	ZIP code

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

Address	City	State	ZIP code

Dates treated (mm/dd/yyyy)

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.

For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state 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	Date signed
X	

Relationship, if other than claimant

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Attending Physician's Statement

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

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
Name(s) of other health care providers the patient has been referred to	Phone(s)

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)

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		

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

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

Mail completed form to: Life Waiver Claims, Thrivent, PO Box 8075, Appleton WI 54912-8075
Fax: 800-225-2264