THRIVENT FINANCIAL®

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

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
Address	City	State	ZIP code
Email			Phone

Section 2 - Questions

1. Describe the nature of the impairment

Work-related? ☐ Yes ☐ No

Impairment began (mm/dd/yyyy) - ______________ Impairment is the result of: ☐ Accident ☐ Sickness

If accident, describe how the accident occurred

2. Employment Information: Immediately prior to the date you are claiming disability, were you:

☐ W2 employee - Complete Section A below and have your employer complete the Employment Statement.
☐ Homemaker/Unemployed/Retired - Complete Section B below. (Employment Statement is not needed.)
☐ Self-Employed - Complete Section C.

Section 2A - W2 Employee

Name of employer			Employment dates (mm/dd/yyyy) ______________ to ______________
Occupation and duties			
Contact person			Phone
Address	City	State	ZIP code

Average monthly earned income prior to disability (gross) - $ ________________

Section 2B - Homemaker/Unemployed/Retired

List your activities, including the number of hours per day and days per week that you typically performed these activities just prior to the time you are claiming disability benefits.

Activities	Hrs/Day	Days/Wk

Name of person(s) currently performing the activities that you are unable to perform

If retired: Date of retirement (mm/dd/yyyy) - ____________ **If unemployed:** Date last worked (mm/dd/yyyy) - ____________

Reason for unemployment - ________________________________

Name of last employer (if unemployment began within the last 24 months)	Phone number of last employer

Section 2C - Self-Employed

Name of business			Phone	
Address	City		State	ZIP code

Describe the nature of your business (be specific)

How long have you owned this business? ____________________

How is your business organized?

☐ Sole Owner/Proprietor ☐ S Corporation ☐ Limited Liability Corporation
☐ Partnership - ________% ☐ C Corporation

Does your business pay any portion of your Thrivent Financial premium? ☐ Yes - _______ % ☐ No

How are you compensated for your work (select all that apply)? ☐ W2 wages ☐ 1099 earnings ☐ ______% of profits

Based on your last federal tax return prior to disability: Net profit: $_______________ Gross profit: $_______________

What was your total earned income for the year? $_____________

Thrivent Financial may require financial records to verify earned income.

List the primary duties/responsibilities you were performing before disability began, including type and number of hours spent doing these tasks each week. *Type: S = Supervisory, C = Clerical, P = Physical, or O=Other

Duties/Responsibilities	Type*	Hrs/Wk

If your duties vary throughout the year, explain - ____________________

Section 2D - Secondary Occupation Information (complete if applicable)

Name of employer		Employment dates (mm/dd/yyyy) _____________ to _____________
Occupation title	Average monthly earned income prior to disability (gross) $	
Contact person		Phone

Section 2E - Other Benefits

3. Select all of the benefits you have applied for and complete the additional information if you are receiving or may receive payment from that benefit.

☐ None	Monthly Amount	Effective Date (mm/dd/yyyy)	Name and Phone Number of Payor
☐ Disability Income Policy(ies)	$		
☐ Group Disability Coverage	$		
☐ Sick Pay ☐ Vacation Pay	$		
☐ Salary Continuation	$		
☐ Workers' Compensation	$		
☐ Railroad Retirement	$		
☐ Government Disability	$		
☐ Automobile/Liability	$		
☐ Veterans' Disability	$		
☐ **Social Security**	$		☐ Disability ☐ Retirement ☐ Supplemental Income

4. Date medically unable to perform regular occupation/activities (mm/dd/yyyy) - ________________

Explain how this condition(s) limits your ability to work or perform your daily activities.

5. Have you returned to work/activities in any capacity? ☐ Yes ☐ No

If yes, on what date (mm/dd/yyyy)? ____________ ☐ Full time ☐ Part time

List what occupation/activities were performed, if applicable.

6. First physician seen who provided treatment for this condition

Name of doctor first seen			Phone
City	State	Dates treated (mm/dd/yyyy)	

7. Hospital where treatment was received and/or additional physicians providing treatment for this condition

Name of hospital or additional treating physician			Phone
City	State	Dates treated (mm/dd/yyyy)	

Name of additional treating physician			Phone
City	State	Dates treated (mm/dd/yyyy)	

8. Medical Provider Information (for claims within two years from the date contract was issued)

Name of other physician seen in the last 10 years			Phone
City	State	Dates treated (mm/dd/yyyy)	

Name of other physician seen in the last 10 years			Phone
City	State	Dates treated (mm/dd/yyyy)	

Section 3 - Agreement and 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 **X**	Date signed
Relationship, if other than claimant	If a cognitive impairment exists and a durable power of attorney for finances has been appointed, send a copy of that document.

Mail completed form to: Disability Income Claims, Thrivent Financial, PO Box 8075, Appleton, WI 54912-8075
Fax: 800-225-2264

Section 4 - Direct Deposit Authorization

Thrivent Financial provides the option of having your monthly disability payment directly deposited into your personal bank account. If you are interested in this service, complete the information below.
Funds can only be sent to a bank account in the insured's name. Funds cannot be sent to a family member (unless joint account with the insured), Power of Attorney, trust, or any business you own.

All sections of this form must be completed even if your premium is being withdrawn from the same account.

I authorize Thrivent Financial to make this electronic deposit and, if necessary, corrections to my financial institution account. My authorization is valid for electronic deposits and corrections that comply with U.S. law. U.S. law grants me certain rights when I request an electronic deposit. These laws also regulate how electronic deposits and corrections are made to my financial institution account. This authorization shall remain in full force and effect until I revoke it by giving 10 days prior notice to Thrivent Financial.

☐ New ☐ Change

Name	Contract number

Deposit my contract benefits into the following account:

☐ Checking ☐ Savings

Routing number - Consult your bank for the correct one.	Account number
Name of bank	Phone of bank

Address	City	
	State	ZIP code

Name in which account is held

The benefit payment will be sent by check until direct deposit can be established.

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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/retired activities

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

Signature of patient | Date signed
X

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 - ______________________________

Date patient became medically unable to perform activities listed above (mm/dd/yyyy) - __________

☐ Yes ☐ No Did you treat the patient on this date?

Initial date of treatment for this condition(s) 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)?

3. Extent of Disability and Treatment

☐ Yes ☐ No Is the patient medically able to return to the above noted occupation/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 occupation/activities (in months)?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 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) -______________

Current limitations/restrictions (be as specific and as quantitative as possible, i.e. lifting = how many pounds):

Lifting/Carrying	Standing	Driving	Squatting	Bending/Twisting	Walking
Overhead	Climbing	Sitting	Psychological	Other	

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

Medications (names and dosages)

Objective findings

☐ Yes ☐ No Do you believe the patient is competent enough to endorse checks and direct the use of proceeds thereof?

4. Physician Information

☐ Yes ☐ No Have you completed claim forms for other disability income or workers' compensation insurance carriers?

Company Name	Address

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.

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

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Fax: 800-225-2264

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Employment Statement

Any cost for completion of the Employment Statement is the responsibility of the employee.

Section 1 - Employee Identification Information (to be completed and signed by the employee)

Name of employee	Date of birth	Contract number(s)

I hereby authorize my employer to release any information acquired in the course of my employment.

Signature of employee X	Date signed

Section 2 - Employment Information (to be completed and signed by the employer)

Date of hire (mm/dd/yyyy) - ______________ Last day worked, prior to disability (mm/dd/yyyy) - ______________

☐ Yes ☐ No Has the insured returned to work? If yes, date (mm/dd/yyyy) - ______________

If yes, returned: ☐ Full time ☐ Part time To: ☐ Regular occupation ☐ Different occupation

If the insured has not returned to work, what is the expected date of return (mm/dd/yyyy)? ______________

☐ Yes ☐ No Are you holding the job open?

☐ Yes ☐ No Has the insured retired or resigned? If yes, effective date (mm/dd/yyyy) - ______________

Do you pay any portion of the insured's Thrivent Financial disability insurance premium? ☐ Yes - ______ % ☐ No

Work History and Earnings for the Last Two Years (list most current position first)

Job Title	Start Date	End Date	Average Hrs/Week	Gross Monthly Income	Job Duties/Physical Requirements (attach job description)
				$	
				$	
				$	
				$	

Other Insurance Coverage	**Group Disability**	**Worker's Compensation**
Has a claim been filed?	☐ Yes ☐ No	☐ Yes ☐ No
Policy number		
Name of carrier		
Phone number of carrier		
Monthly benefit		
Dates benefits began (mm/dd/yyyy) -		
Effective date of coverage		

Waiting period:
Accident - ______________
Sickness - ______________

Maximum period:
Accident - ______________
Sickness - ______________

Is the insured receiving salary continuation or sick pay? ☐ Yes, amount - $ ______________ ☐ No

When did benefits begin? ___________________ Length of time benefits will continue? ___________________

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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 employer X		Date signed
Print name	Title	
Company name	Phone	Fax

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