

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
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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.

	Monthly Amount	Effective Date (mm/dd/yyyy)	Name and Phone Number of Payor
<input type="checkbox"/> None			
<input type="checkbox"/> Disability Income Policy(ies)	\$		
<input type="checkbox"/> Group Disability Coverage	\$		
<input type="checkbox"/> Sick Pay <input type="checkbox"/> Vacation Pay	\$		
<input type="checkbox"/> Salary Continuation	\$		
<input type="checkbox"/> Workers' Compensation	\$		
<input type="checkbox"/> Railroad Retirement	\$		
<input type="checkbox"/> Government Disability	\$		
<input type="checkbox"/> Automobile/Liability	\$		
<input type="checkbox"/> Veterans' Disability	\$		
<input type="checkbox"/> Social Security	\$		<input type="checkbox"/> Disability <input type="checkbox"/> Retirement <input type="checkbox"/> 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
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City	State	Dates treated (mm/dd/yyyy)
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7. Hospital where treatment was received and/or additional physicians providing treatment for this condition

Name of hospital or additional treating physician	Phone
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City	State	Dates treated (mm/dd/yyyy)
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Name of additional treating physician	Phone
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City	State	Dates treated (mm/dd/yyyy)
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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
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City	State	Dates treated (mm/dd/yyyy)
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Name of other physician seen in the last 10 years	Phone
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City	State	Dates treated (mm/dd/yyyy)
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Section 3 - Agreement and 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	If a cognitive impairment exists and a durable power of attorney for finances has been appointed, send a copy of that document.
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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
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Deposit my contract benefits into the following account:

Checking Savings

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

Name in which account is held

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

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 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 - _____

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)
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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, 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

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



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

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

Signature of employee X	Date signed
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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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Waiting period:
Policy number	_____	_____	Accident - _____
Name of carrier	_____	_____	Sickness - _____
Phone number of carrier	_____	_____	
Monthly benefit	_____	_____	Maximum period:
Dates benefits began (mm/dd/yyyy) -	_____	_____	Accident - _____
Effective date of coverage	_____	_____	Sickness - _____
Is the insured receiving salary continuation or sick pay? <input type="checkbox"/> Yes, amount - \$ _____ <input type="checkbox"/> No			
When did benefits begin? _____ Length of time benefits will continue? _____			

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 employer X	Date signed	
Print name	Title	
Company name	Phone	Fax

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