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The Thrivent Financial Guidance Team provides a team of individual representatives to assist you, any of which may assist you at any time. The Thrivent Financial Guidance Team may not offer the full variety of products and services that can be offered by a local representative. If your situation requires a product or service not currently available through the Thrivent Financial Guidance Team, we can put you in contact with a local representative. Whether you purchase a product or service through a Thrivent Financial Guidance Team representative or a local representative, there generally will be no difference in the fees and expenses you will incur.

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Important Privacy Choices for Consumers

Facts	What does Thrivent do with your personal information?
Why?	Financial services and insurance companies choose how they share your personal information. Federal and state law gives clients the right to limit some but not all sharing. Federal and state law also requires us to tell you how we collect, share and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: • Identifying information, such as name and contact information. • Social Security number. • Financial factors, including income, assets, credit history transaction history, and risk tolerance. • Health indicators, such as medical records, prescription history and claims statuses. We may share any/all the information we collect depending on what is needed for the stated purpose.
How?	All companies need to share clients' personal information to run their everyday business. In the section below, we list the reasons companies may share their clients' personal information; the specific reasons Thrivent chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	Does Thrivent share?	Can you limit this sharing?
For our everyday business purposes Such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, report to credit and medical bureaus, or engage with service providers who act on our behalf to support our operations.	YES	NO
For our marketing purposes To offer our products and services to you.	YES	YES
For joint marketing with other financial companies.	YES	YES
For our affiliates' everyday business purposes Information about your transactions and experiences with Thrivent.	YES	NO
For our affiliates' everyday business purposes Information contained on your application or in your credit report.	YES	YES
For nonaffiliates to market to you This includes nonprofit organizations such as churches or partner organizations.	YES	YES*

To limit our sharing	• Call 800-847-4836 between 7 a.m. and 6 p.m. Central time, Monday through Friday. • Log in to your online Preference Center on thrivent.com. • Mail to: Thrivent 4321 N. Ballard Rd. Appleton WI, 54919-0001 **Please note:** If you are a new client, we can begin sharing your information 30 days from the date we provide you this notice. If you are a former client, we will continue to share your information as described in this notice. However, you can contact us at any time to limit our sharing.

Who we are	
Who is providing this notice?	This notice describes the privacy practices of "Thrivent," which includes Thrivent Financial for Lutherans, Thrivent Investment Management Inc., Thrivent Financial Investor Services Inc., Thrivent Insurance Agency Inc., Thrivent Asset Management, LLC, Thrivent Mutual Funds, Thrivent Series Fund, Inc., Thrivent Core Funds, Thrivent Church Loan and Income Fund, Thrivent Cash Management Trust, and Thrivent Education Funding, LLC.

What we do	
How does Thrivent collect my personal information?	We collect your personal information in a few ways: • Directly from you, such as when you use a service, apply for a product or file a claim. • From other third parties, such as credit reporting agencies or your doctor. • Through your transactions and interactions with us.

How does Thrivent protect my personal information?	To safeguard your personal information from unauthorized access and use, we maintain physical, procedural, and electronic security measures. These strategies include: • Frequent internal and external reviews to ensure our technology and protocols are up to date. • Limited access to your personal information; only those with a "need to know" are authorized. • Anyone who uses your data must follow established policies, procedures and laws. Note: Your personal information is processed in the United States, which means that privacy laws may be less stringent than they are in your country of residence. This also means that government agencies, courts or law enforcement in the United States may be able to access your information.
Why can't I limit all sharing?	Federal law gives you the right to limit sharing only in certain situations: •To affiliates: • If we share information about your creditworthiness. • If affiliates use your information to market to you. At Thrivent, if you opt out of marketing, identified in the chart above as "for our marketing purposes," that choice applies to any/all Thrivent affiliates. •To nonaffiliates: • If they wish to obtain your information to market to you. *In addition, residents of CA, MA, MN, NM, ND and VT are opted out of nonaffiliate sharing, per state law. Clients in these states may choose to opt in for this sharing.
What if I am a joint contract owner or joint account owner?	You may be receiving this notice on behalf of all owners. As a joint owner, you may choose one or more of the sharing options that apply in your home state on behalf of all joint owners or only on your own behalf.
What are the data processing options for residents of the European Union?	If you reside in the EU, permanently or temporarily, you may be entitled to the following options: • Revocation of consent or restricted processing. If you revoke your consent for the processing of personal information, or if you wish to restrict the ways in which we can use your information, we may no longer be able to provide you certain services. In some cases, we may be legally required or permitted to use your information for specific reasons—with or without your consent—so we may limit or deny your request to revoke consent or restrict our processing. • Deletion of your information. We retain your personal information for the period necessary to fulfill the purposes outlined in this policy, unless a longer retention period is required by one of Thrivent's industry regulators. However, if required by law and permitted by our regulators, we will grant a request that we delete your personal information. EU residents should mail any applicable requests to the address above.
How do I access and update the information Thrivent has about me?	Accurate information helps us to provide you better customer service, increase the efficiency of our operations and comply with laws. You may request access to and correction of your personal information by writing to us at the address above. Registered users of thrivent.com or Thrivent's mobile application may also update some personal information through their online personal profile.

Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. Thrivent affiliates include lines of business such as life insurance, long-term care insurance, brokerage, investments, trust, banking, mutual funds, and distribution partners.
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. Thrivent nonaffiliates include financial institutions, such as consumer banking, and other non-profit entities, including churches.
Joint marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. Thrivent has joint marketing agreements with other financial institutions, such as consumer banking, and non-profit foundations.

Other important information

For more specific insights into our collection and use of your health information, be sure to review our Health Information Privacy Notice available at thrivent.com/privacy. We also have a Notice of Insurance Information Practices document that describes Thrivent's use of your information to perform insurance operations. You can request a copy of any of our notices at any time by writing to us at the address above.

This notice outlines our privacy practices for clients; those individuals who have purchased, or applied for, a product or service with Thrivent. For additional information regarding our collection, use, and sharing of personal information for situations and scenarios outside of the client relationship, please review our Privacy Policy, available at thrivent.com/privacy.

Complaints can be sent to us at the address provided above. Depending on where you live, you may also be able to contact local or state agencies to report specific concerns.

Questions? Call 800-847-4836 or go to thrivent.com.

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Privacy of Information About Your Health

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Protecting the privacy of information about your medical conditions and health is a responsibility we take very seriously. We understand that medical information about you and your health is personal, and it is important to you that we keep it confidential. We are committed to the practices and procedures we established to protect the confidential nature of information about your health.

This notice describes the ways in which we may use and disclose information about your health to carry out treatment, payment and health care operations, and for other purposes as permitted or required by law. It also describes your rights and our duties regarding the use and disclosure of health information.

Uses and disclosures of information about your health without your authorization

The following categories describe ways that we may use and disclose information about your health without your written authorization. For each category, we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information without written authorization fall within one of the categories.

Treatment: We do not use information about your health to provide you with medical treatment or related services.

Payment: Generally, we use and disclose information about your health so we can administer claims, which includes reimbursing incurred expenses for treatment and services you receive from a health care provider. For example, we may disclose this information to your health care provider to verify insurance coverage for medical treatment or service expenses.

Health care operations: We use and disclose information about your health for our insurance operations. These uses and disclosures are necessary for our business and to make sure our members are receiving quality service. Some examples of how we may use and disclose information about your health include: underwriting insurance, processing transactions, resolving grievances and conducting business planning.

We may also disclose information about your health to our business associates to enable them to perform services for us or on our behalf relating to our operations. At the time you apply for insurance, we may disclose information about your health in encoded form to the Medical Information Bureau (MIB) in an effort to deter fraud, misrepresentation or criminal activity.

Public health risks: As required by law, we may disclose information about your health to public health authorities that receive information to: prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; and notify a person who may be at risk for contracting or spreading a disease or condition.

Health oversight activities: We may disclose information about your health to a health oversight agency for activities authorized by law. Examples of these oversight activities include: audits, investigations and inspections. These activities are necessary for the government to monitor the health care system, government programs and entities subject to civil rights laws.

Lawsuits and disputes: If you are involved in a lawsuit or a dispute, we may disclose information about your health in response to a court or administrative order. We may also disclose this information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute. We will make reasonable efforts to tell you about the request.

Law enforcement: We may release information about your health if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process; and about a death that may be the result of criminal conduct.

We may also release information about your health to law enforcement or other governmental authorities to protect us against perpetration of fraud or other illegal activities.

Coroners, medical examiners and funeral directors: We may release information about your health to a coroner or medical examiner. We also may release information about your health to funeral directors as necessary to carry out their duties.

Research: Under certain circumstances, we may use information about your health for insurance research purposes. We may also disclose information about your health to organizations conducting actuarial or insurance research studies.

To avert a serious threat to health or safety: Although it is not our practice, we may use and disclose information about your health when necessary to help prevent a serious threat to the health and safety of you or others.

Any disclosure, however, would only be to someone able to help prevent the threat.

Military and veterans: If you are a member of the armed forces, we may release information about your health as required by military command authorities.

Workers' compensation: We may release information about your health to comply with laws relating to workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Uses and disclosures of information about your health with your authorization

The following use and disclosures will only be made with authorization from you:

- Uses and disclosures of health information for marketing purposes.
- Uses and disclosures of psychotherapy notes, unless permitted by law.
- Disclosures that constitute the sale of personal health information.

Other uses and disclosures of information about your health that are not described in this notice or are not otherwise permitted by law will be made only with your written authorization. You may revoke such authorization as described in this notice.

Your rights regarding information about your health

You have the following rights regarding the health information we maintain about you, which you may exercise by submitting your request in writing to:

Thrivent
Attention: Privacy Office
4321 N. Ballard Road
Appleton, WI 54919-0001

Right to revoke authorization: You may revoke your authorization that allows us to use or disclose health information that is not otherwise covered by this notice or applicable law in writing at any time except: when the authorization was obtained as a condition of obtaining insurance; during the contestable period; or to the extent that we have taken action in reliance on your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization and that we may retain documents that may contain information about your health.

Right to request restrictions: You have a right to request a restriction on the information about your health that we use or disclose for treatment, payment or health care operations. You also have the right to request a limit on the information we disclose about your health to someone who is involved in your care or the payment for your care, such as a family member.

In your request, you must tell us the information you want to limit; whether you want to limit our use, disclosure or both; and to whom you want the limits to apply (for example, disclosures to your spouse).

We are not required to agree to your requested restriction or limitation, unless the protected health information pertains solely to health care for which you, not a health plan, have paid us or your provider in full.

Right to request confidential communications: If you could be endangered by our normal communication channels, you have the right to request that we communicate information about your health to you by alternative means or at an alternative location. We will ask you the reason for your request, and we will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to inspect and copy: You have a right to inspect and copy information about your health that we maintain. Usually, this includes medical and billing records. Under federal law, this right does not include psychotherapy notes or information about your health compiled in reasonable anticipation of litigation, administrative action or administrative proceeding. If you request a copy of this information, we may charge a standard fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain limited circumstances, such as where disclosure would reasonably endanger the life or physical safety of you or another person. If you are denied access to information about your health, you may request that the denial be reviewed.

Right to amend: If you believe the information we have about your health is incorrect or incomplete, you may ask us to amend the information. You must provide a reason that supports your request. You have the right to request an amendment for as long as the information is kept by or for us.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment.
- Is not part of the information about your health kept by or for us.
- Is not part of the information about your health that you would be permitted to inspect and copy.
- Is accurate and complete.

Right to request an accounting: You have the right to receive an accounting of certain disclosures of information about your health that we made, if any. This right applies to disclosures for purposes other than treatment, payment, health care operations, or as otherwise permitted or required by law. You have a right to receive specific information about these disclosures that occur after Nov. 1, 2002. The right to receive this information is subject to certain exceptions, restrictions and limitations.

Right to a copy of this notice: You have the right to obtain a copy of this notice at any time.

Our duties regarding information about your health

We are required by law to:

- Maintain the privacy of your protected health information.
- Notify you following a breach of your unsecured protected health information.
- Provide you with this notice of our legal duties and health information privacy practices.
- Not use or disclose protected health information that is genetic information to underwrite for Medicare Supplement Insurance.
- Abide by the terms of this notice.

Changes to this notice

We reserve our right to change the terms of this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. If we make a material change to the terms of this notice, we will mail a revised notice to you. Please be aware this notice is also provided on Thrivent.com for you to review.

For more information or to file a complaint

If you have questions or would like additional information, you may contact us at 800-847-4836.

If you believe your privacy rights have been violated, you may file a written complaint with our privacy office and with the Secretary of the Department of Health & Human Services. You will not be retaliated against for filing a complaint.

This notice was published and became effective on Sept. 24, 2013.

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Notice of Insurance Information Practices

Information Collected

We may collect personal information from you and from persons other than you. Depending upon the circumstances, the sources and types of personal information we collect about you may include information we receive:

- From you on your applications or other forms, such as name, address, Social Security number, birth date, assets and income.
- From consumer-reporting agencies, such as credit history, prescription history and public records.
- About your transactions and experience with us, such as products purchased, your certificate values and payment history.
- From insurance support organizations, such as MIB, Inc., about your insurability received in a coded form.
- From your health care providers, such as copies of your medical records.
- From your employers about your occupation and earnings.
- From family members and others who may have knowledge about your character, habits and lifestyle.
- From other insurers, reinsurers or financial institutions, such as other insurance coverage applied for or in force and account information.
- From governmental agencies, such as a motor vehicle report.

Information Collection Techniques

Techniques that may be used to collect information about you include:

- Personal or telephone interview
- Written correspondence
- Examination or assessment
- Investigative consumer report
- Coded reports from MIB, Inc.

Sharing Information Outside Thrivent

As required or permitted by law, we may disclose all the information we have about you as follows:

- To others to enable them to perform services for us or on our behalf to underwrite insurance, process transactions and administer claims.
- To health care providers to verify eligibility for insurance and for coverage or benefits; inform you of medical history you may not be aware of; and to verify medical treatment or services.
- To an insurance regulatory authority to comply with audits and to respond to complaints.
- To a law enforcement or other governmental authority to protect us against perpetration of fraud or other illegal activities.
- To organizations conducting actuarial or research studies; however, no individually identifiable medical information is disclosed.
- To our affiliates to provide you with better customer service and account maintenance; to help you make decisions about your products, services and benefits; and to inform you of other products, services and benefits that may be of interest to you.

We may disclose identifying information we have about you, such as name, address and telephone number, with approved organizations to market products or services that may be of interest to you.

Uses and Disclosures of Information About Your Health With Your Authorization

The following use and disclosures will only be made with authorization from you:

- Uses and disclosures of health information for marketing purposes;
- Uses and disclosures of psychotherapy notes, unless permitted by law;
- Disclosures that constitute the sale of personal health information.

Other uses and disclosures of information about your health that are not described in this notice or are not otherwise permitted by law will be made only with your written authorization. You may revoke such authorization as described in this notice.

Access to Recorded Personal Information from Thrivent

You have the right to access recorded personal information we have about you that you can describe and that we can reasonably locate and retrieve. This right does not extend to information about you that relates to and is collected in connection with or in reasonable anticipation of a claim or civil or criminal proceeding involving you.

If you submit a written request to us describing the recorded information you want to access, then if we can reasonably locate and retrieve the requested information, we shall do the following within thirty (30) business days from the date the request is received:

1. Inform you of the nature, substance and source of your recorded personal information in writing, by telephone or by other oral communication, whichever we prefer;

2. Permit you to see and copy, in person, your recorded personal information or to obtain a copy of your recorded personal information by mail or electronically, whichever you prefer. If the recorded personal information is in coded form, an accurate translation in plain language shall be provided. However, where permitted by law, copies of your medical information will be supplied to a medical provider designated by you and licensed to provide medical care with respect to the condition to which the information relates;

3. Disclose to you the identity, if recorded, of those persons to whom we disclosed your personal information within two (2) years prior to your request, and if the identity is not recorded, the names of those persons to whom such information is normally disclosed; and

4. Provide you with a summary of the procedures by which you may request correction, amendment or deletion of recorded personal information.

Thrivent may charge a reasonable fee to cover the costs incurred in providing a copy of recorded personal information to you.

Correction, Amendment or Deletion of Recorded Personal Information from Thrivent

If you want to correct, amend or delete the recorded personal information we have about you, submit a written request to us. Within thirty (30) business days from the date of receipt of a written request, we will either:

1. Correct, amend or delete the portion of the recorded personal information in dispute; or

2. Notify you of our refusal to make such a correction, amendment or deletion; the reason for the refusal; your right to file a statement stating what you think is the correct, relevant or fair information; and the reasons why you disagree with our refusal to correct, amend or delete the recorded personal information.

If we correct, amend or delete recorded personal information, we will provide written notification to:

- Any person specifically designated by you who may have, within the preceding two (2) years, received such recorded personal information;
- MIB, Inc.;
- Any insurance support organization whose primary source of personal information is from insurance institutions and to whom we disclosed personal information within the preceding seven years, such as MIB, Inc.; and
- Any insurance support organization that furnished the personal information that has been corrected, amended or deleted.

If we refuse to correct, amend or delete your recorded personal information and you disagree, you have the right to file a concise statement with us that sets forth what you think is the correct, relevant or fair information; and the reasons why you disagree. In the event you file a statement, we will provide access to your statement with the disputed information to anyone reviewing it, and include it in any subsequent disclosures.

If the completeness or accuracy of any information furnished or provided to MIB, Inc. by Thrivent Financial is disputed by you, Thrivent Financial will notify MIB, Inc. of such dispute.

Access to and Correction, Amendment or Deletion of Recorded Personal Information from MIB, Inc.

Information regarding your insurability will be treated as confidential. Thrivent Financial, or its reinsurers may, however, make a brief report thereon to MIB, Inc., a not-for profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB, Inc. Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB, Inc. will arrange disclosure of any information it may have in your file. Please contact MIB, Inc. at 866 692-6901. If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB, Inc.'s information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Thrivent Financial, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB, Inc. may be obtained on its website at www.mib.com.

Information obtained from a report prepared by MIB, Inc. may be retained by MIB, Inc. and disclosed to other persons.

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Understanding the Underwriting Process

Life and Disability Income Insurance

Thank you for submitting your application to Thrivent. Now that you've submitted your application it goes through underwriting. Underwriting is the process of collecting and assessing an individual's information to determine whether they qualify for coverage, and if so, what premium they will need to pay for that coverage. We strive to make the underwriting process as easy as possible for you.

Depending on your age, and the type and amount of coverage you're applying for, you may be asked to complete one or more of the following.

Type of Information Collected	Estimated Time
Oral fluid specimen You administer this test yourself by placing the collection device (a cotton fiber pad affixed to a nylon stick) in your mouth between your lower gum and cheek. The sample will be sent to a laboratory designated by Thrivent.	Less than 5 minutes
Tele Interview A trained professional will contact you by telephone to ask you questions about your non-medical and medical history, such as avocations, illnesses, conditions, surgeries, examinations, tests, treatments and medications.	Approximately 20 - 30 minutes
Paramedical exam A paramedical professional will meet with you face to face to ask you questions about your non-medical and medical history, such as avocations, illnesses, conditions, surgeries, examinations, tests, treatments and medications. They will also take your blood pressure, pulse, height and weight.	Approximately 20 - 30 minutes
Blood and urine sample A paramedical professional will draw a blood sample and collect a urine sample. Only sterile, disposable needles and supplies are used. The sample will be sent to a laboratory designated by Thrivent.	Approximately 10 minutes
Electrocardiogram (ECG) A paramedical professional will place electrodes on your chest, arms, and legs while you are lying flat. This test shows the electrical activity of your heart.	Approximately 15 minutes
Senior exam Additional questions and activities conducted during the paramedical exam to assess mobility and memory.	Approximately 15 - 20 minutes

If an exam, blood and urine sample, ECG, and/or senior exam are needed, an examiner will contact you to schedule an appointment to come to your home or other location of your choice, to complete the services.

Tips to help your examination go smoothly:

- Have a government issued picture ID (preferably a driver's license) available.
- Have a list of the medications you are taking.
- Have a list of the names, addresses, and phone numbers of the medical care providers you have visited in the last 10 years.
- Wear a garment that is short-sleeved or has sleeves that can easily be rolled up.
- Be well hydrated. If a urine sample is required, you may want to drink a glass of water about an hour before your exam so you can easily provide a urine sample. Thrivent does not require you to fast for the blood and urine sample collection.
- Avoid smoking, caffeine, and strenuous activity/exercise for about two hours prior to your exam. Try to relax the hour before your exam.

Thrivent may also request your medical records, a motor vehicle report, an electronic inspection report (contains information such as verification of your identity, verification of your telephone number and address, vehicle registration, bankruptcy search, tax liens and judgements, criminal activity), your prescription medication history, or other information we deem appropriate. We also may call you to gather additional information or ask for clarifications of information. You may be asked to complete additional medical exams, provide details about your financial situation, and/or supply additional information deemed necessary to complete your application. This list is not comprehensive.

Typically underwriting is completed within two to three weeks, but it may take longer, depending on the complexity of your needs or the underwriter's need for additional information. You can help shorten the time by responding to requests for examinations and information as quickly as able.

After the underwriter receives all of the information they will make a decision regarding your insurability. One of the following things may happen:

- Your coverage may cost the same as what was shown to you by your representative(s).
- Your coverage may cost less than what was shown to you by your representative(s).
- Your coverage may cost more or be modified from what was shown to you by your representative(s). Your representative(s) may contact you to discuss the decision and any alternate options available to fill your needs. You will receive a letter with your contract providing details for the decision.
- Your coverage may be denied. You will receive a letter from Thrivent providing the reason(s) for the denial.

If you are approved for coverage, you will receive a copy of your contract from your representative(s) or it will be sent directly to you from Thrivent. Please review the contract carefully. If there are any inaccuracies or incomplete information, contact your represenative(s) immediately. If there are any amendments to your contract, you will receive two copies of the amendment. You need to sign both copies. Place one in your contract and return the other to Thrivent.

Thank you for considering Thrivent for your insurance needs.

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Notice and Consent Form for Testing to Determine Exposure to the Causative Agent of AIDS

Dear Proposed Insured:

To evaluate eligibility for insurance coverage, Thrivent may request that you provide a sample of blood, oral, and/or urine specimen for testing to determine the probable causative agents of AIDS. Before an insurer can request a specimen and perform a test, the insurer must explain the testing protocols, as established by the Director of the District of Columbia Department of Health. The insurer is also required to obtain a written consent statement from the applicant for insurance confirming that the insurer has complied with its obligations.

The signing of this form indicates that the procedure used in implementing this test has been explained and has been shown to be in full compliance with the protocol currently adopted by the Director of the Department of Health. Additionally, by signing and dating this form, it is agreed that this test may be performed and that an underwriting decision may be based on the test results.

No insurer shall request or require you to take the testing protocol without first obtaining you or your legal guardian's signature on this consent form. You have the right to decide not to be tested and not to sign this form. Once the insurance company has asked you to sign this consent form, you or your legal guardian may wait 14 days before signing this informed consent.

In the event the test result is positive, the Department of Health recommends that you or your child are immediately put in contact with an HIV (infectious disease) provider. Please see page 4 for further information.

Disclosure Of Test Results:

All information regarding the performance of the test, including the test results, will be treated confidentially. The results of the test will be reported to the insurer identified on this form; the applicant or his or her legal guardian; a physician or health care provider if designated on this form by the applicants; a court of competent jurisdiction pursuant to a lawful court order; any person or entity involved solely in the underwriting process; and any other person or entity expressly named and given separate written authorization by the applicant. Results of the test shall not be otherwise disclosed.

Meaning Of Positive Test Results:

Positive test results may adversely affect your application for insurance. This means that your application may be declined, an increased premium may be charged or other changes may be necessary.

Signature And Written Consent:

I have read and I understand this Notice and Consent Form. I voluntarily consent to having an AIDS test performed and disclosed as described above. I understand that I have the right to request and receive a copy of this form. A certified photocopy of this form may serve and be deemed as valid as the original.

Name of physician		
Address of physician	City	
	State	ZIP code
Name of health care provider		
Address of health care provider	City	
	State	ZIP code

Notice Of Right Of Appeal:

We are required by law to provide you with the following information:

An applicant for insurance who tests positive under this testing protocol certified by the Director of the Department of Health may appeal to the Commissioner of the Department of Insurance, Securities and Banking to review the testing procedures and results, and may present additional medical evidence, including the result of similar tests for exposure to the probable causative agent of AIDS that the named applicant independently obtains. The Commissioner of the Department of Insurance, Securities and Banking can be reached at the following address: 1050 First Street, NE, Suite 801, Washington, D.C. 20002.

Signature of proposed insured or parent/guardian and date signed

Lab code number

This form may be used for Thrivent Life Insurance Company (Minneapolis, MN 55415), a wholly owned subsidiary of Thrivent Financial for Lutherans. If used in this form, "Thrivent" refers to Thrivent Financial for Lutherans and Thrivent Life Insurance Company.

HIV Test For Screening And Diagnosis:

As HIV testing technology progresses and the District of Columbia Department of Health updates its recommendations, the Department of Insurance, Securities and Banking reserves its right to modify its minimum standard for testing protocols. Insurance issuers paying for the administration of the test must comply accordingly with the Department's minimum standards.

There are three types of HIV diagnostic tests: antibody tests, antigen/antibody tests, and nucleic acid (RNA) tests. Antibody tests detect antibodies, proteins that your body makes against HIV, not HIV itself. Antigen tests and RNA tests detect HIV directly.

The current testing protocol required in the District of Columbia is as follows:

Initial Test: Tests for HIV shall be conducted with an FDA-approved antigen/antibody combination (4th generation) immunoassay[1] that detects HIV-1 and HIV-2 antibodies and HIV-1 p24 antigen to screen for established infection with HIV-1 or HIV-2 and for acute HIV-1 infection. No further testing is required for specimens that are nonreactive on the initial immunoassay.

> *Rationale:* Initial testing with a 4th generation antigen/antibody combination immunoassay detects more acute HIV-1 infections than initial testing with a 3rd generation antibody immunoassay and identifies comparable numbers of established HIV-1 and HIV-2 infections, with comparable specificity.

Blood tests can detect HIV infection sooner after exposure than oral fluid tests because the level of antibody in blood is higher than it is in oral fluid. Likewise, antigen/antibody and RNA tests detect infection in blood before antibody tests. Some newer antigen/antibody lab tests can sometimes find HIV as soon as 3 weeks after exposure to the virus. No antigen/antibody or RNA tests are available for oral fluid.

Follow-up Testing: HIV tests are generally very accurate, but follow-up testing allows you and your health care provider to be sure the diagnosis is right. Specimens with a reactive antigen/antibody combination immunoassay result (or repeatedly reactive, if repeat testing is recommended by the manufacturer or required by regulatory authorities) should be tested with an FDA-approved antibody immunoassay that differentiates HIV-1 antibodies from HIV-2 antibodies. Reactive results on the initial antigen/antibody combination immunoassay and the HIV-1/ HIV-2 antibody differentiation immunoassay should be interpreted as positive for HIV-1 antibodies, HIV- 2 antibodies, or HIV-1 and HIV-2 antibodies, undifferentiated.

> *Rationale:* Use of the HIV-1/HIV-2 antibody differentiation assay after a reactive initial 4th generation HIV-1/HIV-2 antibody immunoassay detects HIV-1 antibodies earlier than the HIV-1 Western blot, reduces indeterminate results, and identifies 4 HIV-2 infections. Turnaround time for test results is shorter and the cost is lower for the HIV-1/HIV-2 antibody differentiation assay compared with the HIV-1 Western blot. Available evidence is insufficient to recommend specific additional testing, without clinical follow-up, for specimens that are dually reactive for HIV-1 and HIV-2 antibodies on the differentiation immunoassay.

Proportion Of False Positive Results Expected:

According to the Centers for Disease Control and Prevention clinical data submitted by the manufacturers of Human Immunodeficiency Virus (HIV) antibody tests to the Food and Drug Administration (FDA) for licensure indicate that sensitivity and specificity of tests currently marketed in the United States are greater than 99%.

[1] Exception: As of April 2014, data are insufficient to recommend use of the FDA-approved single-use rapid HIV- 1/HIV-2 antigen/antibody combination immunoassay as the initial assay in the algorithm.

All blood, oral fluid and protocols licensed by the FDA follow the same test algorithm: specimens are tested singly by either a screening enzyme immunoassay or a 4th generation antigen/antibody combination assay, and if found reactive are retested in duplicate. If either duplicate is reactive, the specimen is considered repeatedly reactive and is submitted for further testing using either a FDA approved multi-spot test or an HIV-1/HIV-2 antibody differentiation immunoassay. Specimens found reactive by this second test are reported as positive for HIV antibodies. Although a positive result indicates infection with HIV, a diagnosis of Acquired Immunodeficiency Syndrome (AIDS) can only be made clinically if a person meets the case definition of AIDS established by the Centers for Disease Control and Prevention[1].

Data from multiple studies on 4th generation HIV tests demonstrated an overall sensitivity of 99.9-100%. Thus the achievable false-positive rate of sequentially performed 4th generation tests can be less than 0.1% or less than 1/1,000 persons tested.

Disclosure:

Reference material provided in this notice and consent form is for informational purposes only. Applicants for insurance who have questions should seek guidance from a professional health provider.

HIV Testing Counseling Referrals:

The DC Department of Health (DOH) HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA) has prepared a comprehensive and easy-to-read directory of all DC HIV/AIDS services, most are funded by the District of Columbia Government. The directory contains information ranging from HIV testing locations to medical care, medications and support services, including nutrition services and housing. A special on-line version can be accessed below.

Directory of HIV/AIDS Services in the District of Columbia and Surrounding Areas
(http://haadirectory.doh.dc.gov/)

For a printable list of primary care sites in DC, compiled by the DOH Primary Care Bureau visit them at the link below.

Primary Care Bureau

(http://doh.dc.gov/page/primary-care-bureau)

The DC Primary Care Association (DCPCA) is a non-profit health equity and advocacy organization dedicated to improving the health of DC's vulnerable residents by ensuring access to high quality primary health care, regardless of an ability to pay. They work to ensure that all residents of Washington, DC have the ability and opportunity to lead healthier lives - through increased health care coverage, expanded access, improved quality, workforce development, and enhanced communication. Members of the DCPCA currently includes 15 community health centers and community-based organizations located in the District of Columbia and the Maryland suburbs. Between them, member health centers own and operate nearly 60 health care delivery sites that serve approximately 200,000 residents, most of which offer HIV counseling and testing. A listing of health center locations can be found below.

DCPCA Find a Health Center
(http://www.dcpca.org/find-a-health-center)

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Conditional Temporary Individual Disability Income Insurance Agreement and Receipt for Payment

Read this agreement and receipt carefully.

Make all checks payable to us. Do not make checks payable to the representative. Do not leave the payee blank.

This agreement is void if any check given for payment is not honored.

Name of proposed insured/insured (print title, first, middle, last name and suffix, as applicable)

Amount received	Received from	Source of payment
$		

None of our representatives or other agents acting on our behalf are authorized to change or waive any terms of this agreement or make any promises or representations other than those contained in this agreement.

Signature of representative and date signed

Requirements for Conditional Insurance

If each and every one of the following conditions are met, insurance coverage under this agreement is provided according to the terms and conditions of the contract applied for that are not in conflict with this agreement:

1. All material representations in the application are true and complete.
2. The first full standard premium for the interval selected has been paid.
3. You are an insurable risk for the product and amount of insurance applied for or offered by us if other than applied for. We will determine the insurability of the proposed insured on the later of the following two dates:
   a) the date the application is completed and signed.
   b) the date the declaration of insurability and all exams or tests are completed for the proposed insured in accordance with our published underwriting guidelines.
4. All requirements necessary for underwriting are completed within 60 days from the date of application.
5. This agreement has not terminated.

If one or more of the above conditions is not met, our liability is limited to the premium submitted.

In no event will any insurance ever be in force unless the proposed insured is an acceptable risk under our rules.

Exclusions

Coverage is excluded under this agreement for any disability or loss resulting from any of the following:

1. Operating, descending from or riding in an aircraft being used for private or instructional purposes.
2. Suicide or attempted suicide or intentionally self-inflicted injury.
3. Any disease, disorder, activity or condition that would be excluded by endorsement under our underwriting rules, guidelines, or policies or excluded or limited under provisions of the contract applied for.

Termination of Conditional Insurance

Coverage under this agreement ends on the earliest of the following dates:

1. The date we issue the contract of disability income insurance applied for.
2. The date we refund the premium paid.
3. The date your application is declined or closed as an incomplete application.
4. If we do not issue the coverage as applied for, and we make you a counter-offer, the date our counter-offer is accepted, rejected or expires.

Definitions

application:	all application forms that we require for the product applied for.
date of the application:	the date shown on the application for new business/contract change or on the declaration of insurability, whichever is later.
our, we, us:	Thrivent Financial for Lutherans
you, your:	proposed insured/insured

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Statement of Good Health

Application/Contract number	Date of application

Name of proposed insured/insured (print title, first, middle, last name and suffix, as applicable)

Supplementing the application/contract with Thrivent Financial or its affiliates, I hereby declare that the statements and answers in the application:

- were true and complete when originally made, and
- are true and complete and the same as if made at this time.

Since the date of application, the proposed insured has not:

- Consulted or been advised by a physician, chiropractor, counselor, or other member of the medical profession to consult a physician, chiropractor, counselor, or other member of the medical profession for any reason.
- Been medically treated or evaluated at a hospital, clinic or other facility or been advised by a physician, chiropractor, counselor, or other member of the medical profession to have any medical treatment, test, procedure, surgery, biopsy, hospitalization, nursing home care, or home health care.
- Been advised by a physician, chiropractor, counselor or other member of the medical profession to restrict or avoid normal activities due to illness or injury.
- Other than as specifically stated on the application:
  - Taken any prescription medications
  - Participated in any of the following activities: pilot, copilot, student pilot, or crew member; auto racing, motorcycle racing, powerboat racing, hang gliding, mountain/rock climbing, ballooning, sky diving, skin/scuba diving, or semi-professional/professional sport(s)
  - Used cigarettes, tobacco or other nicotine based products
  - Had any change in occupation
- Had an application for insurance or reinstatement of insurance declined or modified.

Provide details for any exceptions to the above representations.

Details for exceptions and full name and address of any doctors.

The representations above are true to the best of my knowledge. Any false or incomplete statements could result in the loss of coverage. This Statement of Good Health will become part of the insurance contract.

Signature of proposed insured/insured and date signed

Signature of representative and date signed

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Individual Disability Income Insurance Application

Section 1 - Proposed Insured

Name (print first, middle, last name and suffix, as applicable)			Social Security number
Residential address		Mailing address, only if different from residential	
City / State / ZIP code		City / State / ZIP code	
Phone number	Best time to call (CST)	Email address	
Date of birth	Age	Sex ☐ Male ☐ Female	Marital Status
State of birth	Driver license number		State where licensed

☐ Yes ☐ No Are you a citizen of the United States of America (USA)?

☐ Yes ☐ No If no, are you a permanent resident of the USA?
If no, provide detail: _____

Section 2 - Replacement and Other Coverage

☐ Yes ☐ No Is there other disability income or business expense coverage (either with Thrivent or with another company) inforce, pending, or contemplated? **If Yes,** provide details below:

Company name			Contract number	
Elim period	Benefit period	Monthly ben amt $	Type of coverage	Prem payor

☐ Yes ☐ No Does this coverage coordinate with Social Security?

☐ Yes ☐ No Will coverage be discontinued if this Thrivent contract is issued?
If Yes, replacement date -

Company name			Contract number	
Elim period	Benefit period	Monthly ben amt $	Type of coverage	Prem payor

☐ Yes ☐ No Does this coverage coordinate with Social Security?

☐ Yes ☐ No Will coverage be discontinued if this Thrivent contract is issued?
If Yes, replacement date -

Company name			Contract number	
Elim period	Benefit period	Monthly ben amt $	Type of coverage	Prem payor

☐ Yes ☐ No Does this coverage coordinate with Social Security?

☐ Yes ☐ No Will coverage be discontinued if this Thrivent contract is issued?
If Yes, replacement date - _____

Section 3 - Benefit Information

	Elimination Period	Benefit Period	Monthly Benefit Amount
Base Disability Income			$
Social Insurance Offset			$
Supplemental Disability Income			$

Optional Riders: ☐ Residual Disability ☐ Future Purchase Option ☐ Cost of Living Indexing

Section 4 - Premium Payment Information

☐ Total initial premium $ _____

☐ For new business initial payments, I authorize Thrivent to make an **immediate** electronic draw from the bank account listed upon receipt of this form.

☐ No premium with application

Billing Type ☐ Electronic Bank Withdrawal ☐ Direct Billing

Premium billing amount $ _____ Frequency: ☐ Annual ☐ Quarterly ☐ Monthly (not available with direct billing)

Complete bank information for electronic bank draws

Full name of bank	Routing number	Account number	
Name of bank account owner		Draw date	☐ Checking ☐ Savings
Address of bank account owner	City	State	ZIP code
Name of joint bank account owner			
Address, if different than above	City	State	ZIP code

I authorize Thrivent to 1) make electronic deposits, withdrawals, and corrections to my bank account that comply with U.S. law; 2) act on this authorization until I revoke it by contacting Thrivent; 3) apply this authorization to any future bank accounts I may designate; 4) make administrative changes to this authorization which I request such as date and amount changes, or adding or removing contracts for automatic payment; 5) release any and all information related to this authorization to the bank account owner or third party account owner; and 6) act upon electronic deposit, withdrawal, and administrative instructions I provide to my representative.

If this form is received less than 10 days prior to the draw date you entered, your authorization shall take effect on the second occurrence of the mode you have selected. You further acknowledge that if you have selected a deduction to occur on day 29, 30, or 31, Thrivent will make the draw on day 28.

Signature of bank account owner	Date signed
X	

Section 5 - Occupation and Financial Information

1. Name of current employer | Length of current employment Years Months | Average hours worked per week -

City | State | Current occupation | Occ Class

List duties and percent of time spent on each duty.

Duty | Time % | Duty | Time %

Duty | Time % | Duty | Time %

☐ Yes ☐ No Are you enrolled in and presently contributing to Social Security?
If No, explain - _____

☐ Yes ☐ No Is this temporary employment? **If Yes,** explain -

What is your annual earned income from your current employment as reported from your most recent source of earned income? $ _____

Earned income is the total of your annual salary or wages, commissions, bonuses, fees, and income earned for services performed. Do not include income from secondary or part-time employment.

Source of annual earned income information: ☐ YTD pay stub (project annual earned income based on pay stub)
☐ W2 ☐ Tax return ☐ Other -

Are you self-employed? ☐ Yes - Provide details below. ☐ No

How is your current business organized?
☐ Sole proprietor ☐ Partnership ☐ LLC-Limited Liability Company
☐ C-Corporation ☐ S-Corporation ☐ Other - _____
If partnership or S-Corporation, what is your share percentage? _____ %

Number of Employees: Full Time | Part Time

Give income attributable to your labor for the years indicated as reported for federal tax purposes.	Last Year	Prior Year
a. Net income (net profit or net loss) from Schedule C, E or K-1, or F:	$	$
b. Enter 15% of your share of gross income:	$	$

2. If current employment is less than one year, provide details below.

Name of previous employer | Length of previous employment Years Months | Annual earned income $

City | State | Previous occupation

3. If you have secondary or part-time employment, provide details below.

Name of employer | Average hours worked per week - | Annual earned income $

City | State | Secondary or part-time occupation

List duties and percent of time spent on each duty.

Duty | Time % | Duty | Time %

☐ Yes ☐ No Is secondary or part-time income from self-employment?

☐ Yes ☐ No Is secondary or part-time employment temporary? **If Yes,** explain - _____

4. Did you have unearned income (interest, dividends, net rental, alimony/maintenance, royalty income, capital gains, pension, retirement, or disability benefits received) in excess of $15,000 last year? ☐ Yes, $ _____ ☐ No

5. Net worth (assets minus liabilities), if more than $500,000 - $

6. Are you applying based on your monthly mortgage amount? ☐ Yes, provide details below. ☐ No

Minimum required monthly mortgage amount - $	Mortgage lending company	Phone

Does spouse have a disability income insurance contract with Thrivent?

☐ Yes, contract number - _____ ☐ No

Section 6 - Additional Information

Section 7 - Agreements and Signatures

I understand and agree that:

1. I have read (or have had read to me) and verified all statements and answers recorded in the Application. They are, to the best of my knowledge and belief, true, complete and correctly recorded.
2. No representative of Thrivent except the president or secretary can make or alter any contract or waive any of Thrivent's rights or requirements.
3. No representative of Thrivent has the authority to accept risk or determine insurability for Thrivent.
4. The date of the Application is the latest date that the representative, proposed insured, if applicable, sign the Application.
5. If any answers in the Application are incorrect, untrue, or incomplete, Thrivent may have the right to deny benefits, reform the contract, or rescind the contract. I understand that all information must be stated in the Application.

As used herein, "Application" means Application as defined in your contract.

Except as provided in the Conditional Individual Disability Income Insurance Agreement, which is provided if the first premium for the contract applied for is paid, no insurance will take effect unless and until:

a. A contract of insurance is issued and delivered;
b. The first full premium is paid during the lifetime of the person to be covered; and
c. The health of all persons to be insured remains as stated in the Application.

The signature below applies to all sections and statements made in this Application for Individual Disability Income Insurance.

Signed at state _____

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signature of proposed insured	Date signed
X	

I certify that I have asked all questions and recorded all answers as they were given to me and reviewed these with the proposed insured.

Signature of representative	Date signed
X	

Name of representative and ID number

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Declaration of Insurability (Age 16 or Over) Supplement to Application

1. Proposed Insured

Name _____

2. Declaration of Insurability

Height _____ Ft _____ In Weight _____ Lbs Provide weight loss if ≥ 10 Lbs in the past 12 months _____ Lbs

Reason for weight loss if ≥ 10 Lbs _____

1. Do you currently use, or within the past 10 years have you used, tobacco or other nicotine products? ☐ Yes ☐ No

Type of tobacco/nicotine product	Frequency	Quantity	Date last used

Provide details for all 'Yes' answers marked with an (*) in the Additional Details Section.

2. Within the past 10 years have you had, been diagnosed or been medically treated by a member of the medical profession for:

*a. coronary artery disease, chest pain, congestive heart failure, stroke, valve disease, varicose veins, high cholesterol, atrial fibrillation or any other disease or disorder of the heart or circulatory system? ☐ Yes ☐ No

*b. high blood pressure? ☐ Yes ☐ No
***If yes**, provide last blood pressure reading _____/_____ and date _____ ☐ unknown*

*c. clotting disorder, anemia, leukemia, Hodgkin's disease, lymphoma or any other disease or disorder of the blood or immune system excluding Human Immunodeficiency Virus (AIDS virus)? ☐ Yes ☐ No

*d. kidney, bladder, prostate or any other disease or disorder of the urinary system? ☐ Yes ☐ No

*e. any abnormal growth, cyst, tumor, cancer, melanoma or any disease or disorder of the lymphatic system? ☐ Yes ☐ No

*f. diabetes mellitus, elevated blood sugar, thyroid, pituitary, adrenal or any other disease or disorder of the endocrine/hormone system? ☐ Yes ☐ No

*g. chronic bronchitis, COPD, asthma, emphysema, sleep apnea, shortness of breath or any other disease or disorder of the respiratory system? ☐ Yes ☐ No

*h. anxiety, depression, ADHD/ADD, seizures, memory loss, multiple sclerosis, fainting, dizziness, developmental delay, neuropathy, headaches or any other disease or disorder of the nervous system, including psychological and psychiatric care? ☐ Yes ☐ No

*i. ulcers, colitis, cirrhosis, hepatitis, pancreatitis, stomach, intestines, rectum, liver, gallbladder, esophagus or any other disease or disorder of the digestive system? ☐ Yes ☐ No

*j. arthritis, gout, fibromyalgia, back pain, osteoporosis, chronic pain or other disease or disorder of the muscle, skin, bone or joint? ☐ Yes ☐ No

*k. cataracts, glaucoma, meniere's, vertigo, hearing impairment or any other disease or disorder of the eyes, ears, nose or throat? ☐ Yes ☐ No

*l. ovarian cysts, infection of the breast or any other disease disorder of the reproductive system? ☐ Yes ☐ No

Complete the following question when applying for Individual Disability Income Insurance:

*m. pregnancy complications, cesarean section, miscarriage or infertility? ☐ Yes ☐ No

3. Complete your primary health care provider information - **indicate if none.**

Name of primary health care provider _____

City _____ State _____ Phone _____

Date of last visit _____ Reason for last visit _____

Treatment _____

Prescribed Medication(s) _____

4. Within the past 10 years have you been advised by a member of the medical profession to seek medical treatment or counseling, received medical treatment or counseling, joined Alcoholics Anonymous, Narcotics Anonymous or other support organization for the use of alcohol or prescribed or non-prescribed drugs? ☐ Yes ☐ No

***If yes**, provide type of substance used, date last used, treatment, number of times treated and treatment facility*

_____

5. Within the past 10 years have you used or are you currently using amphetamines, barbiturates, cocaine, hallucinogens, heroin, marijuana, narcotics or other habit forming drugs, except as prescribed by a physician or other member of the medical profession? ☐ Yes ☐ No

***If yes**, provide the type of substance, date last used, quantity used, number of times treated and treatment facility*

_____

6. Within the past five years have you made a claim for or received benefits, compensation or pension for any injury, sickness, disability or impaired condition? ☐ Yes ☐ No

***If yes**, provide the reason, date began and ended*

_____

7. Other than reported above, within the past five years have you:

*a. consulted or been advised by a member of the medical profession to consult another member of the medical profession for any reason or been advised to restrict or avoid normal activities due to illness or injury? ☐ Yes ☐ No

*b. been medically treated or evaluated at a hospital, clinic, or other facility or been advised by a member of the medical profession to have any medical treatment, test, procedure, surgery, biopsy, hospitalization, nursing home care, home health care not yet completed (excluding those tests related to the Human Immunodeficiency Virus (AIDS virus))? ☐ Yes ☐ No

c. taken any prescribed medication(s) other than those previously listed? ☐ Yes ☐ No

***If yes**, list below*

If additional space is needed, complete the Supplement to Application Prescribed Medication(s) - Continuation form.

Prescribed medication(s) used	Date last used	Reason for use

*8. Within the past 10 years have you been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus), Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC)? ☐ Yes ☐ No

9. Have your biological parents, brothers, or sisters ever been diagnosed or medically treated by a member of the medical profession for cardiovascular disease (CVD), polycystic kidney disease or Huntington's disease? ☐ Yes ☐ No

Disease or disorder	Relation to proposed insured	Age of onset

10. **Complete the following question when applying for Individual Life Insurance:**

a. Within the past six months have you had a life application declined, postponed, rated, modified or withdrawn? ☐ Yes ☐ No

***If yes**, provide date, application action and reason*

_____

Complete the following question when applying for Individual Disability Income Insurance:

b. Within the past five years have you had a life or health insurance application declined, postponed, rated, modified or withdrawn? ☐ Yes ☐ No

***If yes**, provide date, application action and reason*

_____

11. Within the past five years have you had a driver's license suspended, revoked, plead guilty to, or been convicted of a moving traffic violation? ☐ Yes ☐ No *If additional space is needed, use the Supplement to Application Moving Traffic Violation - Continuation form.*

Type of violation	**MPH over**	**Date**

12. Within the past two years have you traveled outside of the United States or are you planning on traveling outside of the United States within the next two years? ☐ Yes ☐ No

***If yes**, provide country, purpose of travel, length of stay and dates*

_____

13. Within the past two years have you flown other than as a fare paying passenger on a scheduled airline or participated in any hazardous sports or activities, (e.g., piloting, racing, mountain/rock climbing, sky/scuba/skin diving). ☐ Yes ☐ No *If yes, complete the Supplement to Application Aviation, Racing and Avocation Questionnaire form.*

3. Additional Details - Provide details for 'Yes' answers marked with an (*)

Question: Number/Letter _____

Type of Disease, disorder, injury, test, care _____

Date of diagnosis _____ Number of occurrences _____

Date of last visit _____ Date of last occurrence _____

Treatment _____ Ongoing symptoms _____

Prescribed medication(s) currently taking _____

Name of care provider/facility _____

City _____ State _____ Phone _____

Question: Number/Letter ______

Type of Disease, disorder, injury, test, care ______

Date of diagnosis ______ Number of occurrences ______

Date of last visit ______ Date of last occurrence ______

Treatment ______ Ongoing symptoms ______

Prescribed medication(s) currently taking ______

Name of care provider/facility ______

City ______ State ______ Phone ______

Question: Number/Letter ______

Type of Disease, disorder, injury, test, care ______

Date of diagnosis ______ Number of occurrences ______

Date of last visit ______ Date of last occurrence ______

Treatment ______ Ongoing symptoms ______

Prescribed medication(s) currently taking ______

Name of care provider/facility ______

City ______ State ______ Phone ______

Question: Number/Letter ______

Type of Disease, disorder, injury, test, care ______

Date of diagnosis ______ Number of occurrences ______

Date of last visit ______ Date of last occurrence ______

Treatment ______ Ongoing symptoms ______

Prescribed medication(s) currently taking ______

Name of care provider/facility ______

City ______ State ______ Phone ______

4. Additional Underwriting Information

5. Agreements and Signatures

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

I have read (or have had read to me) the statements and answers recorded on this Declaration of Insurability. To the best of my knowledge and belief, they are true, complete and correctly recorded and shall be a basis of any contract issued or for which a change has been requested. My signature applies to all sections and statements on this Declaration of Insurability.

Signed in the state of _____

Signature of proposed insured _____

Date signed _____

Signature of representative _____

Date signed _____

Print name _____ ID number _____

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Supplement to Application for Insurance

Medical Details - Continuation

Proposed Insured

Name ______________________________

Details for all 'Yes' answers marked with a (*)

Question: Number/Letter ____________

Type of Disease, disorder, injury, test, care ______________________________

Date of diagnosis ____________________ Number of occurrences ____________

Date of last visit ____________________ Date of last occurrence ____________

Treatment ____________________ Ongoing symptoms ____________

Prescribed medication(s) currently taking ______________________________

Name of care provider/facility ______________________________

City ____________________ State ______ Phone ____________

Question: Number/Letter ____________

Type of Disease, disorder, injury, test, care ______________________________

Date of diagnosis ____________________ Number of occurrences ____________

Date of last visit ____________________ Date of last occurrence ____________

Treatment ____________________ Ongoing symptoms ____________

Prescribed medication(s) currently taking ______________________________

Name of care provider/facility ______________________________

City ____________________ State ______ Phone ____________

Question: Number/Letter ____________

Type of Disease, disorder, injury, test, care ______________________________

Date of diagnosis ____________________ Number of occurrences ____________

Date of last visit ____________________ Date of last occurrence ____________

Treatment ____________________ Ongoing symptoms ____________

Prescribed medication(s) currently taking ______________________________

Name of care provider/facility ______________________________

City ____________________ State ______ Phone ____________

Question: Number/Letter ______________

Type of Disease, disorder, injury, test, care ______________

Date of diagnosis ______________ Number of occurrences ______________

Date of last visit ______________ Date of last occurrence ______________

Treatment ______________ Ongoing symptoms ______________

Prescribed medication(s) currently taking ______________

Name of care provider/facility ______________

City ______________ State ______ Phone ______________

Question: Number/Letter ______________

Type of Disease, disorder, injury, test, care ______________

Date of diagnosis ______________ Number of occurrences ______________

Date of last visit ______________ Date of last occurrence ______________

Treatment ______________ Ongoing symptoms ______________

Prescribed medication(s) currently taking ______________

Name of care provider/facility ______________

City ______________ State ______ Phone ______________

Question: Number/Letter ______________

Type of Disease, disorder, injury, test, care ______________

Date of diagnosis ______________ Number of occurrences ______________

Date of last visit ______________ Date of last occurrence ______________

Treatment ______________ Ongoing symptoms ______________

Prescribed medication(s) currently taking ______________

Name of care provider/facility ______________

City ______________ State ______ Phone ______________

Agreements and Signatures

I have read (or have had read to me) the statements and answers recorded on this Supplement to Application for Insurance. To the best of my knowledge and belief, they are true, complete and correctly recorded and shall be a basis of any contract issued or for which a change has been requested. My signature applies to all sections and statements on this Supplement to Application for Insurance.

Signed in the state of ________

Signature of proposed insured ______________

Date signed ______________

Signature of representative ______________

Date signed ______________

Print name ______________ ID number ______________

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Supplement to Application for Insurance

Moving Traffic Violations - Continuation

Proposed Insured

Name _____

Type of violation	MPH over	Date

Agreements and Signatures

I have read (or have had read to me) the statements and answers recorded on this Supplement to Application for Insurance. To the best of my knowledge and belief, they are true, complete and correctly recorded and shall be a basis of any contract issued or for which a change has been requested. My signature applies to all sections and statements on this Supplement to Application for Insurance.

Signed in the state of _____

Signature of proposed insured _____

Date signed _____

Signature of representative _____

Date signed _____

Print name _____ ID number _____

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Thrivent Financial for Lutherans
4321 N. Ballard Road, Appleton, WI 54919-0001
Thrivent.com • 800-847-4836

Supplement to Application for Insurance

Prescribed Medication(s) - Continuation

Proposed Insured

Name _____

Prescribed medication(s) used	Date last used	Reason for use

Agreements and Signatures

I have read (or have had read to me) the statements and answers recorded on this Supplement to Application for Insurance. To the best of my knowledge and belief, they are true, complete and correctly recorded and shall be a basis of any contract issued or for which a change has been requested. My signature applies to all sections and statements on this Supplement to Application for Insurance.

Signed in the state of _____

Signature of proposed insured _____

Date signed _____

Signature of representative _____

Date signed _____

Print name _____ ID number _____

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Supplement to Application for Insurance

Aviation, Racing and Avocation Questionnaire

Proposed Insured

Name _____

Provide details for 'Yes' answer to question 13 on the Declaration of Insurability. Complete all that apply.

Pilot, copilot, student pilot, crew member or other aviation activity

Type of flying _____ Type of aircraft _____

Pilot certificate/license currently held _____
required if pilot, not required for crew member

Hours flown in the past 12 months _____ Hours estimated in the next 12 months _____

Have you had your license revoked or been grounded? ☐ Yes ☐ No

Do you fly for pay? ☐ Yes ☐ No

Do you fly in this capacity outside of the United States? ☐ Yes ☐ No

***If yes**, provide destinations.*

_____

Racing of any kind

Type of racing _____ Type of vehicle _____
make, model, year, engine displacement, estimated horsepower

Type of surface _____

Purpose of activity _____

Location of activity _____

Club or organization? ☐ Yes ☐ No

***If yes**, provide name of club or organization.*

_____

Number of times participated in the past 12 months? _____

Number of times estimated in the next 12 months? _____

Sky/scuba/skin diving, mountain/rock climbing, hang gliding or other avocation

Type of activity _____

Typical height/depth _____

Maximum height/depth _____

Location of activity _____

Number of times participated in the past 12 months? _____

Number of times estimated in the next 12 months? _____

Certification? ☐ Yes ☐ No

***If yes**, provide type of certification.*

_____

Agreements and Signatures

I have read (or have had read to me) the statements and answers recorded on this Supplement to Application for Insurance. To the best of my knowledge and belief, they are true, complete and correctly recorded and shall be a basis of any contract issued or for which a change has been requested. My signature applies to all sections and statements on this Supplement to Application for Insurance.

Signed in the state of _____

Signature of proposed insured _____

Date signed _____

Signature of representative _____

Date signed _____

Print name _____ ID number _____

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Thrivent ID

Third Party Notification for Nonpayment of Premium

Name of insured (print title, first, middle, last name and suffix, as applicable)	Contract number

I understand, as Owner, I am able to designate at least one person other than myself to receive notice for nonpayment of premium and, if required by the state where this contract was issued, that person will also receive notice of termination.

Unless otherwise indicated below, this request will replace any third party designee currently on file.

☐ I elect **not** to designate any person to receive such notice.

I request the following action on the person listed below:

☐ **Add designee** (*Will not remove existing designees)*

☐ **Update to existing designee** (*Use when updating a Name, Phone, and/or Address)*

☐ **Replace existing designee** (*Person listed will replace and remove all existing designees)*

☐ **Remove individual existing designee** (*List individuals information below, only this person will be removed)*

☐ **Remove all existing designees** (*Leave below contact section blank)*

Name of third party designee (print title, first, middle, last name and suffix, as applicable)	Phone

Address	City	
	State	ZIP code

Note: If you would like to designate more than one person to receive such notice(s), you will need to complete an additional form for each designee.

Signature (required for all requests) - Please sign below

Signature of owner and date signed (mm/dd/yyyy)

Send completed form to:
Thrivent
4321 N Ballard Road
Appleton WI 54919-0001

Or fax to: 800-225-2264

thrivent

Thrivent Financial for Lutherans
4321 N. Ballard Road, Appleton, WI 54919-0001
Thrivent.com • 800-847-4836

Supplement to Representative's Information

Care Provider Addresses

Name of proposed insured (print title, first, middle, last name and suffix, as applicable)

Primary Care Provider Address

Question: No / Ltr	Name			
	Address	City		
		State	ZIP Code	Phone number

Care Provider Addresses

Question: No / Ltr	Name			
	Address	City		
		State	ZIP Code	Phone number
Question: No / Ltr	Name			
	Address	City		
		State	ZIP Code	Phone number
Question: No / Ltr	Name			
	Address	City		
		State	ZIP Code	Phone number
Question: No / Ltr	Name			
	Address	City		
		State	ZIP Code	Phone number
Question: No / Ltr	Name			
	Address	City		
		State	ZIP Code	Phone number

Question: No / Ltr	Name			
	Address	City		
		State	ZIP Code	Phone number
Question: No / Ltr	Name			
	Address	City		
		State	ZIP Code	Phone number
Question: No / Ltr	Name			
	Address	City		
		State	ZIP Code	Phone number
Question: No / Ltr	Name			
	Address	City		
		State	ZIP Code	Phone number
Question: No / Ltr	Name			
	Address	City		
		State	ZIP Code	Phone number
Question: No / Ltr	Name			
	Address	City		
		State	ZIP Code	Phone number

Signature of representative and date signed

X ______________________________

Notice to Applicant Regarding Replacement of Accident and Sickness Insurance

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Thrivent Financial for Lutherans. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/ health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

The above “Notice to Applicant” was delivered to me on:

_____

Signature of applicant and date signed (mm/dd/yyyy)

_____

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Payment Services Request

Thrivent ID	Contract number

Section 1 - General Information

Name of insured/annuitant (print first, middle, last name and suffix, as applicable)

Section 2 - Initial and Subsequent Payment Information

Source of Payment	Initial Payment	Subsequent Payment
Financial Institution:		
Automatic deduction from checking - Complete form 6568.	$	$
Automatic deduction from savings - Complete form 6568.	$	$
Deduct from existing account - _____	$	$
Expected withdrawal date*		
*The initial premium will be withdrawn 1 to 3 business days after application is signed and submitted with the exception of Medicare Supplement.		
Annuity:		
Partial withdrawal - Complete form 10438C for initial and subsequent withdrawals. Complete form 10438 if only for an initial withdrawal.	$	$
Full withdrawal - Complete form 10438.	$	
Non-Qualified Transfer:		
Non-qualified transfer of assets - Complete form 10136.	$	
Life:		
Partial withdrawal - Complete form 11090.	$	
Full withdrawal - Complete form 11090.	$	
Loan - Complete form 11090.	$	
Dividend/Surplus release - Complete form 11090.	$	
Mutual Fund:		
One-time redemption - Complete Mutual Fund redemption form.	$	
Continuous redemption - Complete form 9368C.	$	$
Settlement Option/Immediate Annuity:		
Partial withdrawal - Complete form 10438.	$	
Full withdrawal - Complete form 10438.	$	
Continuous Payout - Complete form 9368C.	$	$

Rollover/Transfer/Conversion (Annuity only):

Internal - Complete form 24965 for 403(b). Complete form 27058 for Inherited Traditional/Roth IRA. Complete form 11502 for all other retirement plans.	$	
External - Complete form 24965 for 403(b). Complete form 27058 for Inherited Traditional/Roth IRA. Complete form 11502 for all other retirement plans.	$	

1035 Exchanges:

External 1035 exchange - Complete form 8906.	$	
Internal 1035 exchange - Complete form 8906.	$	

Other:

Military Allotment - Complete Section 5 of this form.		$
Check/Money Order - Complete Section 3 of this form, for subsequent payments, if applicable.	$	$
Other - _____	$	$
_____	$	$
☐ No initial payment		
☐ No subsequent bill		

Section 3 - Billing Frequency/Indexing

Choose billing frequency: ☐ Quarterly ☐ Semiannual ☐ Annual ☐ No bill ☐ Monthly (subject to availability)

Bill date - _____ Change billing amount - $ _____

Billed Premium Indexing option added, reduced, changed to: ☐ Fixed _____ % ☐ CPI _____ % ☐ Cancel

Section 4 - Payer Information

☐ Send this contract's bill with other Thrivent contract bills. *Subject to availability.*

☐ Send the bill for this contract to someone or entity other than the owner.

☐ Send the bill for this contract to my employer.

I authorize Thrivent Financial for Lutherans to send my bill to the person or entity named below. I understand that my billing information may be combined with other individuals that are also being billed to this person or entity.

List name, address and account number of person or entity to receive billing notice below.

Name (print first, middle, last name and suffix, as applicable)

Group account number	Phone	Business phone

Address	City	
	State	ZIP code

Section 5 - Military Allotment

Add to existing military allotment? ☐ Yes ☐ No

Name of payor on account (print first, middle, last name and suffix, as applicable)

Payor's Social Security number	Branch of service	Military status

Section 6 - Loan Billing Changes

Add or change the loan billing amount - $ _____

Add or change the loan billing cycle:

- ☐ Monthly (Minimum - $25)
- ☐ Quarterly
- ☐ Semiannual
- ☐ Annual
- ☐ With premium billing
- ☐ Do not send loan billing

Section 7 - Special Requests

Section 8 - Signatures

Signature of proposed insured (age 16 or over) parent or guardian (if proposed insured is age 0-15) and date signed

X _____

Signature of other proposed insured and date signed

X _____

Signature of applicant controller and date signed

X _____

Signature of owner and date signed

X _____

Signature of owner and date signed

X _____

Signature of owner and date signed

X _____

Signature of owner and date signed

X _____

Signature of owner and date signed

X _____

Mail completed form to:
Thrivent
PO Box 8075
Appleton, WI 54912-8075

Fax:
800-225-2264

Form **W-9**

(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions)

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

or

Employer identification number

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	**Signature of U.S. person**	**Date**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and

4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting,* later, for further information.

Note: If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States.

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items.

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 24% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the instructions for Part II for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code,* later, and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships,* earlier.

What is FATCA Reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code,* later, and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account (other than an account maintained by a foreign financial institution (FFI)), list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9. If you are providing Form W-9 to an FFI to document a joint account, each holder of the account that is a U.S. person must provide a Form W-9.

a. **Individual**. Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note: ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C corporation, or S corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box on line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box on line 3.

IF the entity/person on line 1 is a(n) . . .	**THEN check the box for . . .**
• Corporation	Corporation
• Individual • Sole proprietorship, or • Single-member limited liability company (LLC) owned by an individual and disregarded for U.S. federal tax purposes.	Individual/sole proprietor or single-member LLC
• LLC treated as a partnership for U.S. federal tax purposes, • LLC that has filed Form 8832 or 2553 to be taxed as a corporation, or • LLC that is disregarded as an entity separate from its owner but the owner is another LLC that is not disregarded for U.S. federal tax purposes.	Limited liability company and enter the appropriate tax classification. (P= Partnership; C= C corporation; or S= S corporation)
• Partnership	Partnership
• Trust/estate	Trust/estate

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space on line 4 any code(s) that may apply to you.

Exempt payee code.

• Generally, individuals (including sole proprietors) are not exempt from backup withholding.

• Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.

• Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.

• Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

1--An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)

2--The United States or any of its agencies or instrumentalities

3--A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

4--A foreign government or any of its political subdivisions, agencies, or instrumentalities

5--A corporation

6--A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession

7--A futures commission merchant registered with the Commodity Futures Trading Commission

8--A real estate investment trust

9--An entity registered at all times during the tax year under the Investment Company Act of 1940

10--A common trust fund operated by a bank under section 584(a)

11--A financial institution

12--A middleman known in the investment community as a nominee or custodian

13--A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 5[2]
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

A--An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B--The United States or any of its agencies or instrumentalities

C--A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D--A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E--A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F--A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G--A real estate investment trust

H--A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I--A common trust fund as defined in section 584(a)

J--A bank as defined in section 581

K--A broker

L--A trust exempt from tax under section 664 or described in section 4947(a)(1)

M--A tax exempt trust under a section 403(b) plan or section 457(g) plan

Note: You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns. If this address differs from the one the requester already has on file, write NEW at the top. If a new address is provided, there is still a chance the old address will be used until the payor changes your address in their records.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN.

If you are a single-member LLC that is disregarded as an entity separate from its owner, enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note: See *What Name and Number To Give the Requester,* later, for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at *www.SSA.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/Businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. Go to *www.irs.gov/Forms* to view, download, or print Form W-7 and/or Form SS-4. Or, you can go to *www.irs.gov/OrderForms* to place an order and have Form W-7 and/or SS-4 mailed to you within 10 business days.

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, 4, or 5 below indicates otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code,* earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), ABLE accounts (under section 529A), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account) other than an account maintained by an FFI	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Two or more U.S. persons (joint account maintained by an FFI)	Each holder of the account
4. Custodial account of a minor (Uniform Gift to Minors Act)	The minor [2]
5. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
6. Sole proprietorship or disregarded entity owned by an individual	The owner [3]
7. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
8. Disregarded entity not owned by an individual	The owner
9. A valid trust, estate, or pension trust	Legal entity [4]
10. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
11. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
12. Partnership or multi-member LLC	The partnership
13. A broker or registered nominee	The broker or nominee
14. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
15. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships,* earlier.

***Note:** The grantor also must provide a Form W-9 to trustee of trust.

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records From Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Pub. 5027, Identity Theft Information for Taxpayers.

Victims of identity theft who are experiencing economic harm or a systemic problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov*. You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at *spam@uce.gov* or report them at *www.ftc.gov/complaint.* You can contact the FTC at *www.ftc.gov/idtheft* or 877-IDTHEFT (877-438-4338). If you have been the victim of identity theft, see *www.IdentityTheft.gov* and Pub. 5027.

Visit *www.irs.gov/IdentityTheft* to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

thrivent

thrivent.com • 800-847-4836

Life Surrender Request

1. Insured Information

Thrivent ID _____ Contract number _____ Email _____

Name _____

2. Surrender Type

a. Value Distribution

☐ Full Surrender *(this will close the contract and terminate coverage)*

☐ Partial Surrender *(Universal Life/Variable Universal Life only)* $ _____

b. Loan

☐ Loan $ _____

c. Dividend Surrender/Change *(Traditional Life only)*

☐ Dividend/Surplus Refund Release $ _____

☐ Dividend/Surplus Refund Option Change

3. Delivery of Payment

☐ Check

☐ Direct Deposit

Complete bank information for direct deposit

Full name of bank account owner(s) _____

Full name of bank _____

Account type ☐ Checking ☐ Savings

Routing number _____ Account number _____

☐ Apply to another Thrivent contract/account.

Contract number	Premium amount	Loan repayment
_____	$ _____	$ _____
_____	$ _____	$ _____

4. Withholding and Charges

Surrender Charges and Tax Withholding Amount

Any surrender/decrease charges or tax withholding should be selected below.

☐ Add to amount requested. *Your distribution will be for the amount requested. Your account balance will be reduced by this amount plus, any applicable surrender charges, federal/state tax withholding.*

☐ Subtract from amount requested. *Your distribution will be for the amount requested less any applicable surrender charges, federal/state tax withholding. Your account balance will be reduced by the amount requested.*

Unless otherwise indicated on this form, any surrender charges and/or withholding will be added to the distribution amount requested.

Federal and State Withholding Election

Under current federal income tax law, we are required to withhold 10% of the taxable portion of the cash surrender value and pay it to the IRS unless you tell us in writing not to withhold the tax. Some states also require us to withhold state income tax if we withhold federal tax.

If you do not want to withhold or would like a percentage other than the required withholding percentage, indicate below.

☐ Do not withhold federal income tax ☐ Other federal withholding _____%

☐ Do not withhold state income tax ☐ Other state withholding _____%

*Complete **only** if you selected **'Loan'** in section 2, b.*

5. Loan Repayment Information

Loan Repayment Amount $ _____ Payment frequency ☐ Monthly ☐ Quarterly ☐ Semiannually ☐ Annually

Complete bank information for monthly electronic withdrawal

Full name of bank _____

Account type ☐ Checking ☐ Savings Routing number _____ Account number _____

Name of account owner _____ Withdrawal date _____

Address of account owner _____

City _____ State _____ ZIP code _____

Name of joint account owner _____

Address of joint account owner _____

City _____ State _____ ZIP code _____

For new business initial payments, I authorize Thrivent to make an **immediate** electronic withdrawal from the bank account listed upon receipt of this form.

I authorize Thrivent to 1) make electronic deposits, withdrawals, and corrections to my bank account that comply with U.S. law; 2) act on this authorization until I revoke it by contacting Thrivent; 3) apply this authorization to any future bank accounts I may designate; 4) make administrative changes to this authorization which I request such as date and amount changes, or adding or removing contracts for automatic payment; 5) release any and all information related to this authorization to the bank account owner or third party account owner; and 6) act upon electronic deposit, withdrawal, and administrative instructions I provide to my representative.

If this form is received less than 10 days prior to the withdrawal date you entered, your authorization shall take effect on the second occurrence of the mode you have selected. You further acknowledge that if you have selected a deduction to occur on day 29, 30, or 31, Thrivent will make the withdrawal on day 28.

Signature of bank account owner _____

Date signed _____

Signature of joint bank account owner _____

Date signed _____

*Complete **only** if you selected a divided option change in section 2, c.*

6. Dividend/Surplus Refund Option Change

Dividend/surplus refunds have the potential for creating a tax liability for the owner. Tax withholding may apply. Complete the tax withholding information in section 4 and complete a W9 form.

Select one:

- ☐ **Paid in Cash** - A check is mailed to the contract owner/controller when the dividends/surplus refund is earned.
- ☐ **Accumulate at Interest** - Dividends/surplus refund is left to accumulate at interest which is paid annually at the rate established by the Board of Directors.
- ☐ **Paid-up Additions** - Dividend/surplus refund purchases paid-up additional insurance (or retirement annuity) which is in addition to the benefit provided by the basic contract.
- ☐ **Reduce Premium/Excess to Paid-up Additions** - Dividend/surplus refund is used to pay premiums due and any excess is used to purchase paid-up additional insurance.
- ☐ **Reduce Premium/Excess in Cash** - Dividends/surplus refund is used to pay premiums due and any excess is sent by check.
- ☐ **Reduce Premium/Excess to Reduce Loan** - Dividend/surplus refund is used to pay premiums due and any excess is used to reduce the existing loan, if any.
- ☐ **Reduce Premium/Excess to Paid-up Additions/Surrender Paid-up Additions** - Dividend/surplus refund is used to pay premiums due, any excess is used to purchase paid-up additional insurance or any remaining premium due is paid by surrendering paid-up additional insurance.

☐ **Reduce Loan/Excess to Cash** - Dividend/surplus refund is used to reduce the existing loan and any excess is sent by check.

☐ **Reduce Loan/Excess to Paid-up Additions** - Dividend/surplus refund is used to reduce the existing loan and any excess is used to purchase paid-up additional insurance.

The following two options are available only on Presidential Plus, Partner Presidential Plus, Survivor Presidential Plus, Survivor Whole Life and Whole Life Plus plans.

☐ **Adjustable Yearly Term - Reduce Premiums and Surrender Paid-Up Additions** - This option is available only when changing the option from Adjustable Yearly Term. Dividends are used to pay premiums due in addition to Dividend Term or One Year Term Insurance. Any excess dividend is used to purchase paid-up additional insurance.

☐ **Adjustable Yearly Term** - This option is available only when changing the option from Adjustable Yearly Term - Reduce Premiums and Surrender Paid-up Additions. Dividends purchase a combination of Dividend Term or One Year Term Insurance and paid-up additional insurance to maintain the insurance target amount.

7. Additional Information

8. Validation **(see validation requirements in disclosure section)**

Medallion Signature Guarantee Seal or Notary Seal

9. Agreements and Signatures

I authorize Thrivent to process the requested distribution and I certify: 1) I have received, read, and agree to the Disclosures (pages 4-5 of this form) and any other disclosures contained in this form; 2) I understand this transaction may be taxable and subject to surrender charges; 3) I understand I have the opportunity to request a quote of the taxable gain and surrender charges prior to requesting this transaction; and 4) I understand this transaction, including any distribution of taxable gain or assessment of surrender charges, cannot be reversed.

If you are signing in any capacity other than the owner/controller/assignee, a title (power-of-attorney, conservator, guardian, trustee, authorized person, etc.) must be provided.

Signature of owner/controller/assignee _____

Date signed _____

Title _____

Signature of joint owner/controller/assignee _____

Date signed _____

Title _____

Send completed form to:

Thrivent
PO Box 8075
Appleton WI 54912-8075

Fax: 800-225-2264

Disclosures

Surrender Type

Taxable Amount - The distribution may result in reporting taxable amount as ordinary income.

Penalty Tax - If this contract is a Modified Endowment Contract, an IRS penalty tax may apply to the taxable portion of my distribution if I am under age 59 1/2.

Surrender/decease charges may apply.

Any distribution request or dividend/surplus refund option change processed will invalidate any previous sales illustrations. Contact your representative for an illustration that shows the effects of this request on your death benefit and cash value.

If the distribution amount requested is more than the amount available and an internal product to product transfer is not involved, the distribution will be processed for the maximum amount available without terminating the contract. Does not apply to complete surrenders/entire values.

I understand that any taxable gain resulting from this distribution cannot be reversed once the distribution is processed. Such taxable gain will be subject to federal and state income tax withholding unless the Notification for Federal and State Income Tax Withholding is completed. I also understand the distribution I am requesting cannot be reversed once it is processed.

Loan Requests

I understand that:

- The contract is security for any contract loan.
- A contract loan bears interest from the date of disbursement at the rate provided for in said contract, or at the rate of 6 percent if no rate is provided. Interest is payable annually and if not paid will be added to the loan and bear interest at the same rate. If the interest rate is adjustable, contact the Thrivent Customer Interaction Center at 800-847-4836 to obtain the current rate being charged.
- Refer to your prospectus for information on how Variable Universal Life loans affect the subaccounts or fixed account, if available.
- A loan may result in the termination of the Death Benefit Guarantee, Lapse Protection Balance or No Lapse Guarantee, as applicable.

Full Surrender

I understand that:

- All insurance coverage provided by this contract and the rights of the beneficiaries under this contract cease.

Partial Surrender

I understand that:

- The partial surrender will reduce the cash value of the contract so there may be insufficient amounts to pay the monthly deductions and increased risk of lapse of the coverage.
- It may become necessary that additional premiums be paid in order to provide adequate cash value for future monthly deductions.
- The partial surrender may result in the reduction of the specified face amount by the amount of cash value withdrawn which could reduce the payable death benefit.
- As a result of the partial surrender, in addition to the risk of current tax liabilities, there is also an increased risk of future tax liabilities associated with the contract.
- Minimum surrender amounts may apply.
- A partial surrender may result in the termination of the Death Benefit Guarantee, Lapse Protection Balance or No Lapse Guarantee, as applicable.

Delivery of Payment

Direct Deposit - I authorize Thrivent 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 corrects 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.

Checks - For contracts with multiple owners, disbursement checks may be made payable to only the primary owner. If only the primary owner's name appears as the payee on a disbursement check from a contract with multiple owners, it is the responsibility of the primary owner to obtain signatures of the other owners prior to cashing the check. If the disbursement results in taxable income, the tax information will be reported to all owners.

For internal product-to-product transfers only - Unless otherwise indicated herein, I intend the requested transfer(s) from the distributing contract(s) to become effective only if and when:

- Thrivent (including its subsidiaries and affiliates) has approved the first application of the amount(s) requested to the receiving contract(s), as described above, or, if not, as I subsequently agree to accept; and
- with respect to any receiving contract(s) that I have applied for, as described above, Thrivent (including its subsidiaries and affiliates) has approved the issuance of the receiving contract(s), as applied for or, if not, as I subsequently agree to accept.

Withholding and Charges

You are liable for federal and state income tax, where applicable, on the taxable portion of your distribution even if you elect no withholding. Except where prohibited by federal and/or state law, you can elect: 1) no withholding; 2) withholding at the minimum federal and state rates; or 3) withholding at a rate higher than the minimum rates. You may be subject to tax penalties under the estimated tax payment rules if your payments of estimated tax and withholding, if any, are not adequate. Check with your tax advisor to determine if withholding is necessary.

Residents of Connecticut - submit the Form CT-W4P to indicate your withholding election with this form. If you do not submit Form CT-W4P with this form, Thrivent will use your most recently-submitted CT-W4P, if one is on file. If you do not submit Form CT-W4P with this form and you have not previously submitted Form CT-W4P, the maximum rate will be withheld.

Dividend/Surplus Refund Option Change

This option will be effective on the next contract anniversary date. Refer to your contract for information about the availability of options. Dividend/surplus refunds are not guaranteed.

If you select Reduce Loan and your contract does not allow for this dividend option, then you are authorizing Thrivent to set your dividend option to Cash and to apply that cash dividend as a loan repayment to this contract.

Validation

For your protection, validation of your identity is requested for certain variable and non-variable contract transactions. Surrender/disbursement transactions:

a. Greater than $499,999 will require a Medallion Signature Guarantee for variable contract transactions and a Notary Public for non-variable contract transactions.

b. Greater than $99,999 and up to $499,999 will require one of the following forms of validation:
   · Attestation by a Thrivent representative
   · A Notary Public
   · A Medallion Signature Guarantee (not available for fixed contracts)

c. Greater than $10,000, less than $99,999, and the address of record changed within the prior 15 days will require a Notary Public or attestation by a Thrivent representative.

d. Greater than $10,000, less than $99,999, and the bank information provided has been on record for less than 15 days will require a voided check from the bank account, a Notary Public, or attestation by a Thrivent representative.

e. Requesting special distribution instructions will also require one of the three forms of validation listed in (b) above. Examples include: Request to send proceeds to an address other than the one listed on your contract and/or request to make proceeds payable to someone other than the current owner.
   A Notary Public or Medallion Signature Guarantee may generally be obtained at any national bank.

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Thrivent Financial for Lutherans
4321 N. Ballard Road, Appleton, WI 54919-0001
thrivent.com • 800-847-4836

Automatic Payment Authorization

1. Bank Account Owner Information

Thrivent ID _____ Email _____

2. Type of Request

☐ Establish a new automatic payment (complete entire form)
☐ Update bank on an existing automatic payment authorization (complete entire form)
☐ Existing/Old bank account is closed ☐ Existing/Old bank account is open
☐ Change, Cancel or Add contracts/agreements to my existing Automatic Payment Plan (complete section 4 only)

3. Bank Information

Name of account owner _____
Address of account owner _____
City _____ State _____ ZIP code _____
Account type ☐ Checking ☐ Savings ☐ Business
Full name of bank _____
Routing number _____ Account number _____
Name of joint account owner _____ Thrivent ID _____
Address of joint account owner _____
City _____ State _____ ZIP code _____

4. Policy/Contract/Agreement Payment Information

Change	Cancel	Add	Name of Insured/ Annuitant/Owner	Contract/Agreement Number	Draw Date	Frequency	Payment Amount	Loan Amount*
☐	☐	☐						
☐	☐	☐						
☐	☐	☐						
☐	☐	☐						
☐	☐	☐						

*Not applicable for all products and services

5. Agreements and Signatures

I authorize Thrivent to 1) make an **immediate** electronic withdrawal from the bank account listed upon receipt of this form for new business initial payments and policy reinstatements (not applicable for Medicare Supplement products); 2) to withdraw my payment from my bank account in accordance with section 4 of this form; 3) make electronic deposits, withdrawals, and corrections to my bank account that comply with U.S. law; 4) act on this authorization until I revoke it by contacting Thrivent or Thrivent Investment Management Inc., as applicable; 5) apply this authorization to any future bank accounts I may designate; 6) make administrative changes to this authorization which I request such as date and amount changes, or adding or removing contracts for automatic payment; 7) release any and all information related to this authorization to the bank account owner(s); 8) act upon electronic deposit, withdrawal, and administrative instructions I provide to my financial professional; 9) begin drawing on the next occurrence of the day of the month I have indicated above, except when this form is received less than 10 days prior to that date. If that is the case, my authorization may take effect in the following month; 10) make the draw on the 28th if I have selected my automatic payment to occur on day 29, 30, or 31, and if no date is selected it will be my monthaversary; and 11) use only the date indicated by me or my financial professional for future transactions I may request.

I certify I have received, read, and agree to the Disclosures (page 2 of this form) and any other disclosures contained in this form.

Signature of bank account owner _____

Date signed _____

Signature of joint bank account owner _____

Date signed _____

Disclosures

Universal Life, Variable Universal Life, or Annuity Product Authorization

I understand my draw will be established monthly in an amount proportional to my payment mode (e.g., 1/3 of my quarterly billed premium, 1/12 of my annually billed premium), unless requested otherwise on page 1 of this form.

Variable Annuity Product Disclosure

I understand if I establish monthly electronic deposits on a variable annuity contract, the confirmation of these payments will be on my quarterly statement in place of immediate confirmation.

Term Life, Whole Life, Disability Income, Medicare Supplement, or Long-Term Care Product Authorization

I understand my draw will be established monthly unless requested otherwise on page 1 of this form.
I authorize Thrivent to draw at the monthly premium rate which will be higher than 1/12 of my annual premium.
I understand that I can receive a quote of the exact monthly billing amount by contacting Thrivent.

Financial Planning Services Fee

Refer to your Financial Planning Services Agreement Schedule with Thrivent Investment Management Inc. for the Financial Planning Fee, payment amount, withdrawal frequency, and withdrawal date, which could occur immediately upon receipt of this form.

Program Fees for AdvisorFlex Managed Variable Annuity Program

Refer to your AdvisorFlex Managed Variable Annuity Client Agreement with Thrivent Investment Management Inc. for specifics about your Program Fee including your Program Fee amount and frequency.
Because the exact amount and date of your Program Fee fluctuates, Thrivent will notify you in advance of withdrawing every Program Fee payment from your bank account. Thrivent will provide that notice at least 10 days prior to withdrawing your payment. You must notify Thrivent before the draw date indicated on that notice if you want to cancel the draw. If you do not notify Thrivent by that date, Thrivent will deem you to agree to the date and amount of the withdrawal.

Mail completed form to:
Thrivent
PO Box 8075
Appleton, WI 54912-8075

Fax:
800-225-2264

thrivent

eDelivery Consent Disclosures

Thrivent Financial for Lutherans
4321 N. Ballard Road, Appleton, WI 54919-0001
Thrivent.com • 800-847-4836

Thrivent ID

Section 1 - General Information

Name

Email address

By consenting to eDelivery, you are consenting for Thrivent (as defined on page 2) to deliver electronic documents to you instead of mailing paper documents to your mailing address. Thrivent recommends you store your important documents in a secure electronic or paper format for your records. Thrivent is not responsible for any Internet Service Provider, electronic data provider, or hardware or software provider subscription or use fees.

Section 2 - Document Description and Method of Delivery

To receive, print, and view your documents, you must provide a valid email address and have internet access and portable document format (PDF) viewing software, such as Adobe Reader. Review Thrivent.com/faqs/#techsupport for information about browsers and browser settings most compatible with Thrivent's website.

Documents you do not log in to view

- You will receive an email notification containing a link to a publicly available electronic version of the document that can be viewed, printed or saved.
- The documents do not contain personal information.
- Examples of documents you do not log in to view include prospectuses, annual reports and the annual Privacy Notice.

Documents you must log in to view

- Documents you must log in to view contain personal information. You will receive an email notification containing a link. After clicking the link and verifying your identity, you will have electronic access to your document. The document can be viewed, printed or saved.
- Examples of documents you log in to view include activity confirmations, payment notices and statements.

Inserts

- Notification for any documents may include links to inserts that would otherwise be sent with the document if delivered via U.S. mail. You will not be required to log in if the insert is publicly available or if you do not have a log in. Examples of inserts include annual Privacy Notice, prospectus supplements, and other documents.

Section 3 - Document Availability

Your voluntary consent will apply to:

- any product with which you have a relationship now or while your consent is in effect; and
- any document Thrivent is legally permitted to send via eDelivery.

Examples of the documents you might receive are included in Section 2. Thrivent may, at its discretion, mail paper documents. Depending on the relationship you have with Thrivent, Thrivent may allow you to choose eDelivery of specific documents. Thrivent reserves the right to discontinue this type of offering in the future.

The length of time your electronic documents are available online may vary by product and document. The length of time will never be less than legally required.

Section 4 - Revoke eDelivery Preference or Request Paper Copies

Thrivent will act upon your voluntary eDelivery consent until you revoke it. You may revoke your eDelivery preference and receive documents by U.S. mail at any time without penalty. Thrivent accepts notification of revocation through any of the Contact Thrivent options listed. Revocations will be processed within 7 days or sooner as required by law. On some products, Thrivent may discontinue waiving certain contractual fees or charges if you revoke your eDelivery consent. However, you will not incur a separate charge or fee for receiving paper documents. Revocation does not change the effectiveness, validity, or enforceability of documents previously provided to you by eDelivery.

You may request paper copies of any document you previously received by eDelivery without revoking your eDelivery preference. Thrivent will provide these documents to you free of charge.

If Thrivent is unable to successfully eDeliver your documents, Thrivent will contact you by U.S. mail with further instructions. Thrivent may deem unsuccessful eDelivery of your documents as a revocation of consent for eDelivery.

Section 5 - Contact Thrivent

You must notify Thrivent when your contact information changes or you wish to revoke your consent. You may use any of the following methods to update your email address, residential address, or phone number(s), or to revoke your consent:

Thrivent.com

Log in to Thrivent.com and manage your profile

Call 800-847-4836

- A member service professional will be happy to update your contact information
- For details about the documents currently available by eDelivery
- To request a paper copy of a document you received by eDelivery

Send a Written Request

Thrivent
4321 N Ballard Rd
Appleton, WI 54919-0001

Section 6 - Changes to These eDelivery Consent Disclosures

Thrivent reserves the right to modify these eDelivery Consent Disclosures. You will receive an email notification prior to the effective date of any modified eDelivery Consent Disclosures. The email will include instructions to change your preferences if you prefer to receive any document(s) by U.S. mail or do not agree to the new eDelivery Consent Disclosures. Any modification of the eDelivery Consent Disclosures will apply from the effective date forward and not to documents you previously received.

Section 7 - Acceptance and Consent

By electronically signing this form and submitting it to Thrivent, I certify I have reviewed and accept these eDelivery Consent Disclosures. I am voluntarily consenting for Thrivent to act on my eDelivery preference(s) until revoked.

Signature and date signed

X

As used in this form, "Thrivent" refers to Thrivent Financial for Lutherans, Thrivent Life Insurance Company, Thrivent Investment Management Inc., and the Thrivent Series Fund. Thrivent's Privacy Notice also applies to Thrivent Mutual Funds, Thrivent Financial Investor Services Inc., Thrivent Insurance Agency Inc. and the Thrivent Asset Management, LLC.

thrivent

thrivent.com • 800-847-4836

Annuity/Settlement Option Surrender Service Request

1. Owner Information

Thrivent ID and email are optional in the state of California.

Thrivent ID _____ Contract number _____ Email _____

Name _____

2. Surrender Details

☐ Full surrender *(this will close the contract)*

☐ One-time partial surrender amount

☐ Amount $ _____

☐ Amount that is penalty free

☐ Ongoing Automatic Payout Option (APO)

☐ New ☐ Change ☐ Cancel

Payout frequency

☐ Monthly ☐ Quarterly ☐ Semiannually ☐ Annually

Start date - _____

Automatic payout options (select one)

☐ Interest only

☐ Fixed amount $ _____

☐ Fixed percentage _____ %

3. Specific Subaccount Surrender

For Fixed Indexed products, the surrender will be taken from the Fixed Account first and will only be taken from the Indexed Account when the accumulated value in the Fixed Account is not sufficient.

For variable or Multi-Year Guarantee products, indicate account(s) from which payout should be made. If no amounts are indicated, surrenders will be taken proportionately from all subaccounts or allocation periods containing a value.

Subaccount Name or Allocation Period	Amount or Percent
_____	$ _____ _____ %
_____	$ _____ _____ %
_____	$ _____ _____ %

4. Delivery of Payment

☐ Check

☐ Direct Deposit

Complete bank information for direct deposit

Full name of bank account owner(s) _____

Full name of bank _____

Account type ☐ Checking ☐ Savings

Routing number _____ Account number _____

☐ Deposit into an existing Thrivent Mutual Fund account _____

☐ Deposit into a new Thrivent Mutual Fund account.

☐ Apply to another Thrivent contract/account. Only available for one-time partial or complete surrenders.

Contract number	Premium amount	Loan repayment
_____	$ _____	$ _____
_____	$ _____	$ _____

5. Request for Waiver of Surrender Charges (subject to availability)

Optional in the state of California.

- ☐ Confinement to health care facility still applicable. Information already on file at Thrivent.
- ☐ Request for Waiver of Surrender Charges for Health Care Facilities Confinement form will be sent to Thrivent separately.
- ☐ A letter from the nursing home concerning waiver of surrender charges will be sent to Thrivent separately.
- ☐ A letter from an attending physician or doctor indicating a life expectancy of less than 12 months will be sent to Thrivent separately. Attending physician cannot be a family member.
- ☐ A Claimant's Statement for Total Disability form and an Attending Physician's Statement of Disability form will be sent to Thrivent separately.
- ☐ Proof of state unemployment benefits will be sent to Thrivent separately.

6. Withholding and Charges

Surrender Charges and Tax Withholding Amount

Any surrender/decrease charges or tax withholding should be selected below.

- ☐ Add to amount requested. *Your distribution will be for the amount requested. Your account balance will be reduced by this amount plus, any applicable surrender charges, federal/state tax withholding.*
- ☐ Subtract from amount requested. *Your distribution will be for the amount requested less any applicable surrender charges, federal/state tax withholding. Your account balance will be reduced by the amount requested.*

Unless otherwise indicated on this form, any surrender charges and/or withholding will be added to the distribution amount requested.

Federal and State Withholding Election

Under current federal income tax law, we are required to withhold 10% of the taxable portion of the cash surrender value and pay it to the IRS unless you tell us in writing not to withhold the tax. Some states also require us to withhold state income tax if we withhold federal tax.

If you do not want to withhold or would like a percentage other than the required withholding percentage, indicate below.

☐ Do not withhold federal income tax ☐ Other federal withholding _____%

☐ Do not withhold state income tax ☐ Other state withholding _____%

7. Additional Information

8. Plan Trustee Certification

For Qualified Retirement Plan Surrenders from Deferred Annuities

By signing in section 10, I certify that the participant (owner) named in section 1 has had a distributable event (age 59 1/2, termination of employment, financial hardship, etc.) and is able to receive a distribution in accordance with the terms and conditions of the plan owning the contract. I also acknowledge the trustee signature requirements have been satisfied in accordance with the terms of the plan.

Is this complete surrender a result of qualified retirement plan (401(k), profit sharing plan, etc) termination? (If no box is marked, Thrivent will assume this complete surrender is **not** the result of a plan termination.) ☐ Yes ☐ No

9. Validation (see validation requirements in disclosure section)

Medallion Signature Guarantee Seal or Notary Seal

10. Agreements and Signatures

I authorize Thrivent to process the requested distribution and I certify: 1) I have received, read, and agree to the Disclosures (pages 4-6 of this form) and any other disclosures contained in this form; 2) I understand this transaction may be taxable and subject to surrender charges; 3) I understand I have the opportunity to request a quote of the taxable gain and surrender charges prior to requesting this transaction; and 4) I understand this transaction, including any distribution of taxable gain or assessment of surrender charges, cannot be reversed.

If you are signing in any capacity other than the owner/controller/assignee, a title (power-of-attorney, conservator, guardian, trustee, authorized person, etc.) must be provided.

Signature of owner/controller/assignee _____

Date signed _____

Title _____

Signature of joint owner/controller/assignee _____

Date signed _____

Title _____

Employer Certification ***Only*** *for 403(b) surrenders/APO from deferred annuities.*

By signing, I certify that the participant (owner) named in section 1 has had a distributable event (age 59 1/2, termination of employment, financial hardship, etc.) and is able to receive a distribution in accordance with the terms and conditions of the 403(b) plan sponsored by the employer named below. In addition, I certify that I am an authorized representative of the employer.

☐ Hardship surrender only (does not apply to APO) - By checking this box, I represent the distributable event is financial hardship and the employer will suspend employee contributions for a period not less than six months pursuant to the plan.

☐ Hardship surrender only (does not apply to APO) - By checking this box, I represent the distributable event is financial hardship and the employer will not suspend employee contributions.

Name of employer _____

Name of authorized representative of employer _____

Title of authorized representative of employer _____

Signature of authorized representative of employer _____

Date signed _____

Send completed form to:

Thrivent
PO Box 8075
Appleton WI 54912-8075

Fax: 800-225-2264

Disclosures

Surrender Details

I fully acknowledge and understand that by distributing the amount requested from my contract/agreement, the following may result:

Upon complete surrender, I understand that all insurance coverage provided by this contract and the rights of all beneficiaries under this contract cease as of the date this form is properly signed.

Taxable Gain - The distributions may result in the reporting of taxable gains to me.

Penalty Tax - An IRS premature distribution penalty may apply to the taxable portion of the surrender if I am under age 59 1/2 or if this is a SIMPLE IRA and I have participated for less than two years.

Surrender charges may apply.

A market value adjustment (MVA) may apply to distributions from a Fixed Period Allocation.

Surrenders removed from the Indexed Account will not receive any interest credited on the Interest Crediting Date.

Automatic Payout Option (APO) - Only available on Deferred Annuities and FPDAs. If we receive this form in good order after your selected start date, the start date shall be deemed the first business day (or Valuation Date for variable products) that occurs on or after the date of receipt. Subsequent transactions requested pursuant to this form shall be based upon your selected start date.

If 29-31 is chosen, the 28th will be used. If no date is entered, your distribution amount will be the 15th.

Allow 2-5 business days after date selected for funds to be available to you.

Interest only payment must be at least $25.00. Not available for FPDA or Advisor/Flex.

Fixed - Amount - FPDA only - payment amounts under $200 will require direct deposit or payment to another Thrivent product.

Fixed Percent - % of cash value to be distributed at the time of each surrender. i.e. .8% monthly = 9.6%, or approximately 10% annually. Not available for FPDA.

If the payment frequency is blank, illegible or invalid, you are deemed to have elected annual distribution. If annual distribution is elected, but the month is left blank, illegible or invalid, you are deemed to have elected December. If the date of the distribution is left blank, illegible or invalid, you are deemed to have elected the 15th and for distributions to begin when this date next occurs.

If funds are being removed from a specific subaccount, and the value of that subaccount drops below the requested distribution amount, the value in that subaccount will be depleted and the balance will be taken proportionately from the remaining subaccounts. Subsequent payouts will be removed proportionately from all the remaining subaccounts, unless otherwise instructed.

Impact of Withdrawal on Guaranteed Lifetime Withdrawal Benefit (GLWB) rider - I understand that if the GLWB rider is present and a withdrawal request results in a GLWB excess surrender as defined by the GLWB rider, all future GLWB guaranteed values will be reduced. The benefit base and survivor benefit, if any, will be reduced by at least the amount of the excess surrender or in the same proportion the Account Value is reduced. The Guaranteed Withdrawal Amount (GWA) for the next contract year will be reduced in the same proportion as the benefit base. The excess surrender will result in a permanent reduction in all future GWAs. If you would like to make an excess surrender and are uncertain how an excess surrender will reduce your future GWAs, then you may contact us prior to requesting the withdrawal to obtain a personalized, transaction-specific calculation showing the effect of the excess surrender.

For an annuity with the Long-Term Care (LTC) Insurance Rider - If the reason for your surrender request is due to the need to pay for LTC costs, make a claim from your LTC benefits instead of taking a partial surrender from your annuity.

Impact of Surrender or Partial Surrender on LTC Insurance Benefits - I understand that if the LTC Insurance Rider is present, a request to surrender, or a request for a partial surrender which results in the Accumulated Value being less than the required minimum, the LTC Insurance Rider will terminate and all LTC benefits will cease (although nonforfeiture benefits may be available). I understand that if the LTC Insurance Rider is present, a request for a partial surrender will result in a reduction of my available LTC Insurance benefits. Partial surrenders may be subject to income taxation.

I understand that the distribution and any taxable gain resulting from this distribution cannot be reversed once the distribution is processed. Such taxable gain will be subject to federal and state income tax withholding, unless the federal and state tax withholding election is completed.

Transactions are processed as of market close on the day the form is received in good order. If the withdrawal amount requested will cause the value of the contract to fall below the required minimum balance due to market fluctuation, the maximum amount available will be withdrawn.

Disclosure and Important Information Regarding Qualified Charitable Distributions (QCD)

- Use only when IRA owner is 70 1/2 or older.
- The IRS defines QCD as an otherwise taxable distribution from an IRA (other than an ongoing SEP or SIMPLE IRA) owned by an individual who has attained the required age that is paid directly from the IRA to a qualified charity.
- The charity must qualify as a 501(c)(3) organization and be eligible to receive tax-deductible contributions. Certain charities do not qualify; such as, sponsoring charities of donor-advised funds, private foundations and supporting organizations.
- Consult a tax professional to discuss this option as it is your responsibility to ensure the distribution made with this form complies with the IRS rules.
- Thrivent will report this distribution to the IRS on IRS Form 1099-R.

Specific Subaccount Surrender

Minimum requirements may apply. Allocations of percentages are subject to availability. If a specific subaccount or allocation period is chosen, and the percentage field is entered, the percentage requested will be based on the specific subaccount or allocation period value, not the entire contract value. If more than 3 subaccounts, use section 7 - Additional Information.

Delivery of Payment

Direct Deposit - I authorize Thrivent to make this electronic deposit and, if necessary, corrections to my bank account. I further authorize Thrivent to act upon future electronic deposit instructions I provide to my representative or directly to Thrivent. My authorization is valid for electronic deposits and corrections that comply with U.S. law. This authorization shall remain in full force and effect until I revoke it by giving 10 day prior notice to Thrivent.

Checks - For contracts with multiple owners, disbursement checks may be made payable to only the primary owner. If only the primary owner's name appears as the payee on a disbursement check from a contract with multiple owners, it is the responsibility of the primary owner to obtain signatures of the other owners prior to cashing the check. If the disbursement results in taxable income, the tax information will be reported to all owners.

For internal product-to-product transfers only - Only available for One-time Partial or Complete Surrenders. Unless otherwise indicated herein, I intend the requested transfer(s) from the distributing contract(s) to become effective only if and when:

- Thrivent (including its subsidiaries and affiliates) has approved the first application of the amount(s) requested to the receiving contract(s), as described above, or, if not, as I subsequently agree to accept; and
- with respect to any receiving contract(s) that I have applied for, as described above, Thrivent (including its subsidiaries and affiliates) has approved the issuance of the receiving contract(s), as applied for or, if not, as I subsequently agree to accept.

Withholding and Charges

Notification of Withholding and Surrender Charges (Not Applicable for FPDAs) - You are liable for federal and state income tax, where applicable, on the taxable portion of your distribution even if you elect no withholding. Except where prohibited by federal and/or state law, you can elect: 1) no withholding; 2) withholding at the minimum federal and state rates; or 3) withholding at a rate higher than the minimum rates. You may be subject to tax penalties under the estimated tax payment rules if your payments of estimated tax and withholding, if any, are not adequate. Check with your tax advisor to determine if withholding is necessary.

Federal Withholding - If withholding is indicated and the dollar amount or percentage is less than 10%, then 10% federal withholding will occur.

State Withholding - If withholding is indicated and the dollar amount or percentage is less than the state minimum, or if amount or percentage is not completed, we will withhold at your State's minimum rate.

Residents of Connecticut - submit the Form CT-W4P to indicate your withholding election with this form. If you do not submit Form CT-W4P with this form, Thrivent will use your most recently-submitted CT-W4P, if one is on file. If you do not submit Form CT-W4P with this form and you have not previously submitted Form CT-W4P, the maximum rate will be withheld.

You have the right to revoke or change your withholding election at least 10 days prior to the effective date of the distribution.

Mandatory Tax - Distributions from a 403(b) or qualified retirement plan that are eligible for rollover and are not directly rolled over are subject to mandatory 20% federal tax withholding. Refer to the 403(b) and Qualified Plan Distribution Disclosure (form 9972) for more information. If your distribution is subject to mandatory 20% federal tax withholding, your distribution may also be subject to mandatory state tax withholding.

Roth IRA Distributions - No tax withholding will be withheld from your Roth IRA.

Qualified Charitable Distribution - No tax withholding will be withheld from your qualified annuity.

Plan Trustee Certification

Notice to Qualified Plan Trustee(s) - Trustee(s) of Qualified Retirement Plans (such as Money Purchase Plans, Profit Sharing Plans, 401(k) Plans, Defined Benefit Plans, etc.) or 457(b) Plans must provide the Qualified Joint and Survivor Annuity Notice, when applicable, to plan participants. Your Thrivent representative will provide you with the required participant-specific benefit illustration to accompany the Qualified Joint and Survivor Annuity Notice. If a form of benefit other than the Qualified Joint and Survivor Annuity is elected, spousal consent must be obtained. Trustee(s) are also required to provide participants with a Distribution Disclosure Notice.

If you do not have the above referenced notices, Thrivent has generic notices for your use. These notices should be reviewed by your tax advisor to verify suitability for your plan. You are responsible for providing the applicable notices and obtaining any required signatures. Thrivent does not require a copy of these notices be sent to our office.

Generic Notices Available:

- Qualified Joint and Survivor Annuity Notice form
- Spousal Consent form
- 403(b) and Qualified Plan Distribution Disclosure form

Validation

For your protection, validation of your identity is requested for certain variable and non-variable contract transactions.
Surrender/disbursement transactions:

a. Greater than $499,999 will require a Medallion Signature Guarantee for variable contract transactions and a Notary Public for non-variable contract transactions.
b. Greater than $99,999 and up to $499,999 will require one of the following forms of validation:
   · Attestation by a Thrivent representative
   · A Notary Public
   · A Medallion Signature Guarantee (not available for fixed contracts)
c. Greater than $10,000, less than $99,999, and the address of record changed within the prior 15 days will require a Notary Public or attestation by a Thrivent representative.
d. Greater than $10,000, less than $99,999, and the bank information provided has been on record for less than 15 days will require a Notary Public or attestation by a Thrivent representative.
e. Requesting special distribution instructions will also require one of the three forms of validation listed in (b) above. Examples include: Request to send proceeds to an address other than the one listed on your contract and/or request to make proceeds payable to someone other than the current owner.
   A Notary Public or Medallion Signature Guarantee may generally be obtained at any national bank.

Agreements and Signatures

403(b) or Tax Sheltered Annuity Distribution Acknowledgement - I acknowledge that if this distribution is an eligible rollover distribution from a 403(b) and is not a direct rollover to a qualified retirement plan or IRA, the taxable amount of the distribution will be subject to 20% income tax withholding. I also acknowledge that I have received and read the 403(b) and Qualified Plan Distribution Disclosure (form 9972). I acknowledge that I have the right to delay making a decision regarding the distribution from the above plan for at least 30 days after receiving the 403(b) and Qualified Plan Distribution form and have been given this opportunity. I hereby elect to waive my right to the 30 day waiting period and request Thrivent to make this distribution as soon as administratively possible. Due to the tax consequences, I have been advised to seek competent tax advice pertaining to this distribution.

thrivent

thrivent.com • 800-847-4836

Automated Annuity Withdrawal to Pay Other Thrivent Product Premium/Loan

Thrivent ID	Contract number

Section 1 - General Information

☐ Fixed Annuity - Not available for premerger AAL APRA, SPDA, or Annuity with Long-Term Care Insurance Rider.

☐ Variable Annuity - Withdrawals will be removed proportionally from all subaccounts.

Name of annuitant (print first, middle, last name and suffix, as applicable)

Address	City		
	State	ZIP code	Phone

Section 2 - Premium Payment Request

☐ Pay initial premium and subsequent premium payments

☐ Pay only subsequent premium payments

Contract Types and Frequencies:
UL/VUL (premium or premium with loan) - Monthly, Quarterly, Semiannually, Annually
UL/VUL (direct monthly loan) - Monthly
Traditional Life/Health contracts* - Quarterly, Annually
Annuity contracts - Monthly, Quarterly, Semiannually, Annually

*PUIO (Paid-Up Insurance Option)/APO (Additional Premium Option) payments will be paid when the premium is paid.

Section 3 - Contract(s) to be Paid Information

1. Name of owner of contract to be paid (print first, middle, last name and suffix, as applicable) | Contract number

☐ Premium - $ _____ ☐ Loan - $ _____ ☐ PUIO/APO - $ _____
Frequency - _____ Frequency - _____ Start date - _____

2. Name of owner of contract to be paid (print first, middle, last name and suffix, as applicable) | Contract number

☐ Premium - $ _____ ☐ Loan - $ _____ ☐ PUIO/APO - $ _____
Frequency - _____ Frequency - _____ Start date - _____

3. Name of owner of contract to be paid (print first, middle, last name and suffix, as applicable) | Contract number

☐ Premium - $ _____ ☐ Loan - $ _____ ☐ PUIO/APO - $ _____
Frequency - _____ Frequency - _____ Start date - _____

4. Name of owner of contract to be paid (print first, middle, last name and suffix, as applicable) | Contract number

☐ Premium - $ _____ ☐ Loan - $ _____ ☐ PUIO/APO - $ _____
Frequency - _____ Frequency - _____ Start date - _____

Section 4 - Request for Waiver of Surrender Charges (subject to availability)

☐ Confinement to health care facility still applicable. Information already on file at Thrivent.

☐ Request for Waiver of Surrender Charges for Health Care Confinement form will be sent to Thrivent separately.

☐ A letter from the nursing home concerning Waiver of Surrender charges will be sent to Thrivent separately.

☐ A letter from an attending physician or doctor indicating a life expectancy of less than 12 months will be sent to Thrivent separately. Attending physician cannot be a family member.

☐ A Claimant's Statement for Total Disability form and an Attending Physician's Statement of Disability form will be sent to Thrivent separately.

☐ Proof of state unemployment benefits will be sent to Thrivent separately.

Section 5 - Notification for Federal and State Income Tax Withholding

You are liable for federal and state income tax, where applicable, on the taxable portion of your distribution even if you elect no withholding. Except where prohibited by federal and/or state law, you can elect: 1) no withholding; 2) withholding at the minimum federal and state rates; or 3) withholding at a rate higher than the minimum rates. You may be subject to tax penalties under the estimated tax payment rules if your payments of estimated tax and withholding, if any, are not adequate. Check with your tax advisor to determine if withholding is necessary.

If no box is checked, federal (10%) and possibly state income tax will be withheld.

Federal Tax Withholding (must be at least 10%):

☐ Do not withhold federal income tax

☐ Withhold federal income tax amount of $ _____ or _____ %. If dollar amount or percentage is less than 10%, then 10% federal withholding will occur.

State Tax Withholding:

☐ Do not withhold state income tax*

☐ Withhold the applicable state income tax amount of $ _____ or _____ %. If dollar amount or percentage is less than the state minimum, or if amount or percentage is not completed, we will withhold at your state's minimum rate.

Residents of Connecticut - submit the Form CT-W4P to indicate your withholding election with this form. If you do not submit Form CT-W4P with this form, Thrivent will use your most recently-submitted CT-W4P, if one is on file. If you do not submit Form CT-W4P with this form and you have not previously submitted Form CT-W4P, the maximum rate will be withheld.

*If your state requires withholding, we will withhold at your state's minimum rate unless you indicate a higher rate.

Roth Distributions - No tax withholding will be withheld from your Roth IRA.

Mandatory Tax - Distributions from a 403(b) or qualified retirement plan that are eligible for rollover and are not directly rolled over are subject to mandatory 20% federal tax withholding. Refer to the 403(b) and Qualified Plan Distribution Disclosure (form 9972) for more information. If your distribution is subject to mandatory 20% federal tax withholding, your distribution may also be subject to mandatory state tax withholding.

Section 6 - Additional Information

Section 7 - Disclosures for Distribution Request

For internal product-to-product transfers only: Unless otherwise indicated herein, I intend the requested transfer(s) from the distributing contract(s) to become effective only if and when:

- Thrivent (including its subsidiaries and affiliates) has approved the first application of the amount(s) requested to the receiving contract(s), as described above, or, if not, as I subsequently agree to accept; and
- With respect to any receiving contract(s) that I have applied for, as described above, Thrivent (including its subsidiaries and affiliates) has approved the issuance of the receiving contract(s), as applied for or, if not, as I subsequently agree to accept.

I fully acknowledge and understand that:

The withdrawal will occur approximately 10 days before the payment due date.

The payments to the recipient contract are withdrawals from my annuity contract. The withdrawals will automatically increase or decrease based upon changes to the amount billed for the recipient contract and will reduce and possibly deplete the value of my annuity contract. Subject to availability.

For variable or Multi-Year Guarantee products, the withdrawal will be made proportionately from all subaccounts or allocation periods. Specific subaccounts or allocation periods cannot be selected for the distribution.

Fixed Indexed Annuity surrenders are withdrawn from the Fixed Account first and will only be taken from the Indexed Account when the accumulated value in the Fixed Account is not sufficient. Surrenders removed from the Indexed Account will not receive any interest credited on the Interest Crediting Date.

Penalty Tax - If I am under age 59 1/2, a 10% premature distribution tax penalty may apply.

Withdrawal charges may apply.

A market value adjustment (MVA) may apply to distributions from a Fixed Period Allocation.

Impact of withdrawal on Guaranteed Living Withdrawal Benefit (GLWB) rider: I understand that if a GLWB rider is present and a withdrawal request results in a GLWB Excess Surrender as defined by the GLWB rider contract, all GLWB guaranteed values will be reduced. The Benefit Base and Survivor Benefit, if any, will be reduced by at least the amount of the Excess Surrender or in the same proportion the Account Value is reduced. The Guaranteed Withdrawal Amount for the next contract year will be reduced in the same proportion as the Benefit Base.

The withdrawals may result in reporting taxable gain to me even though the withdrawals will be applied to another Thrivent contract. I also understand that any withdrawal and reporting of any taxable gain cannot be reversed. This taxable gain will be subject to federal and state income tax withholding unless I have completed Notification for Federal and State Income Tax Withholding. Each withdrawal amount will be increased by the applicable withholding.

403(b) or Tax Sheltered Annuity Distribution Acknowledgement - I acknowledge that if the distribution from the above plan is an eligible rollover distribution and is not a direct rollover to a qualified retirement plan or IRA, the taxable amount of the distribution will be subject to 20% income tax withholding. I also acknowledge that I have received and read the 403(b) and Qualified Plan Distribution Disclosure (form 9972). I acknowledge that I have the right to delay making a decision regarding the distribution from the above plan for at least 30 days after receiving the 403(b) and Qualified Plan Distribution form and have been given this opportunity. I hereby elect to waive my right to the 30 day waiting period and request Thrivent to make this distribution as soon as administratively possible. Due to the tax consequences, I have been advised to seek competent tax advice pertaining to this distribution.

Notice to Qualified Plan Trustee(s) - Trustee(s) of Qualified Retirement Plans (such as Money Purchase Plans, Profit Sharing Plans, 401(k) Plans, Defined Benefit Plans, etc.) or 457(b) Plans must provide the Qualified Joint and Survivor Annuity Notice, when applicable, to plan participants. Your Thrivent representative will provide you with the required participant-specific benefit illustration to accompany the Qualified Joint and Survivor Annuity Notice. If a form of benefit other than the Qualified Joint and Survivor Annuity is elected, spousal consent must be obtained. Trustee(s) are also required to provide participants with a Distribution Disclosure Notice.

If you do not have the above referenced notices, Thrivent has generic notices for your use. These notices should be reviewed by your tax advisor to verify suitability for your plan. You are responsible for providing the applicable notices and obtaining any required signatures. Thrivent does not require a copy of these notices be sent to our office.

Generic Notices Available
- Qualified Joint and Survivor Annuity Notice (form 15081)
- Spousal Consent (form 9336)
- 403(b) and Qualified Plan Distribution Disclosure (form 9972)

Section 8 - Employer Certification (complete for 403(b) automated withdrawals only)

By signing below, I certify that the participant/annuitant named on page 1 has had a distributable event (age 59 1/2, termination of employment, etc.) and is able to receive a distribution, in the form of a systematic withdrawal, in accordance with the terms and conditions of the 403(b) plan sponsored by the employer named below. In the event the participant is no longer eligible to receive such systematic withdrawals, the employer will notify Thrivent in writing. In addition, I certify that I am an authorized representative of the employer.

Name of employer

Name of authorized representative of employer	Title of authorized representative of employer

Signature of authorized representative of employer and date signed

X

Section 9 - Signatures

Signature of owner/controller/assignee* and date signed

X

Title (if applicable)

Signature of owner/controller/assignee* and date signed

X

Title (if applicable)

***Absolutely Assigned Contracts** - Absolute assignee is:

1) Person(s) - individual(s) signature required; or
2) Business Entity - one authorized signer's signature is required. Business Entity Authorization (form 23438) must be on file; or
3) Qualified Retirement Plan - plan trustee(s) signature is required. Qualified Retirement Plan Certification (form 24742) must be on file.

457 plans and nonqualified deferred compensation plans require Business Entity Authorization (form 23438) on file.

Collaterally Assigned Contracts - Owner and collateral assignee; one officer's signature and title for a corporation, church or partnership.

Irrevocable Beneficiary - All irrevocable beneficiaries' signatures are required if the contract(s) contains irrevocable beneficiaries.

Name and code number of representative

Mail completed form to:
Thrivent
PO Box 8075
Appleton, WI 54912-8075

Fax:
800-225-2264

thrivent

Thrivent Financial for Lutherans
4321 N. Ballard Road, Appleton, WI 54919-0001
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Employee Disability Benefits Information Request

Section 1 - Employee Authorization

Name of employee (print title, first, middle, last, and suffix name, if applicable)	Date of birth

I hereby authorize release of information regarding my employee disability benefits to my financial representative. Please give specific information regarding short term, long term, salary continuation or sick pay benefits separate from Worker's Compensation, and if these benefits coordinate with Social Security.

Signature of employee and date signed (mm/dd/yyyy)

Signature of financial representative and date signed (mm/dd/yyyy)

Section 2 - Coverage Information

Coverages	Short Term	Long Term	Salary Continuation	Sick Pay
Waiting Period				
Monthly Amount				
Maximum Period				
Coordinate with Social Security	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Maximum Amounts				

Section 3 - Plan Features

☐ Yes ☐ No Are premiums paid by the employer?
☐ Yes ☐ No Do premiums remain level as the employee's age increases?
☐ Yes ☐ No Are premiums waived during the employee's disability?
☐ Yes ☐ No Are partial benefits paid during the employee's partial disability?
☐ Yes ☐ No Are there cost of living increases for the employee's long term disability?
☐ Yes ☐ No Is there a guaranteed right to buy more coverage regardless of health?
☐ Yes ☐ No Is there a guaranteed right to convert coverage to a private plan?
☐ Yes ☐ No Are benefits paid for both sickness and accident?
☐ Yes ☐ No Are benefits paid for both on and off work disabilities?
☐ Yes ☐ No Can the employee opt out of an involuntary plan?

Section 4 - Signature

Signature of employer and date signed (mm/dd/yyyy)

Send completed form to the financial representative below.

Name of financial representative		Phone	
Address	City	State	ZIP Code

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Membership Application

Congratulations and Welcome! At Thrivent (“Thrivent Financial for Lutherans”), we believe humanity thrives when people make the most of all they've been given. By joining Thrivent, you are more than a consumer of financial products and services; you are our client and we seek to help you and your family achieve financial clarity, to enable you to live lives full of meaning and gratitude.

Member Protection, Community Support. At our heart, Thrivent is a membership-owned fraternal organization. This means when you become a member, you become part of something bigger: our collective ownership. Thrivent members share a commitment to help strengthen the communities where they live, work and worship.

But we're more than that. Since our beginnings over a century ago, we've grown to become a strong Fortune 500 company that offers a full range of expert solutions to meet needs and goals throughout your lifetime, including advice, investments, insurance, banking and generosity. Our goal is to help millions more clients build their financial futures with clarity and confidence and make the most of all they've been given.

Because Thrivent is owned by our membership, our focus starts with our members' needs and goals. This allows us to be true to what we believe in: Our client's values.

Thrivent's Common Bond. We welcome Christians* seeking to live out their faith. *For more information on Thrivent's Christian Common Bond, visit **thrivent.com/christiancalling**.

Name of proposed member _____

Address _____

City _____ State _____ ZIP code _____

Phone _____ Date of birth _____

Email _____

Church name (optional) _____ City _____ State _____

The information gathered on this form will be used in accordance with Thrivent's privacy policy.

Statement of Christian Common Bond:
I am age 16 or older and am applying for membership with Thrivent and a Thrivent Member Network, or I am age 18 or older and applying for membership on behalf of a youth under age 16.

Select only one of the following qualification types:

- ☐ I am a Christian, seeking to live out my faith; or
- ☐ I am the spouse of a Christian who seeks to live out his or her faith; or
- ☐ If applying on behalf of a youth under age 16, the youth is being raised in the Christian faith.

I agree to support and further Thrivent's shared purpose of helping people achieve financial clarity, so they can make the most of all they've been given. I verify that the information I provided is true and correct.

Signature of proposed member (age 16 or older)
or parent/guardian of youth age 0-15 _____

Date signed _____

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4321 N. Ballard Road, Appleton, WI 54919-0001
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Health and Other Personal Information Authorization

(This authorization complies with the HIPAA Privacy Rule.)

Name _____

Date of birth _____ Contract number _____

This authorization applies to Thrivent Financial for Lutherans, Thrivent Insurance Agency Inc. and third party administrator LTCG, 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 determining my eligibility for insurance, payment, or health care, or for any other use, collection or disclosure permitted by law, You may need to obtain, use or disclose any and all information about my physical and mental health, including but not limited to services for preventive, diagnostic and therapeutic care, tests, counseling and medical prescriptions; and non-health information about me including but not limited to financial, insurance, credit, occupational, avocational and driving history. This medical or health information includes information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law.

I authorize any health care professional, medical facility, pharmacy, pharmacy benefit manager, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearinghouse, other insurer, insurance broker, health plan, Your affiliate, health care component of Your company, Department of Motor Vehicles, government agency, consumer reporting agency, employer, family member and acquaintance to provide information about me, including my entire medical record, which may contain DNA or genetic testing analysis results, to You. I authorize the release of this information in any format including but not limited to paper and/or electronic format. This includes but is not limited to electronic interchange through a Health Information Exchange or directly through My Provider's electronic health record system. I authorize MIB, Inc. to give to You, or Your reinsurers, any records of me or my health. **By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.**

I authorize You and Your reinsurers to make a brief report of my personal health information to MIB, Inc.

I authorize You to disclose information about me, including any DNA or genetic testing analysis results contained within my medical history to any insurance broker and other insurer approved by You for the purpose of securing insurance for me. This includes You disclosing health information I provide to You with the writing agent or agency. Information about my health may be released as required or permitted by law such as to MIB, Inc. to deter fraud, misrepresentation or criminal activity, or to my indicated physician where state law requires notification. Health information about me, 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.

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

I understand that to determine my eligibility for insurance, You may request an investigative consumer report. This inquiry may include information as to my character, general reputation, personal characteristics and mode of living, whichever is applicable. I further understand that upon my written request, I will be informed whether or not an investigative consumer report was requested, and if such report was requested, the name and address of the consumer reporting agency to whom the request was made so that I may inspect and receive a copy of such report by contacting such agency. I authorize you to procure or prepare such consumer report.

I understand that the application which holds personally identifiable health information and financial information will be attached to the contract for purposes of contract issuance. I understand that if this contract is owned by someone other than me a copy of the contract which contains the application will be provided to the owner.

I understand that failure to sign this Authorization, or subsequent revocation of this Authorization, may impair Your ability to process my application or evaluate claims, and may be a basis for denying an application or claim for benfits.

I have read 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 proposed insured or personal representative _____

Date signed _____

Description of personal representative's authority to act _____

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Thrivent ID

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4321 N. Ballard Road, Appleton, WI 54919-0001
thrivent.com • 800-847-4836

Additional Client Information

Please print. This form is required when completing a paper application.

Name of annuitant/insured (print title, first, middle, last name and suffix, as applicable)

Sex ☐ Male ☐ Female	State of birth	Country of citizenship if not U.S.		
Marital status	Residential phone	Best time to call (CST)	Business phone	Best time to call (CST)
Residential address		Mailing address		
City / State / ZIP code		City / State / ZIP code		

Name of other insured (print title, first, middle, last name and suffix, as applicable)

Sex ☐ Male ☐ Female	State of birth	Country of citizenship if not U.S.		
Marital status	Residential phone	Best time to call (CST)	Business phone	Best time to call (CST)
Residential address		Mailing address		
City / State / ZIP code		City / State / ZIP code		

Name of applicant controller/owner (print title, first, middle, last name and suffix, as applicable) — Living trust? ☐ Yes ☐ No

Sex ☐ Male ☐ Female	State of birth	Country of citizenship if not U.S.		
Marital status	Residential phone	Best time to call (CST)	Business phone	Best time to call (CST)
Residential address		Mailing address		
City / State / ZIP code		City / State / ZIP code		

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Direct Deposit Worksheet/ Account Owners' Agreement

Thrivent ID

Section 1 - Transaction Requested

☐ **Establish new**

This authorization is being set up to have deposits sent to my bank account from contract - _____.

☐ **Change existing**

For clients with multiple contracts, complete the Payment Services Request - Direct Payment (form 23045A) to make individual contract-specific changes. Any updates requested with this form will apply to all contracts.

☐ Existing/Old bank account is now closed ☐ Existing/Old bank account is still open

Name of bank account owner or business

Address	City	State	ZIP code
Name of joint bank account owner		Thrivent ID	
Address, if different than above	City	State	ZIP code
Full name of bank		Routing number	
Bank account number	Type of account ☐ Checking ☐ Savings		

Section 2 - Agreements and Signature

General Authorization

I authorize Thrivent to:

- Make electronic deposits and corrections to my bank account that comply with U.S. law.
- Act on this authorization until I revoke it by contacting Thrivent.
- Apply this authorization to any future bank accounts I may designate.
- Make administrative changes to this authorization which I request such as date and amount changes, or adding or removing contracts for automatic payment.
- Release any and all information related to this authorization to the third party account/contract owner.
- Act upon electronic deposit and administrative instructions I provide to my representative.

Signature of bank account owner and date signed

X

Mail completed form to:
Thrivent
P.O. Box 8075
Appleton WI 54912-8075

Fax:
800-225-2264

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Representative's Information

1. Proposed Insured

Name _____

2. Requirements

List preferred vendor for medical requirements (Thrivent approved)

_____

Do you want to order the medical requirements? ☐ Yes ☐ No

3. Other Information

Did you complete the application in person with the proposed insured? ☐ Yes ☐ No

If no, explain - _____

Did the proposed insured or their family member contact you for this coverage? ☐ Yes ☐ No

4. Additional Details

5. Agreements and Signatures

To the best of my knowledge and belief, I know nothing about the proposed insured's health, habits, or lifestyle affecting insurability which has not been stated in this application.

Signature of representative _____

Date signed _____

Mail contract to ☐ Representative ☐ Owner

If no box is selected, the contract will be mailed to the representative for delivery.