MS CA

September 15, 2020

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.

Application packet

Thrivent Financial for Lutherans
thrivent.com • 800-847-4836

Medicare Supplement Insurance Application

☐ New Business

☐ Contract Change: Contract number - ____________________

Section 1 - Proposed Insured

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

Date of birth	Sex	Age	State of residence	ZIP code

Medicare claim number	Date shown on Medicare ID card

Section 2 - Medicare and Other Coverage Information

You do not need more than one Medicare supplement contract. If you purchase this contract, you may want to evaluate your existing health coverage and decide if you need multiple coverages. You may be eligible for benefits under Medi-Cal and may not need a Medicare supplement contract.

If, after purchasing this contract, you become eligible for Medi-Cal, the benefits and premiums under your Medicare supplement contract can be suspended, if requested, during your entitlement to benefits under Medi-Cal for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal. If you are no longer entitled to Medi-Cal, your suspended Medicare supplement contract (or, if that is no longer available, a substantially equivalent contract) will be reinstituted if requested within 90 days of losing Medi-Cal eligibility. If the Medicare supplement contract provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your contract was suspended, the reinstituted contract will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

If you are eligible for, and have enrolled in a Medicare supplement contract by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement contract can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement contract under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement contract (or, if this is no longer available, a substantially equivalent contract) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement contract provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your contract was suspended, the reinstituted contract will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

Counseling services are available in this state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the Medi-Cal program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). If you want to discuss buying Medicare Supplement insurance with a trained insurance counselor, call the California Department of Insurance's toll-free telephone number 1-800-927-HELP, or access the department's Internet Web site, www.insurance.ca.gov, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance contract, or that you had certain rights to buy such a contract, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. Please Answer All Questions.

Yes No To the best of your knowledge:

☐ ☐ 1. Do you have another Medicare Supplement contract in force?
If Yes,
Name of company - ____________________
Name of plan - ____________________ Contract number - ____________________

☐ ☐ Do you intend to replace your current Medicare supplement contract with this contract?
If Yes, submit a replacement form. If No, this coverage cannot be issued.

☐ ☐ 2. Have you had coverage under any other health insurance within the past 63 days?
(For example, an employer, union, or individual plan.)
If Yes,
Name of company - ____________________
Type of contract - ____________________ Contract number - ____________________
What are your dates of coverage under the other contract?
If you are still covered under the other contract, leave "**End date**" blank.
Start date - ____________________ (mm/dd/yyyy) End date - ____________________ (mm/dd/yyyy)

☐ ☐ 3. Have you had coverage from any Medicare plan other than original Medicare within the past 63 days?
(For example, a Medicare Advantage plan, or a Medicare HMO or PPO.)
If Yes, fill in your start and end date. If you are still covered under this plan, leave "**End date**" blank.
Start date - ____________________ (mm/dd/yyyy) End date - ____________________ (mm/dd/yyyy)

☐ ☐ Do you intend to replace your current coverage with this new Medicare supplement contract?
If Yes, submit a replacement form.

☐ ☐ Was this your first time in this type of Medicare plan?

☐ ☐ Did you drop a Medicare supplement contract to enroll in the Medicare plan?

☐ ☐ 4. Are you covered for medical assistance through California's Medi-Cal program?
Note: If you have a share of cost under the Medi-Cal program, please answer **No** to this question.
If Yes,

☐ ☐ Will Medi-Cal pay your premiums for this Medicare supplement contract?

☐ ☐ Do you receive any benefits from Medi-Cal **other than** payments toward your Medicare Part B premium?

☐ ☐ 5. Did you turn 65 years of age in the last six months?

☐ ☐ 6. Did you enroll in Medicare Part B in the last six months?
If Yes, what is the effective date? ____________________ (mm/dd/yyyy)

Section 3 - New Business Product Information

1. Plan selected - ____________________
2. Premiums: ☐ Attained Age ☐ Issue Age
3. Requested effective date - ____________________ (mm/dd/yyyy)

Section 4 - Contract Change

☐ Delete Part A Deductible ☐ Delete prescription drug rider ☐ Remove rating ☐ Change to non-tobacco
If you are NOT in an Open Enrollment or Guaranteed Issue Period, answer question 1 in Section 5.

Requested effective date of change - ____________________ (mm/dd/yyyy)

Section 5 - Declaration of Insurability - This section should not be completed if you are in the Open Enrollment or Guaranteed Issue Period, see Section 10 and 11 for complete information about Open Enrollment and Guaranteed Issue.

1. Within the past 12 months, have you used tobacco or other nicotine products? ☐ Yes ☐ No ☐ Not Sure

2. To the best of your knowledge, within the past five years, have you been diagnosed, been treated, or taken medication for:

Yes	No	Not Sure		Yes	No	Not Sure	
☐	☐	☐	a. Angina	☐	☐	☐	s. Chronic lung disease
☐	☐	☐	b. Heart attack	☐	☐	☐	t. Pancreatitis
☐	☐	☐	c. Heart surgery	☐	☐	☐	u. Cirrhosis
☐	☐	☐	d. Peripheral artery disease or gangrene	☐	☐	☐	v. Crohn's disease
☐	☐	☐	e. Angioplasty	☐	☐	☐	w. Ulcerative colitis
☐	☐	☐	f. Stroke	☐	☐	☐	x. Kidney disease requiring dialysis
☐	☐	☐	g. Congestive heart failure	☐	☐	☐	y. Kidney failure
☐	☐	☐	h. Atrial fibrillation	☐	☐	☐	z. Insulin dependent diabetes
☐	☐	☐	i. Pacemaker	☐	☐	☐	aa. Amyotrophic lateral sclerosis (Lou Gehrig's disease)
☐	☐	☐	j. Carotid or femoral artery surgery				
☐	☐	☐	k. Cardiomyopathy	☐	☐	☐	bb. Alzheimer's disease or other dementia
☐	☐	☐	l. Aneurysm	☐	☐	☐	cc. Parkinson's disease
☐	☐	☐	m. Transient Ischemic Attack (TIA)	☐	☐	☐	dd. Multiple sclerosis
☐	☐	☐	n. Internal cancer	☐	☐	☐	ee. Rheumatoid arthritis
☐	☐	☐	o. Melanoma	☐	☐	☐	ff. Systemic lupus erythematosus
☐	☐	☐	p. Leukemia	☐	☐	☐	gg. Schizophrenia
☐	☐	☐	q. Lymphoma	☐	☐	☐	hh. Bipolar or manic depression
☐	☐	☐	r. Emphysema	☐	☐	☐	ii. Alcohol or drug abuse
				☐	☐	☐	jj. Organ transplant (other than corneal)

Yes	No	Not Sure	
☐	☐	☐	3. To the best of your knowledge, within the past five years, have you ever been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS related complex?
☐	☐	☐	4. Within the past two years, have you been medically advised to have surgery not yet completed?
☐	☐	☐	5. Have you been confined in a hospital or nursing facility or has confinement to a hospital or nursing facility been recommended to you in the last six months?
☐	☐	☐	6. Have you been confined in a hospital or nursing facility three or more times in the past two years?
☐	☐	☐	7. Are you currently bedridden or using a wheelchair, walker, chairlift, or oxygen?

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

If there are any 'Yes' answers to questions 2 through 7, do not proceed with completing this application as coverage will not be issued. No other sources of information will be reviewed.

If there are any 'Not Sure' answers to questions 1 through 7, provide additional information in the Details Section.

It is the responsibility of the proposed insured to provide the correct responses to the questions in the application.

Section 6 - Details for Questions Answered 'Not Sure' - This section should not be completed if you are in the Open Enrollment or Guaranteed Issue Period, see Section 10 and 11 for complete information about Open Enrollment and Guaranteed Issue. If you are unsure of the answer, do not know how to respond, or do not understand the question you may state 'Not Sure' in the space provided.

Question: No/Ltr	Type of disorder, injury, test			Date of diagnosis
Date of onset	Number of occurrences	Treatment	Date of last hospitalization, nursing home care, or home health care	
Last occurrence date	Released from medical care ☐ Yes ☐ No	Date released from medical care	Surgery date	Last consultation date
Time lost from work/school	Medication(s) currently taking			
Care provider/Facility with records if other than primary care provider				

Question: No/Ltr	Type of disorder, injury, test				Date of diagnosis
Date of onset	Number of occurrences	Treatment	Date of last hospitalization, nursing home care, or home health care		
Last occurrence date	Released from medical care ☐ Yes ☐ No	Date released from medical care	Surgery date	Last consultation date	
Time lost from work/school	Medication(s) currently taking				
Care provider/Facility with records if other than primary care provider					

Question: No/Ltr	Type of disorder, injury, test				Date of diagnosis
Date of onset	Number of occurrences	Treatment	Date of last hospitalization, nursing home care, or home health care		
Last occurrence date	Released from medical care ☐ Yes ☐ No	Date released from medical care	Surgery date	Last consultation date	
Time lost from work/school	Medication(s) currently taking				
Care provider/Facility with records if other than primary care provider					

Section 7 - Premium Payment Information
(Premium must be submitted with application if proposed insured is 64 years and 10 months or older.)

Initial monthly premium
$

Section 8 - Third Party Notification

I understand I have the right to designate at least one person other than myself to receive notice of cancellation of this insurance contract or rider for nonpayment of premium. I understand that notice to my designee will be given at least 10 days prior to the effective date of cancellation of my contract. I request you notify the following person:

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

Name (print title, first, middle, last name and suffix, as applicable)			
Address	City		
	State	ZIP code	Phone

Section 9 - Agreement and Signature

I understand and agree that:

1. I have personally read (or have had read to me) and verified all statements and answers provided to the Thrivent agent as part of this application.
2. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
3. If your answers on this application are fraudulent or intentional misrepresentation of material fact, Thrivent may have the right to deny benefits or rescind your contract.
4. This application will become part of the contract.
5. No change in this application shall be made without my written consent.
6. No change to this contract is valid unless it is made in writing and signed by our president or secretary.
7. Coverage begins at 12:01 a.m. on the date of issue of the contract or, if later, the date we receive the initial premium on the contract.
8. I have received a copy of the Medicare Supplement Outline of Coverage and a copy of the NAIC-HHS Guide to Health Insurance for People with Medicare.
9. A rate guide is available that compares the policies sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Insurance's consumer toll-free telephone number (1-800-927-HELP), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free telephone number (1-800-434-0222), or by accessing the Department of Insurance's Internet Web site (www.insurance.ca.gov).
10. The date of this application is the date the application is signed.

Signed at ______________________________ ______

City State

Signature of proposed insured and date signed

X ______________________________

Caution: If your answers on this application are fraudulent or intentional misrepresentation of material fact, Thrivent may have the right to deny benefits or rescind your contract.

The below information is completed by Agent, not applicant.

I certify that, to the best of my knowledge, the information on the application is complete and accurate

I certify that I have reviewed the answers with the proposed insured and explained, in easy-to-understand language, the risk of providing inaccurate information and the proposed insured indicated understanding of the explanation.

The contract applied for ☐ is ☐ is not intended to replace any part of, or all of, another contract.

List any health insurance contract you've sold to the proposed insured that are still in force.

____

List any health insurance contract you've sold to the proposed insured in the past five years that are no longer in force.

____

If any agent willfully states as true any material fact he or she knows to be false in an insurance application, that person shall, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to ten thousand dollars ($10,000).

Signature of agent and date signed

X ______________________________

Name and code number of agent

____

Section 10 - Open Enrollment

The following provides you with information about Medicare Supplement Open Enrollment and eligibility criteria.

1. An issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in case of an application for a policy or certificate that is submitted prior to or during the six-month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an issuer shall be made available to all applicants who qualify under this subdivision and who are 65 years of age or older.

2. An issuer shall make available Medicare supplement benefit plan A, B, C, F, K, or L, if currently available, to an applicant who qualifies under this subdivision who is 64 years of age or younger and who does not have end-stage renal disease. Applicants who are 64 years of age or younger and do not have end-stage renal disease, and who are newly-eligible for Medicare on or after January 1, 2020, may choose plans D or G, if currently available, instead of plans C and F.

3. For an individual enrolled in Medicare by reason of disability who does not have end-stage renal disease, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in case of an application for a policy or certificate for six months after the date of his or her enrollment in Medicare Part B, or if notified retroactively of his or her eligibility for Medicare, for six months following notice of eligibility.

4. For an applicant who qualifies under above criteria and submits an application during the above time period:
   - If, as of the date of application, he or she has had a continuous period of creditable coverage of at least six months, the issuer shall not exclude benefits based on a preexisting condition.
   - If, as of the date of application, he or she has had a continuous period of creditable coverage that is less than six months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. An individual enrolled in Medicare by reason of disability shall be entitled to open enrollment as described above for six months after the date of his or her enrollment in Medicare Part B, or if notified retroactively of his or her eligibility for Medicare,for six months following notice of eligibility. Every issuer shall make available to every applicant qualified for open enrollment all policies and certificates offered by that issuer at the time of application.

5. An individual enrolled in Medicare Part B is entitled to open enrollment as described above for six months following:
   - Receipt of notice of termination or, if no notice is received,the effective date of termination from any employer-sponsored health plan.
   - Receipt of notice of loss of eligibility due to the divorce or death of a spouse or, if no notice is received, the effective date of loss of eligibility due to the divorce or death of a spouse, from any employer-sponsored health plan.
   - Termination of health care services for a military retiree or the retiree's Medicare eligible spouse or dependent as a result of a military base closure or loss of access to health care services because the base no longer offers services or because the individual relocates.

6. An individual enrolled in Medicare Part B is entitled to open enrollment as described above if the individual was covered under a policy, certificate, or contract providing Medicare supplement coverage but that coverage terminated because the individual established residence at a location not served by the plan.

7. An individual whose coverage was terminated by a Medicare Advantage plan shall be entitled to an additional 60-day open enrollment period to be added on to and run consecutively after any open enrollment period authorized by federal law or regulation, for any Medicare supplement coverage provided by Medicare supplement issuers and available on a guaranteed basis under state and federal law or regulation for persons terminated by their Medicare Advantage plan.

8. An individual shall be entitled to an annual open enrollment period lasting 60 days, commencing with the individual's birthday, during which time that person may purchase any Medicare supplement policy that offers benefits equal to or lesser than those provided by the previous coverage. During this open enrollment period, no issuer shall deny or condition the issuance or effectiveness of Medicare supplement coverage, nor discriminate in the pricing of coverage, because of health status, claims experience, receipt of health care, or medical condition of the individual if, at the time of the open enrollment period, the individual is covered under another Medicare supplement policy or contract.

9. An issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an individual enrolled in Medicare Part B upon being notified that, because of an increase in the individual's income or assets, he or she meets one of the following requirements:
   - He or she is no longer eligible for Medi-Cal benefits.
   - He or she is only eligible for Medi-Cal benefits with a share of cost and certifies at the time of application that he or she has not met the share of cost.

Section 11 - Guaranteed Issue

The following are definitions of categories of individuals who are eligible for Guaranteed Issue. If any of the definitions apply to you, please complete an Application for Medicare Supplement Insurance and submit evidence of the date of termination, disenrollment, or Medicare Part D enrollment. The application for coverage must be made no later than 63 days after the effective date of termination, disenrollment, or enrollment in Medicare Part D.

1. Enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare and:
   - The plan either terminates or ceases to provide all of those supplemental health benefits to the individual, or
   - The employer no longer provides the individual with the insurance that covers all of the payment for the 20-percent coinsurance.
2. Enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, and:
   - The certification of the organization or plan has been terminated, or
   - The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides, or
   - The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances, not including termination of the individual's enrollment because the individual has not paid premiums on a timely basis, or
   - The Medicare Advantage plan in which the individual is enrolled reduces any of its benefits or increases the amount of cost sharing or discontinues for other than good cause relating to qualify of care, its relationship or contract under the plan with a provider who is currently furnishing services to the individual, or
   - The individual demonstrates that (A) the organization offering the plan substantially violated a material provision of the organization's contract or (B) the organization, or producer or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual, or (C) the individual meets other exceptional conditions the HHS Secretary may provide.
3. The individual is 65 years of age or older, is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and circumstances similar to those described above in Paragraph 2 exist that would permit discontinuance of the individual's enrollment with the provider, if the individual were enrolled in a Medicare Advantage plan.
4. The individual is enrolled with (A) an eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost), or (B) a similar organization operating under demonstration project authority, effective for periods before April 1, 1999, or (C) an organization under an agreement under Section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan), or (D) an organization under a Medicare Select policy; and the enrollment ceases under circumstances similar to those described above in Paragraph 2 or 3.
5. Enrolled under a Medicare supplement policy and the enrollment ceases because:
   - The insolvency of the issuer or bankruptcy of the nonissuer organization, or of other involuntary termination of coverage or enrollment under the policy, or
   - The issuer of the policy substantially violated a material provision of the policy, or
   - The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual.
6. The individual meets both of the following conditions:
   - Enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, any eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under section 1894 of the Social Security Act, or any Medicare Select policy, and
   - That subsequent enrollment is terminated by the individual during any period within the first 12 months of the subsequent enrollment (during which the enrollee is permitted to terminate the subsequent enrollment under Section 1851(e) of the federal Social Security Act).

7. Upon first becoming eligible for benefits under Medicare Part A at 65 years of age, enrolls in a Medicare Advantage plan under Part C of Medicare, or with a PACE provider under Section 1894 of the Social Security Act, and disenrolls from the plan or program not later than 12 months after the effective date of enrollment.
8. The individual while enrolled under a Medicare supplement policy that covers outpatient prescription drugs enrolls in a Medicare Part D plan during the initial enrollment period, terminates enrollment in the Medicare supplement policy, and submits evidence of enrollment in Medicare Part D along with the application for a policy that has a benefit package classified as Plan A, B, C, F (including a high deductible Plan F), K, or L offered by any issuer.

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

Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage

Save this notice! It may be important to you in the future.

If you intend to cancel or terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a contract issued by Thrivent Financial for Lutherans, please review this new coverage carefully and replace the existing coverage **only** if the new coverage materially improves your position. **Do not cancel your present coverage until you have received your new contract and are sure that you want to keep it**.

If you decide to purchase the new coverage, you will have 30 days after you receive the contract to return it to the insurer, for any reason, and receive a refund of your money.

If you want to discuss buying Medicare supplement or Medicare Advantage coverage with a trained insurance counselor, call the California Department of Insurance's toll-free telephone number 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

Statement to Applicant by Thrivent Representative:

I have reviewed your current health insurance coverage. To the best of my knowledge, the replacement of insurance involved in this transaction does not duplicate coverage or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. In addition, the replacement coverage contains benefits that are clearly and substantially greater than your current benefits for the following reasons:

- ☐ Additional benefits that are: ______________________
- ☐ No change in benefits, but lower premiums.
- ☐ Fewer benefits and lower premiums.
- ☐ Plan has outpatient prescription drug coverage and applicant is enrolled in Medicare Part D.
- ☐ Disenrollment from a Medicare Advantage plan. Reasons for disenrollment: ______________________
- ☐ Other - Please specify: ______________________

1. State law provides that your replacement contract may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new contract for similar benefits to the extent such time was spent (depleted) under the original contract.
2. If you still wish to terminate your present contract and replace it with new coverage, be certain to truthfully and completely answer any and all questions on the application concerning your medical and health history. Failure to include all material medical information on an application requesting that information may provide a basis for the insurer to deny any future claims and to refund your premium as though your contract had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. (If the contract is guaranteed issue, this paragraph does not apply.)

Do not cancel your present Medicare supplement coverage until you have received your new contract and are sure that you want to keep it.

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

Thrivent Financial for Lutherans
4321 N. Ballard Road, Appleton, WI 54919-0001
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Automatic Payment Authorization

1. Bank Account Owner Information

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

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, 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 to any insurance broker and other insurer approved by You for the purpose of securing insurance for me. Information about my health may be released as required or permitted by law such as to MIB, Inc. in an effort to deter fraud, misrepresentation or criminal activity. 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.

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.

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 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 You may not be able to determine my eligibility for insurance if I do not agree to the terms of this authorization.

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 ______________________________

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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Payment Services Request

Member 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

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800-225-2264

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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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Automated Annuity Withdrawal to Pay Other Thrivent Product Premium/Loan

Member 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

Receipt For Payment And Conditional Temporary Coverage Agreement

Thrivent Financial for Lutherans
4321 N. Ballard Road, Appleton, WI 54919-0001
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No representative or other agent of Thrivent is authorized to change or waive any terms of this agreement or make any promises or representations other than those contained in this agreement. Please read this agreement carefully.

Proposed Insured's / Annuitant's Name	Coverage Applied For

Received from:	Total Amount $

By	☐ Check - Amount: $	☐ Other - Amount: $	Source:

Note:	Make all checks payable to Thrivent Financial for Lutherans. Do not leave the payee blank or make checks payable to the Thrivent representative. The agreement is void if any check given for payment is not honored.

Signature of Thrivent representative / Date signed (mo/day/yr) >

Important - Read Carefully

This agreement outlines the terms and conditions under which Thrivent will provide temporary coverage for the proposed insured / annuitant. If coverage is provided, it will be provided according to the terms, limitations, and conditions contained in the certificate applied for. The certificate applied for will not become effective unless and until it has been delivered to you and you have accepted it.

When Conditional Temporary Coverage Is Provided

Temporary coverage is provided for the proposed insured / annuitant only if all of the following conditions are met:
1. There is no material misrepresentation in the application.
2. The first full standard premium for the interval selected has been paid or Electronic First Payment is selected and payment is made at the time of the preauthorized withdrawal.
3. The proposed insured / annuitant is insurable the later of either: the date the proposed insured / annuitant signs the application; or the date any additional exams and tests required by the underwriting guidelines or policies of Thrivent are completed. To be insurable, the proposed insured / annuitant must qualify as insurable under Thrivent's underwriting guidelines or policies for the type and amount of coverage applied for.

There is no coverage under this conditional agreement for the person who Thrivent has determined to be uninsurable according to its underwriting guidelines or policies.

When Coverage Begins

If coverage is provided under this agreement, it begins on the date the proposed insured / annuitant completes the Declaration of Insurability and signs and dates the application, or the date any additional exams and tests required by the underwriting guidelines or policies of Thrivent are completed, or on the date the premium has been paid, if later.

When Coverage Ends

If coverage is provided under this agreement, it ends at the earliest of the following dates:

1. The effective date of the certificate applied for.
2. The effective date of the certificate issued by Thrivent, if Thrivent offers to issue a certificate different than the one applied for, and you accept Thrivent's offer. (Does not apply to annuity.)
3. The date you reject Thrivent's offer, if Thrivent offers to issue a certificate different than the one applied for.
4. The date Thrivent notifies you that your application is retired or denied.
5. The date which is sixty days from the date the proposed insured / annuitant completes the Declaration of Insurability and signs and dates the application, or the date the initial premium is refunded.

There is no coverage under this conditional agreement for the proposed insured / annuitant for:

1. Accidental death benefits if death results from operating or descending from an aircraft.
2. Death or other loss incurred as a result of suicide or attempted suicide or intentionally self-inflicted injury.
3. Any condition, body area, or avocation that would be excluded by endorsement under Thrivent's underwriting rules, guidelines, or policies or excluded or limited under provisions of the certificate applied for.

Premium Paid

Any premium paid with the application will be handled in the following manner:

1. If you accept a certificate as issued by Thrivent, it will be applied toward the premium due.
2. If an additional premium is required, and a claim occurs before it is paid, this premium will be subtracted from the insurance benefit payable. (Does not apply to annuity.)
3. If temporary coverage ends, and no other coverage is issued and accepted, the premium is refunded to you.

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.

Privacy of Your Information

Important choices for consumers

Protecting the privacy of your data is a responsibility we take very seriously. We understand your data is personal, and it is important that we keep it confidential. The practices and procedures we have in place to protect your data are rigorous and thorough.

This notice describes Thrivent's privacy policy for 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. It also explains the types of data about you that we collect and disclose, with whom that data may be shared, and how we protect your data.

After you read this notice, if you decide that our practices and procedures meet your expectations, there is nothing you need to do. If you do not want data about you shared as outlined, you may tell us your data-sharing choices, as described in this notice. Once you tell us your choice, we will honor it until you change it.

Security of data about you

We have strict security standards to safeguard your personal data, including physical, electronic and procedural safeguards. The technology we use to protect your data is reviewed often. Those who use your data must follow established standards, procedures and laws.

Data collected

Having correct data about you permits us to provide better customer service, increase the efficiency of our operations, and comply with legal and regulatory requirements. The data we collect about you varies by the products, services or benefits you request, and may include data:

- We receive from you on applications or other forms, such as name, address, Social Security number, birth date, assets and income.
- We receive from consumer-reporting agencies, such as credit history.
- Obtained from churches or Thrivent Member Networks, such as church name and volunteer activities.
- About your transactions and experience with us, such as products or services purchased, your contract values, and payment history.
- From outside sources relating to their relationship with you or that verifies representations made by you. This includes your employment history, other insurance coverage and medical or public records.
- That's general in nature, such as email addresss and demographic data.

Data sharing within our organization

We may share the data we have about you within our family of businesses.* We only share information about your health as permitted by law. For example, we share your health information to process claims and underwrite your application for insurance. Sharing your data allows us to:

- Provide you with better customer service.
- Help you make decisions about your products and benefits.
- Inform you of products, services and benefits that may be of interest to you.

Federal law gives you the right to limit some, but not all, marketing from our subsidiaries. Federal law also requires us to give you this notice to tell you about your choice to limit marketing from our subsidiaries.

Sharing data outside our organization

We do not share data about you with other organizations, except as permitted by law. For example, we are permitted to share data about you to:

- Help us underwrite your insurance or open your account.
- Process transactions and administer your claims.
- Organizations that act for us or on our behalf or provide services for us.
- Detect fraud and other criminal activity.
- Comply with an inquiry by a government agency or regulator.
- Assist us in providing benefits to you as part of your membership.

We may share data that identifies you (such as name, address, telephone number, age and gender) and your fraternal relationship data (such as Thrivent Member Network number) with organizations that perform marketing services on our behalf, and other financial institutions with which we have joint marketing agreements. In all states except California, Massachusetts, Minnesota, New Mexico, North Dakota and Vermont, we also may share data that identifies you, as described above, with nonprofit Christian organizations, such as churches and schools, or partner organizations.

Transmission of data to other countries

Your personal information is processed in the United States, where privacy laws may be less stringent than the laws in your country and where the government, courts or law enforcement may be able to access your information. By submitting your personal information to us you agree to the transfer, storage and processing of your information in the United States.

Accuracy of your data

Our goal is to keep your data accurate and up-to-date. You may request access to and correction of your data by writing to us at the following address:

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

Our treatment of data about former customers

If you no longer have products or services with us, we will not share your data with other organizations, other than as permitted by law. We may still share data about you within our family of businesses.*

Do you reside in the European Union?

If you reside, permanently or temporarily, in the European Union, we may provide you with additional options about your information.

- **Changes to your personal information.** We rely on you to update and correct your personal information. If you identify an error in your information, you can request that we modify it by contacting us using the information in the "Accuracy of your data" section above.
- **Access to your personal information.** If required by law, we will grant reasonable access to personal information we hold about you. All requests must be directed to the address included in the "Accuracy of your data" section above.
- **Revocation of consent or restricting processing.** If you revoke your consent for us to process personal information, or wish to restrict the ways in which we can use it, then we may no longer be able to provide you certain services. In some cases, we may limit or deny your request to revoke consent or restrict use if the law permits or requires us to do so, or if our processing is not based on your consent. If you would like to revoke your consent or restrict our use of information, such a request must be directed to the address included in the "Accuracy of your data" section above.
- **Deletion of your information.** Typically, 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. If required by law, and permitted by our regulators, we will grant a request that we delete your personal information. All such requests must be directed to the address included in the "Accuracy of your data" section above.

Restrict information sharing with others

You may tell us not to share data about you by writing to us at the address included in the "Accuracy of your data" section above or by calling us toll-free at 800-847-4836. We are available to answer calls between the hours of 7 a.m. and 6 p.m. Central time, Monday through Friday. You may also visit our online Preference Center within the Manage My Profile section of MyThrivent on Thrivent.com. Click **"Update communication choices"** and select **"Opt out"** to restrict our information-sharing practices. You may:

- Request that we remove your name from some or all of our internal marketing lists. Our regular service mailings may still contain marketing materials.
- Tell us not to share data about you within our organization.* However, we may still share your name, address and telephone number; your Social Security number (for tax-reporting and identification purposes); the existence of your products, services or benefits; and data about you as needed by our fraternal operations, including branches.
- Direct us not to share data about you with other financial institutions with which we have joint marketing agreements.
- Tell us not to share data about you with nonprofit Christian or partner organizations.

It may take six to eight weeks to make your choice(s) fully effective. If you are a joint-contract owner or a joint-account holder, you may receive this notice on behalf of all joint owners. As a joint-contract owner or joint-account holder, you may choose one or more of the listed options that apply in your home state on behalf of all joint owners or only on your own behalf.

Complaints

Complaints can be sent to us at the address included in the "Accuracy of your data" section above. Some jurisdictions may allow you to complain to a data protection authority as well.

Other privacy-related notices

- Our Privacy of Information About Your Health notice describes the ways in which Thrivent may use and disclose information about your health.
- Our Notice of Insurance Information Practices provides a more detailed explanation of the use of your information in our insurance operations.

To request a paper copy of this notice or any of the notices above, you can write to us at the address included in the "Accuracy of your data" section above.

*Information about you may be shared between Thrivent and the following subsidiaries:

Thrivent Trust Company
Thrivent Investment Management Inc.
Thrivent Advisor Network, LLC
Thrivent Church Loan and Income Fund
Thrivent Asset Management, LLC
Thrivent Mutual Funds
Thrivent Series Fund, Inc.
Newman Financial Services, LLC
Thrivent Cash Management Trust
Thrivent Distributors, LLC
Thrivent Education Funding, LLC
Thrivent Insurance Agency Inc.
Thrivent Financial Investor Services Inc.
Thrivent Core Funds
North Meadows Investment Ltd.

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.

Member ID

Thrivent Financial for Lutherans
4321 N. Ballard Road, Appleton, WI 54919-0001
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Additional Customer 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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Representative's Information for Medicare Supplement

Section 1 - General Information

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

☐ Yes ☐ No 1. Did you personally see the proposed insured and ask each question?
If 'No', explain: ______

☐ Yes ☐ No 2. Did the proposed insured or proposed insured's family contact you for this coverage?

3. List any other health insurance contracts that you sold to the applicant that are still in force.

4. List any other health insurance contracts that you sold to the applicant in the past five years that are no longer in force.

Section 2 - Compensation Split Information

Complete the Split Compensation Request (form 28024) and submit with this form.

Additional Information and Details

Section 3 - Agreements and Signature

I certify that I have confirmed the proposed insured's/annuitant's identity, date of birth, and sex information by:

☐ Verbal confirmation; or

☐ Review of their driver's license or other government-issued documentation (Birth Certificate, Identification Card from the Department of Motor Vehicles, Marriage Certificate, Military Service Record, Naturalization or Passport Records, Death Certificate).

☐ No validation of insured's/annuitant's identity, date of birth, and sex information was required or is on file.

To the best of my knowledge and belief:

- I have verified the Medicare Part B enrollment date with the proposed insured, and the date indicated on the Medicare Supplement Insurance Application is correct.
- I know nothing about the proposed insured's health, habits, or lifestyle affecting insurability which has not been stated in this application.
- **The outline(s) of coverage, required disclosures, the Privacy of Information About Your Health notice, the Privacy of Your Information notice, and Buyer's Guide were left with the proposed insured.**

Signature of representative and date signed	Mail contract to:
X	☐ Representative ☐ Owner If no box is selected, the contract will be mailed to the financial representative for delivery.

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

Representative's Information for Medicare Supplement

Section 1 - General Information

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

☐ Yes ☐ No 1. Did you personally see the proposed insured and ask each question?
If 'No', explain: ____________________

☐ Yes ☐ No 2. Did the proposed insured or proposed insured's family contact you for this coverage?

3. List any other health insurance contracts that you sold to the applicant that are still in force.

4. List any other health insurance contracts that you sold to the applicant in the past five years that are no longer in force.

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Additional Information and Details

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I certify that I have confirmed the proposed insured's/annuitant's identity, date of birth, and sex information by:

☐ Verbal confirmation; or

☐ Review of their driver's license or other government-issued documentation (Birth Certificate, Identification Card from the Department of Motor Vehicles, Marriage Certificate, Military Service Record, Naturalization or Passport Records, Death Certificate).

☐ No validation of insured's/annuitant's identity, date of birth, and sex information was required or is on file.

To the best of my knowledge and belief:

- I have verified the Medicare Part B enrollment date with the proposed insured, and the date indicated on the Medicare Supplement Insurance Application is correct.
- I know nothing about the proposed insured's health, habits, or lifestyle affecting insurability which has not been stated in this application.
- **The outline(s) of coverage, required disclosures, the Privacy of Information About Your Health notice, the Privacy of Your Information notice, and Buyer's Guide were left with the proposed insured.**

Signature of representative and date signed	Mail contract to:
X	☐ Representative ☐ Owner If no box is selected, the contract will be mailed to the financial representative for delivery.

thrivent

Thrivent.com • 800-847-4836

Split Compensation Request

Section 1 - General Information

Name of client (print first, middle, last name, and suffix as applicable)	Application date
Name of writing financial representative (print first and last name)	TS number

Section 2 - Sales Compensation

Type of agreement on file: ☐ None ☐ Blanket ☐ Revenue Sharing

For the **Sales Compensation** on this contract/account:

☐ Do not split **sales** compensation - 100% of the **sale** will be paid to the writing representative

☐ Use existing blanket or revenue sharing **sales** agreement on file

☐ Create new **sales** split or override the blanket or revenue sharing **sales** split on file. Paper applications complete below.

Agent Code and Name	Split %	Agent Code and Name	Split %
	%		%
	%		%
	%		%
	%		%
	%		%

Section 3 - Premium Trail Compensation*

Type of agreement on file: ☐ None ☐ Blanket ☐ Revenue Sharing

***Premium trail split is only used for Life and DI - G Series contracts - LHI Premium Trail Split**

The writing representative must receive the same or greater percentage of the **trail** split as they received of the **sales** split. Exceptions must be requested by email to: BOX Field Revenue

For the **Premium Trail Compensation** on this contract/account:

☐ Do not split the premium based **trail** - 100% of the **trail** compensation will be paid to the assigned representative

☐ Match the premium based **trail** to the **sales** split

☐ Use existing blanket or revenue sharing premium based **trail** on file

☐ Create a new premium based **trail** or override the blanket or revenue share **trail** split on file. Paper application complete below.

Agent Code and Name	Split %	Agent Code and Name	Split %
	%		%
	%		%
	%		%
	%		%
	%		%

Premium trail splits will stay in effect for five years from the date of application. To override the default, please provide an end date. Enter 12/31/9999 for open ended splits _____________ .

Section 4 - Asset Based Trail Compensation*

Type of agreement on file: ☐ None ☐ Blanket ☐ Revenue Sharing

***Asset based trail split includes: LHIAUM Incentive, Variable Deferred Annuity Trails, Fixed Indexed Annuity Trails with or without GLWB, and FPDA and DISO Trails.**

The writing representative must receive the same or greater percentage of the **trail** split as they received of the **sales** split. Exceptions must be requested by email to: BOX Field Revenue

For the **Asset Based Trail Compensation** on this contract/account:

☐ Do not split the asset based **trail** - 100% of the **trail** compensation will be paid to the assigned representative

☐ Match the asset based **trail** to the **sales** split

☐ Use existing blanket or revenue sharing asset based **trail** on file

☐ Match the asset based **trail** to the premium based **trail** split. (only used for UL, VUL, and Whole Life contracts)

☐ Create a new asset based **trail** split or override the blanket or revenue sharing agreement on file. Paper applications complete below.

Agent Code and Name	Split %	Agent Code and Name	Split %
	%		%
	%		%
	%		%
	%		%
	%		%

Asset based trail splits will stay in effect for five years from the date of application. To override the default, please provide an end date. Enter 12/31/9999 for open ended splits ______________ .

Section 5 - Health Service Compensation

Type of agreement on file: ☐ None ☐ Blanket ☐ Revenue Sharing

For the **Health Service Compensation** on this contract/account:

☐ Do not split the **health service** commission - 100% of the **health service** compensation will be paid to the assigned representative

☐ Use existing blanket or revenue sharing **health service** split on file

☐ Match the **health service** split to the **sales** split

☐ Create a new **health service** split or override the blanket or revenue sharing agreement on file. Paper applications complete below.

Agent Code and Name	Split %	Agent Code and Name	Split %
	%		%
	%		%
	%		%
	%		%
	%		%

Health service contract splits will stay in effect indefinitely. To override these defaults please provide an end date ____________ .

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

Statement of Good Health

Application/Contract number	Date of application
Name of proposed insured (print title, first, middle, last name and suffix, as applicable)	
Name of other proposed insured (print title, first, middle, last name and suffix, as applicable)	
Name of proposed insured child(ren)	Name of proposed insured child(ren)
Name of proposed insured child(ren)	Name of proposed insured child(ren)
Name of proposed insured child(ren)	Name of proposed insured child(ren)

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/other proposed insured/insured child(ren) have not:

- Consulted or been advised to consult a physician, or other member of the medical profession, chiropractor, counselor or any other health care provider for any reason.
- Been medically treated or evaluated at a hospital, clinic or other facility or been medically advised to have any treatment, test, surgery, biopsy, hospitalization.
- Received or been advised to utilize nursing home care or home health care or been unable to care for himself/herself without the help or supervision of another person.
- Been advised by a physician, chiropractor or medical therapist 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 aviation activities, motorcycle racing, mountain climbing, powerboat racing, hang gliding, auto racing, ballooning, sky diving or skin/scuba diving
  - 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. Include the full name and address of any doctors.

Name of proposed insured/other proposed insured/child

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

Name of proposed insured/other proposed insured/child

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

Name of proposed insured/other proposed insured/child

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

Name of proposed insured/other proposed insured/child

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 (age 16 or over) and date signed (mm/dd/yyyy)

Signature of parent or guardian (if insured is age 0-15) and date signed (mm/dd/yyyy)

Signature of other proposed insured and date signed (mm/dd/yyyy)

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