thrivent

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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

Application For: Medicare Supplement Coverage

Thrivent Financial for Lutherans

Home Office
4321 N. Ballard Road, Appleton, WI 54919-0001
Toll-free 844-221-7813

Service Center
PO Box 14008
Clearwater, FL 33766-4008

Writing Agent Name	Writing Agent #

Applicant acknowledges and agrees that if there is more than one applicant on this application, all information provided will be viewed or shared with the other applicant.

SECTION 1. PLAN & PREMIUM PAYMENT INFORMATION - TO BE COMPLETED BY PRODUCER

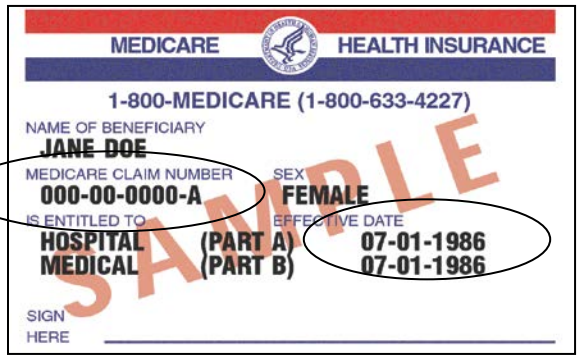
NOTE: If more than 1 applicant, complete Applicant B sections.

Applicant A	**Applicant B**
Medicare Supplement Plan Applied for: ☐ Plan A ☐ Plan C ☐ Plan F ☐ Plan G ☐ Plan N	Medicare Supplement Plan Applied for: ☐ Plan A ☐ Plan C ☐ Plan F ☐ Plan G ☐ Plan N
Requested Effective Date _____/_____/_____ mo / day / yr	Requested Effective Date _____/_____/_____ mo / day / yr
Mail Contract To: ☐ Insured ☐ Agent	Mail Contract To: ☐ Insured ☐ Agent
Calculated Premium (include contract fee; HHD) $ _____ - $ _____ + $ _____= $ _____ premium HHD contract fee total	Calculated Premium (include contract fee; HHD) $ _____ - $ _____ + $ _____= $ _____ premium HHD contract fee total
Select Premium Payment Option: ☐ ACH Annual ☐ Annual direct ☐ ACH Semi-annual ☐ Semi-annual direct ☐ ACH Quarterly ☐ Quarterly direct ☐ ACH Monthly (direct monthly is not available)	Select Premium Payment Option: ☐ ACH Annual ☐ Annual direct ☐ ACH Semi-annual ☐ Semi-annual direct ☐ ACH Quarterly ☐ Quarterly direct ☐ ACH Monthly (direct monthly is not available)

SECTION 2. APPLICANT INFORMATION – PLEASE ANSWER ALL QUESTIONS COMPLETELY

Applicant A	**Applicant B**
Name (First/Middle/Last) should match Medicare health ins. card.	Name (First/Middle/Last) should match Medicare health ins. card.
Physical Address	Physical Address
City	City
State ZIP _____+_____	State ZIP _____+_____
Mailing Address (if different from physical address)	Mailing Address (if different from physical address)
City	City
State ZIP _____+_____	State ZIP _____+_____

SECTION 2. APPLICANT INFORMATION, CONTINUED – PLEASE ANSWER ALL QUESTIONS COMPLETELY	
Home Phone No. (_____) _____-_____ (area code)	Home Phone No. (_____) _____-_____ (area code)
Best Time to Contact:	Best Time to Contact:
Current Age_____ Date of Birth_____/_____/_____ mo / day / yr	Current Age_____ Date of Birth_____/_____/_____ mo / day / yr
☐ Male ☐ Female State of Birth _____	☐ Male ☐ Female State of Birth _____
Social Security No. _____-_____-_____	Social Security No. _____-_____-_____
Please reference your Medicare Card to complete this section.	



Applicant A	Applicant B	
Medicare Health Insurance Card Claim Number (if known)	Medicare Health Insurance Card Claim Number (if known)	
E-mail Address	E-mail Address	
Have you received a copy of the **Guide to Health Insurance for People with Medicare** and the **Outline of Coverage?**.....	**Applicant A** ☐ Yes ☐ No	**Applicant B** ☐ Yes ☐ No
To the Best of your Knowledge:		
1. Did you turn age 65 in the last 6 months?.....	☐ Yes ☐ No	☐ Yes ☐ No
2. Did you enroll in Medicare Part B in the last 6 months?...	☐ Yes ☐ No	☐ Yes ☐ No
Please complete the following:		
Medicare Part A Effective Date:……	____/____/_____	____/____/_____
Medicare Part B Effective Date:……	____/____/_____	____/____/_____

SECTION 3: HOUSEHOLD PREMIUM DISCOUNT INFORMATION.		
You may be eligible for a contract with a lower premium rate based on your answers to the questions in this section. 1. Do you currently reside with at least one, but no more than three, individual(s) (1) with whom you have continuously resided for the past year or who is your legal spouse, including validly recognized civil union and domestic partners, and (2) at least one of whom owns or is being issued a Medicare supplement contract from us? 2. If you answered "YES" to Question 1 above, please fill out the following information about the household resident, except if both applicants are applying for coverage on this application.	**Applicant** ☐ Yes ☐ No	**Applicant B** ☐ Yes ☐ No
Name (First/Middle/Last)		
Street Address		
City/State/Zip		
Name (First/Middle/Last)		
Street Address		
City/State/Zip		
Name (First/Middle/Last)		
Street Address		
City/State/Zip		

Application For: Medicare Supplement Coverage

SECTION 4. FOR YOUR PROTECTION, the National Association of Insurance Commissioners requests that we ask the following questions about insurance policies or certificates you may have.

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 policy or certificate, or that you had certain rights to buy such a policy or certificate, 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. Please mark "YES" or "NO" with an "X" to the questions below.

To the Best of Your Knowledge:	**Applicant A**	**Applicant B**
1. Are you applying during a guaranteed issue period? ..... **(NOTE: If the answer above is "YES," please attach proof of eligibility.)**	☐ Yes ☐ No	☐ Yes ☐ No
2. Do you have another Medicare Supplement or Medicare Select insurance policy or certificate in force?	☐ Yes ☐ No	☐ Yes ☐ No
(a) If "YES," with what company, and what plan do you have?		

Applicant A	**Applicant B**
Name of Company	Name of Company
Plan	Plan
Effective Date ____/____/_____	Effective Date ____/____/_____

	Applicant A	**Applicant B**
(b) If "YES," do you intend to replace your current Medicare Supplement policy/certificate with this policy?.....	☐ Yes ☐ No	☐ Yes ☐ No
(c) If "YES," indicate termination date.....	____/____/_____	____/____/_____
(d) If "YES," have you received a copy of the replacement notice?	☐ Yes ☐ No	☐ Yes ☐ No
(e) NOT INCLUDING Medicare Supplement, have you had before or do you now have any other Medicare plan coverage as referenced below? …..... If you answer "NO" skip to question #4 below. If you answer "YES," please complete questions 3 (a-g) below.	☐ Yes ☐ No	☐ Yes ☐ No
3. If 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), fill in your start and end dates. If you are still covered under this plan, leave "END" blank…….	Start ____/____/_____ End ____/____/_____	Start ____/____/_____ End ____/____/_____
(a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?.....	☐ Yes ☐ No	☐ Yes ☐ No
(b) If "YES," have you received a copy of the replacement notice?.....	☐ Yes ☐ No	☐ Yes ☐ No
(c) Reason for termination/disenrollment?	_____ Applicant A	_____ Applicant B
(d) Planned date of termination/disenrollment?	____/____/_____ Applicant A	____/____/_____ Applicant B

Application For: Medicare Supplement Coverage

SECTION 4. FOR YOUR PROTECTION, the National Association of Insurance Commissioners requests that we ask the following questions about insurance policies or certificates you may have, CONTINUED

	Applicant A	Applicant B
(e) Was this your first time in this type of Medicare plan?.....	☐ Yes ☐ No	☐ Yes ☐ No
(f) Did you drop a Medicare Supplement or Medicare select policy/certificate to enroll in this Medicare plan? .... If "YES,"	☐ Yes ☐ No	☐ Yes ☐ No
(g) Is your former Medicare Supplement plan or Medicare select policy/certificate still available?.....	☐ Yes ☐ No	☐ Yes ☐ No
4. Have you had coverage under any other health insurance within the past 63 days?	☐ Yes ☐ No	☐ Yes ☐ No
(For example, an employer, union, or individual non-Medicare Supplement plan) (a) If "YES," with what company and what kind of policy/certificate? (List below.)		

Applicant A		Applicant B	
Name of Company	Kind of Policy/Certificate	Name of Company	Kind of Policy/Certificate

	Applicant A	Applicant B
(b) What are your dates of coverage under the other policy/ certificate? If you are still covered under this plan, leave "END" blank. (c) Reason for termination/disenrollment? _____/_____ **Applicant A** **Applicant B**	Start ____/____/_____ End ____/____/_____	Start ____/____/_____ End ____/____/_____
(d) Planned date of termination/disenrollment?	____/____/_____	____/____/_____
5. Are you covered for medical assistance through the state Medicaid program?..... (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question.) If "YES",	☐ Yes ☐ No	☐ Yes ☐ No
(a) Will Medicaid pay your premiums for this Medicare Supplement policy?.....	☐ Yes ☐ No	☐ Yes ☐ No
(b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium?.....	☐ Yes ☐ No	☐ Yes ☐ No
6. Producers shall list any other health insurance policies/certificates they have sold to the applicant. (a) List policies/certificates sold which are still in force.		

Applicant A	Applicant B
Name of Company	Name of Company
Description of Benefits	Description of Benefits
Effective Date of Coverage / /	Effective Date of Coverage / /

(b) List policies/certificates sold in the past five (5) years which are no longer in force.

Applicant A	Applicant B

Application For: Medicare Supplement Coverage

Are you applying during Open Enrollment or a Guaranteed Issue period? If yes, SKIP TO SECTION 7.

SECTION 5. HEALTH QUESTIONS

	Applicant A	Applicant B
Are you applying for coverage because you have been diagnosed or treated for End Stage Renal Disease (ESRD) or Kidney Disease requiring dialysis?.....	☐ Yes ☐ No	☐ Yes ☐ No

Applicant A	Applicant B
Have you used tobacco in any form in the past 12 months?..... ☐ Yes ☐ No	Have you used tobacco in any form in the past 12 months?..... ☐ Yes ☐ No
Height: ___ Ft _____ In Weight: _____ Lbs	Height: ___ Ft _____ In Weight: _____ Lbs

- **If either Applicant A or Applicant B answer "YES" to any of the following questions 1-14, that person is not eligible for Medicare Supplement Coverage.**

	Applicant A	Applicant B
1. Are you currently hospitalized, confined to a nursing facility, receiving hospice or home health care; or, are you bedridden or confined to a wheelchair?.....	☐ Yes ☐ No	☐ Yes ☐ No
2. Have you been diagnosed with emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders?	☐ Yes ☐ No	☐ Yes ☐ No
3. Have you been diagnosed with Parkinson's Disease, Systemic Lupus, Myasthenia Gravis, Multiple or Lateral Sclerosis, Osteoporosis with fractures, Cirrhosis or kidney disease requiring dialysis?.....	☐ Yes ☐ No	☐ Yes ☐ No
4. Have you been diagnosed with Alzheimer's Disease, Senile Dementia, or any other cognitive disorder?.....	☐ Yes ☐ No	☐ Yes ☐ No
5. Have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or the Human Immunodeficiency Virus (HIV)?.....	☐ Yes ☐ No	☐ Yes ☐ No
6. Within the past two years have you been treated for or been advised by a physician to have treatment for alcoholism or drug abuse, mental or nervous disorder requiring psychiatric care or have you had any amputation caused by disease?.....	☐ Yes ☐ No	☐ Yes ☐ No
7. Within the past two years have you been treated for or been advised by a physician to have treatment for internal cancer?.....	☐ Yes ☐ No	☐ Yes ☐ No
8. Within the past two years have you been treated for or been advised by a physician to have treatment for heart attack, heart, coronary or carotid artery disease (not including high blood pressure), peripheral vascular disease, congestive heart failure or enlarged heart, stroke, transient ischemic attacks (TIA) or heart rhythm disorders?.....	☐ Yes ☐ No	☐ Yes ☐ No
9. Within the past two years have you been treated for degenerative bone disease, crippling/disabling or rheumatoid arthritis or have you been advised to have a joint replacement?	☐ Yes ☐ No	☐ Yes ☐ No
10. Have you been advised by a physician that surgery may be required within the next 12 months for cataracts?.....	☐ Yes ☐ No	☐ Yes ☐ No
11. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed?.....	☐ Yes ☐ No	☐ Yes ☐ No
12. Have you been hospital confined three or more times in the last two years?.....	☐ Yes ☐ No	☐ Yes ☐ No
13. Have you had an organ transplant or been advised by a physician to have an organ transplant?.....	☐ Yes ☐ No	☐ Yes ☐ No
14. Do you have diabetes that requires insulin?.....	☐ Yes ☐ No	☐ Yes ☐ No

SECTION 5. HEALTH QUESTIONS, CONTINUED		
15. Do you have diabetes that is treated by medication or by diet? If yes, as a result of your diabetes do you have;	☐ Yes ☐ No	☐ Yes ☐ No
A. Numbness in your hands, feet or legs?	☐ Yes ☐ No	☐ Yes ☐ No
B. Eye disorder?	☐ Yes ☐ No	☐ Yes ☐ No
C. Kidney problems?	☐ Yes ☐ No	☐ Yes ☐ No
D. Skin ulcers or had an amputation?	☐ Yes ☐ No	☐ Yes ☐ No
E. Circulatory or peripheral vascular disease? .... (If applicant answers "YES" to any of questions A-E then applicant is not eligible for coverage.)	☐ Yes ☐ No	☐ Yes ☐ No

To the best of your knowledge, within the past two (2) years have you had any medical advice, including referrals to other physicians for diagnostic test(s) and surgery or treatment from a member of the medical profession, for any other condition not listed in section 5?

Applicant A ☐ Yes ☐ No (please attach a separate sheet if needed)		**Applicant B** ☐ Yes ☐ No (please attach a separate sheet if needed)
	Specific Condition	
	Type of Treatment	
Begin: ____/____/______ End: ____/____/______ (leave blank if current)	Dates of Diagnosis	Begin: ____/____/______ End: ____/____/______ (leave blank if current)
	Specific Condition	
	Type of Treatment	
Begin: ____/____/______ End: ____/____/______ (leave blank if current)	Dates of Diagnosis	Begin: ____/____/______ End: ____/____/______ (leave blank if current)
	Specific Condition	
	Type of Treatment	
Begin: ____/____/______ End: ____/____/______ (leave blank if current)	Dates of Diagnosis	Begin: ____/____/______ End: ____/____/______ (leave blank if current)
	Specific Condition	
	Type of Treatment	
Begin: ____/____/______ End: ____/____/______ (leave blank if current)	Dates of Diagnosis	Begin: ____/____/______ End: ____/____/______ (leave blank if current)

Application For: Medicare Supplement Coverage

SECTION 6. MEDICATION INFORMATION		
1. Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? If "YES," please list the drug and the condition in the following table.		
Applicant A ☐ Yes ☐ No (please attach a separate sheet if needed)		**Applicant B** ☐ Yes ☐ No (please attach a separate sheet if needed)
	Medication Name (as shown on label)	
___/___/_____	Date **Originally** Prescribed	___/___/_____
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (as shown on label)	
___/___/_____	Date **Originally** Prescribed	___/___/_____
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (as shown on label)	
___/___/_____	Date **Originally** Prescribed	___/___/_____
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (as shown on label)	
___/___/_____	Date **Originally** Prescribed	___/___/_____
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (as shown on label)	
___/___/_____	Date **Originally** Prescribed	___/___/_____
	Frequency and Dosage	
	Diagnosis/Condition	

Application For: Medicare Supplement Coverage

SECTION 7. METHOD OF PAYMENT – PLEASE COMPLETE ALL QUESTIONS

IMPORTANT: When choosing to pay initial premium by Automated Bank Account Withdrawal,

THE FIRST PREMIUM WILL BE WITHDRAWN FROM YOUR ACCOUNT IMMEDIATELY

WHEN YOUR CONTRACT IS ISSUED.

The first withdrawal date may be different from the monthly date selected for renewal premiums. Subsequent premiums will be withdrawn approximately thirty (30) days from the effective date of coverage or on the date specified on this application.

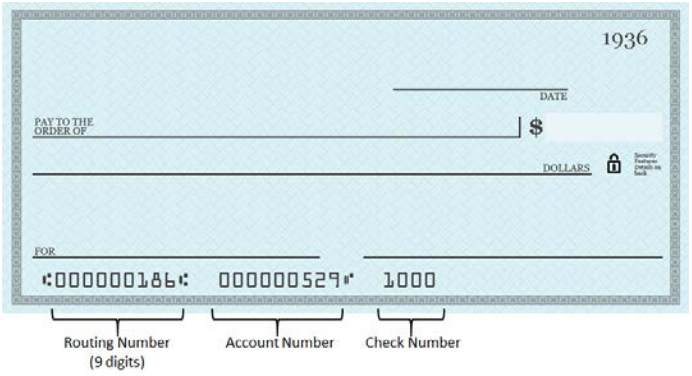
I authorize Thrivent Financial for Lutherans to withdraw funds from my account for my initial and/or monthly renewal premiums and understand that the amounts may differ. I understand my rights and responsibilities with each electronic payment will be the same as if personally paid by me. I understand this authorization will be effective until I give at least three business days' notice to cancel to Thrivent Financial. If notice is given verbally, I understand Thrivent Financial may require written confirmation from me within 14 days after my verbal notice.

I authorize Thrivent Financial to make my automatic monthly withdrawal from my (check one below) on the _____ day (must be between the 1st and 28th) of the month:

Checking ☐
Please attach a voided check

Savings ☐
Please ask your financial institution to verify that this EFT will be accepted and that the information below is correct.

- Payments cannot be postponed from the date selected.
- Payment from a third party, including any foundation, will not be accepted.
- All refunds will be made to the applicant in the event of rejection, incomplete submission, overpayment, cancellation, etc.



Financial Institution Name: Phone #:

Financial Institution Address:

Routing # (from left side of check)	Account # (from right side of check)
_____	_____
X_____ Authorized Signature as Shown on Account _____/_____/_____ Date	X_____ Authorized Signature as Shown on Account _____/_____/_____ Date

Application For: Medicare Supplement Coverage

SECTION 7. AUTHORIZATION AND ACKNOWLEDGEMENT

IMPORTANT STATEMENTS TO BE READ BY APPLICANT

- You do not need more than one Medicare Supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
- If, after purchasing the policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted, if requested, within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for and have enrolled in a Medicare Supplement policy 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 policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted, if requested, within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

I authorize Thrivent Financial for Lutherans, its third party administrator or its reinsurers for the purpose of evaluating this application for insurance to acquire, review, research the release of information from any of the following: Hospital; Physician; Medical Practitioner; Clinic; Pharmacy; Pharmacy Benefits Manager or other pharmacy-related services organization; Health Plan; other medical or medically related facilities; Government Agency; MIB, Inc.; Consumer Reporting Agency; Thrivent Financial for Lutherans own records; and I authorize any of the foregoing parties that have any records or knowledge of me or my protected health information to give to Thrivent Financial for Lutherans or its reinsurers, any such information. Thrivent Financial for Lutherans will acquire through a personal phone interview or another means from the above any needed information on the Insured, his/her dependents including but not limited to copies of records, concerning advice, care or treatment, on past or present health, the use of drugs or alcohol, and information relating to mental illness. I also authorize Thrivent Financial for Lutherans or its reinsurers to disclose all such information to any doctor, the MIB, Inc. or any other insurance company in order to evaluate a claim or an application for insurance. I authorize Thrivent Financial for Lutherans, or its reinsurers to make a brief report of my protected health information to MIB, Inc. Federal and state laws protect the information disclosed pursuant to this authorization. I understand that any disclosure of information carries with it the potential for any unauthorized re-disclosure and the information may not be protected by the federal confidentiality rules. I understand this consent may be revoked in writing at any time, with the exception to the extent that disclosure of information has already occurred prior to the receipt of revocation by the above named provider. If written revocation is not received, authorization will be considered valid for a period of two years from the date of signing. A photocopy of this authorization will be as valid as the original. A copy of the authorization is available to you or your representative upon request to Thrivent Financial for Lutherans. Failure to sign this authorization may impair the ability of Thrivent Financial for Lutherans to evaluate or process this application and may be a basis for denying this application. 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 understand that the application which holds personally identifiable information and financial information will be attached to the contract for purposes of contract issuance. I understand that personally identifiable health and financial information on the application will be provided to the other applicant.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

To the best of my knowledge and belief, I wish to apply for a Medicare Supplement insurance contract. I represent that my answers and statements on this application are true and complete. I understand that, (a) upon acceptance of the completed application, each applicant will receive a separate contract; (b) my contract benefits can start no earlier than my Medicare effective date, my first month's premium has been received and/or processed and my application has been approved by Thrivent Financial for Lutherans.

Dated at _____ , on _____/_____/_____ _____
City State mo / day / yr **Applicant A's Signature**

Dated at _____ , on _____/_____/_____ _____
City State mo / day / yr **Applicant B's Signature**

Application For: Medicare Supplement Coverage

SECTION 7. AUTHORIZATION AND ACKNOWLEDGEMENT, CONTINUED

Premium payment information must accompany application.
I certify that during an interview with the proposed applicant, I/we have truly and accurately recorded in the application the information supplied by the applicant.

_____
PRODUCER NUMBER

X_____ _____
(Signature of Licensed Producer) Date

SECTION 8. FOR ADDITIONAL COMMENTS

Applicant A (please attach a separate sheet if needed)	**Applicant B** (please attach a separate sheet if needed)

THRIVENT FINANCIAL®
Thrivent Financial for Lutherans
4321 N. Ballard Road, Appleton, WI 54919-0001

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

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

According to your application and information you have furnished, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a contract to be issued by Thrivent Financial for Lutherans. Your new contract will provide thirty (30) days within which you may decide without cost whether you desire to keep the contract.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this contract.

Statement to Applicant by Thrivent Representative:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement contract will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement contract is being purchased for the following reason (check one):

- ☐ Additional benefits.
- ☐ No change in benefits, but lower premiums.
- ☐ Fewer benefits and lower premiums.
- ☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- ☐ Disenrollment from a Medicare Advantage plan. Explain reason 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 (or coverage) 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 all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your 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 you are in a guaranteed issue time period, this paragraph does not apply.)

Do not cancel your present contract 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

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 _____

thrivent®

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.

thrivent®

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.

THRIVENT FINANCIAL®

Administrative Office: P.O. Box 14008 Clearwater, FL 33766-4008

PRODUCER CERTIFICATION

I the undersigned insurance producer certify:

THAT I have taken an application for:

Applicant:
Medicare Supplement
- ☐ Plan A
- ☐ Plan F
- ☐ Plan G
- ☐ Plan N

Applicant B:
Medicare Supplement
- ☐ Plan A
- ☐ Plan F
- ☐ Plan G
- ☐ Plan N

Offered by **Thrivent Financial**,

to _____
(Applicant(s)),

THAT I have explained the provisions of the contract being applied for, including specifically, all the different benefits, exceptions and limitations of the plan.

THAT I have asked each question on the application and accurately recorded the applicant's response.

THAT I have clearly explained any benefits of this plan are a supplement to any benefits that the applicant may be entitled to receive from the Medicare Program of the Federal Government.

THAT I have not made any representation to the applicant that there is any endorsement whatsoever by the Social Security Administration or the Centers for Medicare and Medicaid Services in connection with this insurance contract being applied for.

_____ Date

_____ Signature of Producer

I, the undersigned applicant, understand that I will receive a copy of this form when my contract is issued and delivered to me.

_____ Name of Agency

_____ Signature of Applicant

_____ Address of Producer or Agency

_____ Signature of Applicant B, if applying

_____ Phone Number

TF-CERT **RETURN TO COMPANY**