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

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Thrivent Financial for Lutherans
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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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Thrivent Financial for Lutherans
4321 N. Ballard Road, Appleton, WI 54919-0001
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Application for Individual Life Insurance

1. Proposed Insured

Name _____

Primary residential address _____

City _____ State _____ ZIP code _____

Email _____ Phone _____

State of birth/country if not US _____ Sex ☐ Male ☐ Female

Date of birth _____ Social Security number _____

Drivers license state _____ Drivers license number _____

Current occupation _____

Earned income $ _____ Other income $ _____ Source of other income _____

Net worth $ _____ Total existing life insurance $ _____

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

2. Ownership

Will you be the sole owner of this new policy? ☐ Yes ☐ No

If yes and age 15 or under, complete Proposed Applicant Controller section.
If yes and age 16 or over, skip to section 3.
If no, complete reason for third party ownership, type of owner and Third Party Owner Supplement form.

Reason for third party ownership _____

Type of owner ☐ Individual(s)
☐ Trust - The trust must be for the benefit, direct or indirect, of the member, member's family or dependent(s).
☐ Business

Proposed Applicant Controller

Name _____

Date of birth _____ Sex ☐ Male ☐ Female

What is your relationship to the proposed insured? _____

Is the proposed insured a member of your household? ☐ Yes ☐ No

Is the proposed insured dependent upon you for support? ☐ Yes ☐ No

3. Military Service

Are you a member or have you entered into a written agreement to become a member of the military? This includes, but is not limited to, Reserve and National Guard. ☐ Yes ☐ No *If yes, complete Military Personnel Disclosure form.*

4. Replacement

Do you have any existing life insurance policies or annuity contracts with Thrivent or any other insurance companies? ☐ Yes ☐ No

Is the contract intended to replace any part of, or all of, an existing life insurance policy or annuity contract? ☐ Yes ☐ No

If yes is answered to either question, review replacement form requirements.

5. New Business Product and Benefit/Rider Information

Face amount $ _____

Target amount $ _____ *(available on Whole Life Plus and Survivor Whole Life)*

Are you purchasing this insurance as a result of a Term Conversion? ☐ Yes ☐ No Contract number _____ Amount $ _____

Are you purchasing this insurance to exercise a Guaranteed Increase Option/Guaranteed Purchase Option (GIO/GPO)? ☐ Yes ☐ No *If yes,* ☐ Regular ☐ Alternate Contract number _____ Amount of GPO $ _____

Term Product:

Term length ☐ 10 year ☐ 15 year ☐ 20 year ☐ 30 year

Extended Term Conversion Option ☐ Yes ☐ No

Disability Waiver of Premium ☐ Yes ☐ No

Whole Life Product:

☐ 10 years ☐ To age 70 ☐ Single Premium Whole Life ☐ Survivor Whole Life

☐ 20 years ☐ To age 95 ☐ Whole Life Plus

Disability Waiver of Premium ☐ Yes ☐ No

Disability Waiver of Premium for Other Proposed Insured *(Survivor Whole Life only)* ☐ Yes ☐ No

Guaranteed Purchase Option ☐ Yes ☐ No *If yes,* Amount $ _____

Paid-Up Additions Rider ☐ Yes ☐ No *If yes,* Amount $ _____

Universal/Variable Universal Life Product:

☐ Accumulation Universal Life ☐ Protection Universal Life ☐ Accumulation Variable Universal Life

Death Benefit Option ☐ Option 1 ☐ Option 2

Disability Waiver of Monthly Deductions ☐ Yes ☐ No

Guaranteed Increase Option ☐ Yes ☐ No *If yes,* Amount $ _____

6. Dividend Options

Term Product

☐ Cash

Whole Life Product

☐ Paid in Cash
☐ Buy Paid-Up Additions
☐ Reduce Premium
☐ Accumulate at Interest
☐ Reduce Premium/Buy Paid-Up Additions
☐ Reduce Debt/Buy Paid-Up Additions
☐ Reduce Debt

Whole Life Plus or Survivor Whole Life Product

☐ Adjustable Yearly Term/Paid-Up Additions

☐ Adjustable Yearly Term/Reduce Premium/Paid-Up Additions

I elect the Automatic Premium Loan provision to be in effect ☐ Yes ☐ No
(available on Whole Life Products)

7. Premium Payment Information

Total initial premium submitted with application $ _____

Planned Premium $ _____ (*UL/VUL only*)

New business initial payment ☐ Electronic Bank Withdrawal ☐ Check

Billing type ☐ Electronic Bank Withdrawal ☐ Direct Bill

Frequency ☐ Annual ☐ Monthly (*not available with direct bill*) ☐ No Bill UL/VUL

Additional Premium Option *(WL Plus and Survivor only)* ☐ Yes ☐ No

If yes, APO Amount at issue $ _____

Billed APO Amount $ _____

Complete bank information for electronic bank withdrawal

Full name of bank _____

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

Name of account owner _____ Withdrawal date _____

Address of account owner _____

City _____ State _____ ZIP code _____

Name of joint account owner _____

Address of joint account owner _____

City _____ State _____ ZIP code _____

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

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

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

Signature of bank account owner _____

Date signed _____

8. Designee Election - Optional

I elect to designate the below to receive notice of lapse or termination of this life insurance contract for non payment of premium. I understand the notice will not be given until 30 days after a premium is due and unpaid.

☐ Yes ☐ No

If yes, provide the following:

Name _____

Address _____

City _____ State _____ ZIP code _____

9. Beneficiary Designation

List the full name, relationship to member, date of birth, Social Security number, address and phone number for each beneficiary. If this application is completed electronically, only the beneficiary's name and relationship will display or print on this application. Any additional information collected is stored electronically.

Primary

First Contingent

10. Agreements and Signatures

I understand and agree that:

I have read (or have had read to me) and verified all statements and answers recorded in the Application. They are, to the best of my knowledge and belief, true, complete and correctly recorded.

No representative of Thrivent Financial for Lutherans except the president or secretary can make or alter any contract or waive any of Thrivent's rights or requirements.

No representative of Thrivent Financial for Lutherans has the authority to accept risk or determine insurability for Thrivent Financial for Lutherans.

The date of the Application is the latest date that the representative, proposed insured, and proposed owner, if applicable sign the Application.

If any answers in the Application are incorrect, untrue, or incomplete, Thrivent Financial for Lutherans may have the right to deny benefits, reform the contract, or rescind the contract. I understand that all information must be stated in the Application.

I have received the current Beneficiary Provisions. I understand the provisions and agree to their terms.

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

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

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

In addition, for Variable Universal Life:

- I have received and reviewed the current prospectus for this contract. I understand the provisions of the prospectus and agree to its terms.
- I understand that, under the contract applied for, the amount of the accumulated value may increase or decrease daily based on the investment experience of the variable account and that the amount or duration of the death benefit may vary with the accumulated value.
- With this in mind, the contract applied for is in accord with my investment objectives, anticipated insurance and financial needs.

The signature below applies to all sections and statements made on this Application for Individual Life Insurance.

Signed in the state of _____

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

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

Date signed _____

Signature of proposed applicant
controller for 15 or under _____

Date signed _____

Signature of other proposed insured _____

Date signed _____

Signature of owner _____

Date signed _____

Signature of owner _____

Date signed _____

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

Signature of representative _____

Date signed _____

Print name _____ ID number _____

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4321 N. Ballard Road, Appleton, WI 54919-0001
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Conditional Temporary Life Insurance Agreement and Receipt for Payment

Make all checks payable to Thrivent.

1. Proposed Insured (s)

Name _____

Name _____

Amount received $ _____ Date received _____

No representative or agent acting on our behalf is authorized to change or waive any terms of this agreement or make any promises or representations other than those contained by this agreement.

Signature of representative _____

Date signed _____

Print name _____ ID number _____

2. Requirements for Conditional Insurance

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

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

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

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

*For a Survivor product both proposed insureds must be an insurable risk for the product and amount of insurance applied for or offered by Thrivent if other than applied for.

3. Amount of Conditional Insurance

In no event will coverage exist under both this agreement and the contract.

The amount of insurance provided by this agreement is the **lesser** of 1 and 2 below:

1. The initial death benefit of the life insurance applied for in the application, including any Accidental Death Benefit if the proposed insured's death results solely from accidental causes and coverage is not excluded as stated below.
2. $1,000,000 of life insurance including any Accidental Death Benefit applied for.

Child Rider: For any Child Rider applied for, the amount of insurance coverage payable is based on the child's age at death: birth through 14 days - no benefit; age 15 days to 6 months - 50% of the Child Rider amount; age 6 months and older - Child Rider amount.

4. Exclusions

Coverage is excluded under this agreement for:

1. Any Accidental Death Benefit applied for if death results from operating, descending from or riding in an aircraft being used for private or instructional purposes.
2. Death* as a result of suicide, attempted suicide or intentional self-inflicted injury.
3. Death* as a result of activities excluded by endorsement under our underwriting rules, guidelines or policies or excluded or limited under provisions of the contract applied for.
4. Any payment not honored.

* For a Survivor product this exclusion applies to the death of either proposed insured.

5. Termination of Conditional Insurance

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

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

6. Definitions

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

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Replacement Evaluation

Section 1 - Client Information

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

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

Section 2 - Comparative Information

Replacement occurs when a new life insurance or annuity contract is purchased and an existing life insurance or annuity contract (within four months before or 13 months after the effective date of the new contract) will or may be:

- Lapsed, forfeited, surrendered (full or partial), assigned to the replacing insurer or terminated
- Converted to reduced paid-up insurance, continued as extended term insurance or otherwise reduced in value by the use of nonforfeiture benefits or other contract values
- Amended to reduce benefits or the coverage period
- Reissued with a reduction in cash value
- Used in a "financed purchase" - A financed purchase means the purchase of a new life insurance contract involving the actual or intended use of funds obtained by the withdrawal or surrender of, or by borrowing from, values of an existing life insurance contract to pay all or part of any premium of a new life insurance contract.
- Billing/Premium cancellation or reduction

Name of company being replaced	Existing contract number

	Existing Contract	Proposed Contract
Type of contract		
Date of issue		
Total current death benefit	$	$
Total current value	$	$
Current loan	$	
Rated	☐ Yes ☐ No	
Modified Endowment Contract	☐ Yes ☐ No	☐ Yes ☐ No
Accidental death	$	$
Disability waiver or premium waiver	☐ Yes ☐ No	☐ Yes ☐ No
Guaranteed Purchase Option	$	$
Spousal rider	$	$
Child rider	$	$
Term rider	$	$
Current annualized premium outlay	$	$

Section 3 - Additional Information

All replacement transactions must be suitable for the client. Explain, in detail, **all** of the reasons why this transaction is suitable and why the new product is more advantageous than the existing product.

How will the first-year premium be paid for the proposed contract?

How will subsequent premiums be paid for the proposed contract?

☐ Yes ☐ No Was an in-force illustration for the existing contract reviewed as part of the product suitability analysis?

If no, what alternative source was used to compare the existing contract to the proposed contract?

Federal Tax Bracket

☐ 0 - 12% ☐ 13 - 31% ☐ 32% +

I certify that I understand the following:

- The premium schedule and renewal provisions.
- Premium payments may be required for a longer period of time on the new contract.
- There is no guarantee that future premiums can be paid in full or in part by values from other contracts or from this contract's future cash value or dividends (surplus refunds).
- The new contract may be issued at nonstandard rates.
- New contestability (two years), suicide (up to two years, depending on the state of issue), and convertibility provisions will apply.
- A new surrender charge schedule may apply.
- Once a contract has been replaced, you may not be able to reinstate that contract.
- The transaction may result in a taxable gain.

Taxable Gain - Approximately $ _____ will be reported to the IRS as being taxable in the year the distribution is processed (if nothing will be taxable, enter zero). In certain situations, the tax gain will be greater than estimated above due to previous withdrawals from your contract(s).

Surrender Charges - A $ _____ surrender charge will be levied (if no surrender charges, enter zero).

Section 4 - Acknowledgement and Signatures

I acknowledge that my representative and I reviewed the information on this form and that any questions I had have been answered. I believe replacing my existing contract is in my best interest.

Signature of owner/trustee/authorized person and date signed

X

Signature of owner/trustee/authorized person and date signed

X

Signature of owner/trustee/authorized person and date signed

X

Signature of owner/trustee/authorized person and date signed

X

Signature of owner/trustee/authorized person and date signed

X

Signature of representative/witness and date signed

X

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Military Personnel Financial Services Disclosure Regarding Life Insurance Products (Including Annuities)

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

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

No person may sell, or offer for sale, any life insurance product to any active member of the Armed Forces (or his or her dependents in some states), regardless of the location of the sale, unless this disclosure is provided.

Disclosure

1. Subsidized life insurance is available to members of the Armed Forces from the Federal Government under the Servicemembers' Group Life Insurance ("SGLI") program, under subchapter III of Chapter 19, Title 38, United States Code.
2. SGLI coverage is available in $50,000 increments up to the maximum of $400,000. As of July 1, 2019 SGLI premiums are $.06 per $1,000 of insurance per month, regardless of the member's age. More detailed information (including SGLI family rates, tables indicating the amount of insurance available and monthly premium deduction amounts) can be obtained by contacting Service Members Group Life Insurance at 1-800-419-1473 or at www.insurance.va.gov.
3. The life insurance product being offered to you at this time is not offered or provided by the Federal Government, and the Federal Government has in no way sanctioned, recommended, or encouraged the sale of the life insurance product being offered.
4. No person, other than a licensed life insurance producer, has received any referral fee or incentive compensation in connection with the offer or sale of this life insurance product.
5. As required by state law, your contract will contain a Right to Return or Free Look provision. It is important to review the contract immediately upon receipt. Your contract will provide at least a minimum of a 10-day free look, please refer to your contract for specific length of free look period in your state. If you decide you do not wish to keep your contract, return it to the representative or the Company within the free look period specified and your contract will be void from the beginning. Any payment made will be returned as specified in your contract.
6. You may obtain additional information regarding your state insurance department and how to contact them at this website: http://www.naic.org/state_web_map.htm.

Department of Insurance having Primary Jurisdiction (Representative will complete)

Name of state regulator

Address	City		
	State	ZIP code	Phone

For Life Insurance Only

Policy type applied for:	Death benefit applied for	First year cost
☐ Term Life ☐ Universal Life ☐ Variable Universal Life ☐ Whole Life	$	$

Signatures

Signature of proposed insured/annuitant (age 16 or over) applicant controller (if proposed insured/annuitant is under age 16) and date signed (mm/dd/yyyy)

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

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

Name of financial professional	Code number of financial professional

Send completed form to:
Thrivent
4321 N Ballard Road
Appleton WI 54919-3300

Or fax to: 800-225-2264

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

(This authorization complies with the HIPAA Privacy Rule.)

Name _____

Date of birth _____ Contract number _____

This authorization applies to Thrivent Financial for Lutherans, Thrivent Insurance Agency Inc. and third party administrator LTCG, their employees, representatives, agents, reinsurers and any other persons performing business, legal, medical or insurance services for them or on their behalf, hereafter called "You" or "Your."

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

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

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

I authorize You to disclose information about me, including any DNA or genetic testing analysis results contained within my medical history to any insurance broker and other insurer approved by You for the purpose of securing insurance for me. This includes You disclosing health information I provide to You with the writing agent or agency. Information about my health may be released as required or permitted by law such as to MIB, Inc. to deter fraud, misrepresentation or criminal activity, or to my indicated physician where state law requires notification. Health information about me, which is used or disclosed pursuant to this authorization, may be subject to redisclosure by the recipient, and may no longer be protected under federal law.

This authorization is valid for 24 months following the date of my signature shown below. However, for health insurance benefit claims this authorization is valid for the coverage of the policy, or for all other claims for the duration of the claim. A copy, image or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing as outlined in the Privacy of Information about Your Health notice. I acknowledge that such a revocation is not effective to the extent You have relied on the use or disclosure of my health information or You have a legal right to contest the insurance contract or a claim under the insurance contract.

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

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

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

I have read this authorization, and I agree to its terms as indicated by my signature below.

I am entitled to receive a copy of this authorization.

Signature of proposed insured or personal representative _____

Date signed _____

Description of personal representative's authority to act _____

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4321 N. Ballard Road, Appleton, WI 54919-0001
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Notice and Consent for Blood or Other Body Fluid Testing and Disclosure Which May Include AIDS Virus (HIV) Antibody/Antigen Testing

To determine your insurability, Thrivent may request that you provide a sample of a body fluid for testing and analysis. Any tests requested will be performed by a licensed laboratory.

Tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats), screening for liver or kidney disorders, diabetes, and immune disorders.

Confidentiality

All test results will be treated confidentially. The results of tests will be reported by the laboratory to Thrivent. Results of this test may be used to underwrite all applications, whether or not all applications require the test. When necessary for business reasons in connection with insurance you have or have applied for with Thrivent, Thrivent may disclose test results to others such as its affiliates, reinsurers, employees, or contractors to whom disclosure is reasonably necessary in the ordinary course of business to carry out the purpose for which that disclosure is authorized. Thrivent is a member of MIB, Inc., and if the test results for HIV antibodies/antigens are other than normal, Thrivent will report to MIB, Inc., a generic code which signifies only a nonspecific test abnormality. If your HIV test is normal, no report will be made about it to MIB, Inc. Other test results may be reported to MIB, Inc. in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There may be other disclosure of test results as permitted by law or authorized by you.

Notification of Results

If your HIV test results are normal, no routine notification will be sent to you. If you are a resident of North Dakota and your HIV test is other than normal, Thrivent will disclose test results to the North Dakota Department of Health and Consolidated Laboratories as required by law. If the HIV test results are other than normal, the North Dakota Department of Health and Consolidated Laboratories will contact you.

Significance of Positive Test Results and Affect on Application for Insurance

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test results or other significant blood abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

I have read and I understand this Notice and Consent for Blood or Other Body Fluid Testing and Disclosure Which May Include AIDS Virus (HIV) Antibody/Antigen Testing. I voluntarily consent to the testing of my blood or other body fluids and the disclosure of the test results as described above.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Name of examiner

Address of examiner	City	
	State	ZIP code

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

Date of birth	State of residence	Lab code number

Signature of proposed insured or parent/guardian and date signed

X

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Life Surrender Request

1. Insured Information

Thrivent ID _____ Contract number _____ Email _____

Name _____

2. Surrender Type

a. Value Distribution

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

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

b. Loan

☐ Loan $ _____

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

☐ Dividend/Surplus Refund Release $ _____

☐ Dividend/Surplus Refund Option Change

3. Delivery of Payment

☐ Check

☐ Direct Deposit

Complete bank information for direct deposit

Full name of bank account owner(s) _____

Full name of bank _____

Account type ☐ Checking ☐ Savings

Routing number _____ Account number _____

☐ Apply to another Thrivent contract/account.

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

4. Withholding and Charges

Surrender Charges and Tax Withholding Amount

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

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

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

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

Federal and State Withholding Election

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

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

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

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

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

5. Loan Repayment Information

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

Complete bank information for monthly electronic withdrawal

Full name of bank _____

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

Name of account owner _____ Withdrawal date _____

Address of account owner _____

City _____ State _____ ZIP code _____

Name of joint account owner _____

Address of joint account owner _____

City _____ State _____ ZIP code _____

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

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

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

Signature of bank account owner _____

Date signed _____

Signature of joint bank account owner _____

Date signed _____

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

6. Dividend/Surplus Refund Option Change

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

Select one:

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

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

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

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

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

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

7. Additional Information

8. Validation (see validation requirements in disclosure section)

Medallion Signature Guarantee Seal or Notary Seal

9. Agreements and Signatures

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

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

Signature of owner/controller/assignee _____

Date signed _____

Title _____

Signature of joint owner/controller/assignee _____

Date signed _____

Title _____

Send completed form to:

Thrivent
PO Box 8075
Appleton WI 54912-8075

Fax: 800-225-2264

Disclosures

Surrender Type

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

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

Surrender/decease charges may apply.

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

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

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

Loan Requests

I understand that:

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

Full Surrender

I understand that:

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

Partial Surrender

I understand that:

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

Delivery of Payment

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

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

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

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

Withholding and Charges

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

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

Dividend/Surplus Refund Option Change

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

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

Validation

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

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

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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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Thrivent Financial for Lutherans
4321 N. Ballard Road, Appleton, WI 54919-0001
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Third Party Owner Application Supplement

Section 1 - General Information

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

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

Section 2 - Member Information

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

Relationship of member to proposed insured/annuitant

Section 3 - Proposed Third Party Owner(s)

The first owner named will receive all correspondence for the contract.

Name of owner/business/trust (print first, middle, last name and suffix, as applicable)		Date of birth
Relationship to proposed insured/annuitant	Date of trust	Percentage of common ownership* %

Complete additional names if multiple owners.

Multiple owners shall be: ☐ Joint Tenants ☐ Tenants in Common

Name of owner/business/trust (print first, middle, last name and suffix, as applicable)	Date of birth
Relationship to proposed insured/annuitant	Percentage of common ownership* %
Name of owner/business/trust (print first, middle, last name and suffix, as applicable)	Date of birth
Relationship to proposed insured/annuitant	Percentage of common ownership* %
Name of owner/business/trust (print first, middle, last name and suffix, as applicable)	Date of birth
Relationship to proposed insured/annuitant	Percentage of common ownership* %
Name of owner/business/trust (print first, middle, last name and suffix, as applicable)	Date of birth
Relationship to proposed insured/annuitant	Percentage of common ownership* %

*If you mark the Tenants in Common box and fail to provide percentage of common ownership or the percentages do not total 100%, then each Tenants in Common owner will be deemed to own an equal share. If you mark the Joint Tenants box and provide percentage of common ownership, your ownership will be recorded as Joint Tenants without percentage of ownership.

Section 4 - Agreements and Signatures

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

Signed at state - _____

Signature of owner and date signed

X

Signature of member 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 representative and date signed

X

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Payment Services Request

Thrivent ID	Contract number

Section 1 - General Information

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

Section 2 - Initial and Subsequent Payment Information

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

Rollover/Transfer/Conversion (Annuity only):

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

1035 Exchanges:

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

Other:

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

Section 3 - Billing Frequency/Indexing

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

Bill date - _____ Change billing amount - $ _____

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

Section 4 - Payer Information

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

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

☐ Send the bill for this contract to my employer.

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

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

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

Group account number	Phone	Business phone

Address	City	
	State	ZIP code

Section 5 - Military Allotment

Add to existing military allotment? ☐ Yes ☐ No

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

Payor's Social Security number	Branch of service	Military status

Section 6 - Loan Billing Changes

Add or change the loan billing amount - $ _____

Add or change the loan billing cycle:

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

Section 7 - Special Requests

Section 8 - Signatures

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

X _____

Signature of other proposed insured and date signed

X _____

Signature of applicant controller and date signed

X _____

Signature of owner and date signed

X _____

Signature of owner and date signed

X _____

Signature of owner and date signed

X _____

Signature of owner and date signed

X _____

Signature of owner and date signed

X _____

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

Fax:
800-225-2264

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Thrivent Financial for Lutherans
4321 N. Ballard Road, Appleton, WI 54919-0001
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Declaration of Insurability (Age 16 or Over) Supplement to Application

1. Proposed Insured

Name _____

2. Declaration of Insurability

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

Reason for weight loss if ≥ 10 Lbs _____

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

Type of tobacco/nicotine product	Frequency	Quantity	Date last used

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Name of primary health care provider _____

City _____ State _____ Phone _____

Date of last visit _____ Reason for last visit _____

Treatment _____

Prescribed Medication(s) _____

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

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

_____

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

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

_____

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

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

_____

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

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

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

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

***If yes**, list below*

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

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

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

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

Disease or disorder	Relation to proposed insured	Age of onset

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

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

_____

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

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

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

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

_____

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

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

Question: Number/Letter _____

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

Date of diagnosis _____ Number of occurrences _____

Date of last visit _____ Date of last occurrence _____

Treatment _____ Ongoing symptoms _____

Prescribed medication(s) currently taking _____

Name of care provider/facility _____

City _____ State _____ Phone _____

Question: Number/Letter _____

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

Date of diagnosis _____ Number of occurrences _____

Date of last visit _____ Date of last occurrence _____

Treatment _____ Ongoing symptoms _____

Prescribed medication(s) currently taking _____

Name of care provider/facility _____

City _____ State _____ Phone _____

Question: Number/Letter _____

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

Date of diagnosis _____ Number of occurrences _____

Date of last visit _____ Date of last occurrence _____

Treatment _____ Ongoing symptoms _____

Prescribed medication(s) currently taking _____

Name of care provider/facility _____

City _____ State _____ Phone _____

Question: Number/Letter _____

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

Date of diagnosis _____ Number of occurrences _____

Date of last visit _____ Date of last occurrence _____

Treatment _____ Ongoing symptoms _____

Prescribed medication(s) currently taking _____

Name of care provider/facility _____

City _____ State _____ Phone _____

4. Additional Underwriting Information

5. Agreements and Signatures

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

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

Signed in the state of _____

Signature of proposed insured _____

Date signed _____

Signature of representative _____

Date signed _____

Print name _____ ID number _____

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

Declaration of Insurability (Age 0 - 15) Supplement to Application

1. Proposed Insured

Name _____

2. Declaration of Insurability

Height _____ Ft _____ In Weight _____ Lbs

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

Name of primary health care provider _____

City _____ State _____ Phone _____

Provide details for all 'Yes' answers in the Additional Details Section.

1. Within the past year, has the proposed insured been confined to a hospital for 48 hours or more (excluding confinement for normal childbirth) or administered oxygen for any condition for which the proposed insured has not fully recovered? ☐ Yes ☐ No
2. Other than reported above, within the past 10 years has the proposed insured had any of the following:
   a. anxiety, depression or any other psychological or psychiatric disorder? ☐ Yes ☐ No
   b. Asperger's syndrome or autism spectrum disorder? ☐ Yes ☐ No
   c. Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD)? ☐ Yes ☐ No
   d. cancer including leukemia? ☐ Yes ☐ No
   e. cerebral palsy? ☐ Yes ☐ No
   f. chromosomal disorder or syndrome including Down syndrome? ☐ Yes ☐ No
   g. cognitive impairment? ☐ Yes ☐ No
   h. congenital abnormality or defect? ☐ Yes ☐ No
   i. cystic fibrosis? ☐ Yes ☐ No
   j. diabetes? ☐ Yes ☐ No
   k. disease or disorder of the brain? ☐ Yes ☐ No
   l. disease or disorder of the heart (not including innocent flow/functional murmur)? ☐ Yes ☐ No
   m. disease or disorder of the liver? ☐ Yes ☐ No
   n. epilepsy or seizure disorder? ☐ Yes ☐ No
   o. muscular dystrophy? ☐ Yes ☐ No
3. Other than reported above, within the past 5 years has the proposed insured been medically treated or evaluated at a hospital, clinic, or other facility or been advised by a member of the medical profession to have any medical treatment, test, procedure, surgery, biopsy, and/or hospitalization not yet completed (excluding those tests related to the Human Immunodeficiency Virus (AIDS virus))? ☐ Yes ☐ No

3. Additional Details - Provide details for 'Yes' answers

Question: Number/Letter _____

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

Date of diagnosis _____ Number of occurrences _____

Date of last visit _____ Date of last occurrence _____

Treatment _____ Ongoing symptoms _____

Prescribed medication(s) currently taking _____

Name of care provider/facility _____

City _____ State _____ Phone _____

Question: Number/Letter _____

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

Date of diagnosis _____ Number of occurrences _____

Date of last visit _____ Date of last occurrence _____

Treatment _____ Ongoing symptoms _____

Prescribed medication(s) currently taking _____

Name of care provider/facility _____

City _____ State _____ Phone _____

4. Additional Underwriting Information

5. Agreements and Signatures

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

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

Signed in the state of _____

Signature of parent or guardian _____

Date signed _____

Signature of representative _____

Date signed _____

Print name _____ ID number _____

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

Automatic Payment Authorization

1. Bank Account Owner Information

Thrivent ID _____ Email _____

2. Type of Request

☐ Establish a new automatic payment (complete entire form)

☐ Update bank on an existing automatic payment authorization (complete entire form)

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

☐ Change, Cancel or Add contracts/agreements to my existing Automatic Payment Plan (complete section 4 only)

3. Bank Information

Name of account owner _____

Address of account owner _____

City _____ State _____ ZIP code _____

Account type ☐ Checking ☐ Savings ☐ Business

Full name of bank _____

Routing number _____ Account number _____

Name of joint account owner _____ Thrivent ID _____

Address of joint account owner _____

City _____ State _____ ZIP code _____

4. Policy/Contract/Agreement Payment Information

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

*Not applicable for all products and services

5. Agreements and Signatures

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

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

Signature of bank account owner _____

Date signed _____

Signature of joint bank account owner _____

Date signed _____

Disclosures

Universal Life, Variable Universal Life, or Annuity Product Authorization

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

Variable Annuity Product Disclosure

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

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

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

Financial Planning Services Fee

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

Program Fees for AdvisorFlex Managed Variable Annuity Program

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

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

Fax:
800-225-2264

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

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

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

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

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

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

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

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

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

☐ Other (see instructions)

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

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

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

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

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

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

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

Social security number

or

Employer identification number

Part II Certification

Under penalties of perjury, I certify that:

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

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

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

General Instructions

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

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

Purpose of Form

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

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

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

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

By signing the filled-out form, you:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. The treaty article addressing the income.

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

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

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

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

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

Backup Withholding

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

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

Payments you receive will be subject to backup withholding if:

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

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

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

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

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

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

Also see *Special rules for partnerships,* earlier.

What is FATCA Reporting?

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

Updating Your Information

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

Penalties

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

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

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

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

Specific Instructions

Line 1

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

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

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

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

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

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

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

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

Line 2

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

Line 3

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

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

Line 4, Exemptions

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

Exempt payee code.

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

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

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

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

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

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

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

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

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

5--A corporation

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

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

8--A real estate investment trust

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

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

11--A financial institution

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

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

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

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

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

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

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

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

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

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

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

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

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

G--A real estate investment trust

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

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

J--A bank as defined in section 581

K--A broker

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

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

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

Line 5

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

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

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

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

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

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

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

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

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

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

Part II. Certification

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

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

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

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

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

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

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

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

What Name and Number To Give the Requester

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

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

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

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

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

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

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

Secure Your Tax Records From Identity Theft

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

To reduce your risk:

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

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

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

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

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

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

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

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

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

Privacy Act Notice

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

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Disclosure Notice for Life Insurance Illustration

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

I certify that at the time the application for insurance was completed:

☐ An illustration was not used or provided.

☐ An illustration was used, but it does not match the contract applied for.
The difference between the illustration and the contract applied for is:

Signature of representative and date signed (mm/dd/yyyy)	Print name of financial associate and code number

I acknowledge that at the time the application for insurance was completed, no illustration conforming to the policies applied for was provided to me.

I understand that an illustration conforming to the contract as issued will be provided to me no later than at the time the contract is delivered.

Signed at _____ City _____ State

Signature of proposed insured (Parent or guardian if under age 16) and date signed (mm/dd/yyyy)	Signature of other proposed insured and date signed (mm/dd/yyyy)
Signature of owner/applicant, if other than proposed insured and date signed (mm/dd/yyyy)	

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Thrivent ID

Third Party Notification for Nonpayment of Premium

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

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

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

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

I request the following action on the person listed below:

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

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

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

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

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

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

Address	City	
	State	ZIP code

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

Signature (required for all requests) - Please sign below

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

Send completed form to:

Thrivent
4321 N Ballard Road
Appleton WI 54919-0001

Or fax to: 800-225-2264

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Understanding the Underwriting Process

Life and Disability Income Insurance

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

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

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

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

Tips to help your examination go smoothly:

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

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

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

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

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

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

Thank you for considering Thrivent for your insurance needs.

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Information Disclosure
Modified Endowment Contract

Contract number (if available)

Section 1 - General Information

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

The life insurance contract you have applied for, or have requested a change to, will be considered a Modified Endowment Contract (MEC). First and foremost, a MEC is life insurance and retains the most important federal income tax benefit of a life insurance contract. Beneficiaries of a MEC life insurance contract receive the death benefit income tax-free.

However, certain other tax benefits of a life insurance contract are not retained. Distributions (including, but not limited to withdrawals, loans and loan interest, and certain dividends) made from the contract while the insured is living are subject to income tax. They are taxed to the extent there is gain in the contract. The gain is taxed at ordinary income tax rates, not at capital gains tax rates. Only after the entire gain in the contract is distributed are further distributions from the contract considered a tax-free return of premiums paid.

In addition, distributions made before the insured reaches age 59 1/2 may be subject to a 10% penalty tax. It is not advisable to fund a MEC with assets that will be necessary for living expenses.

Thrivent does not provide tax advice. We encourage you to seek the advice of a professional tax advisor before entering into any transactions which could cause taxable consequences.

The statements contained here reflect the provisions of the current Internal Revenue Code, as amended. However, federal tax laws are subject to change at any time and could impact your MEC life insurance contract. Thrivent cannot be responsible for the consequences of any changes in the federal tax laws.

Section 2 - Agreements and Signature

I acknowledge that I have read this form (or have had it read to me) and that I fully understand its contents. I also acknowledge receipt of the modified endowment contract brochure. My questions were answered to my satisfaction.

I understand that the contract will remain a MEC as long as it remains in force. Exchanging the contract for a new contract will simply transfer the MEC status to the new contract.

Signature of owner/applicant, if other than insured/proposed insured and date signed

X

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Personal Financial Information Supplement

Section 1 - General Information

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

☐ Yes ☐ No Have you completed a Thrivent approved financial analysis?

If "Yes", do not complete this form. Instead, send a copy of the analysis to the home office.

Section 2 - Purpose of Insurance

Purpose of insurance - Check all that apply.

☐ Family Protection ☐ Estate Protection ☐ Personal Loan ☐ Charitable Giving

☐ Other Personal Reason - _____

☐ Wealth Replacement

Type of asset being gifted - _____

Current value of asset being gifted - $ _____

When will asset be gifted? _____

Section 3 - Financial Information

Earned Income	Amount
Proposed Insured's Annual Earned Income	$
Other Income	**Amount**
	$
	$
	$
	$
	$
	$
	$
	$
Total Income	$
Total individual Life Insurance in force and/or pending, excluding amount being replaced	$

How was the amount applied for determined?

Assets	Amount
	$
	$
	$
	$
	$
	$
	$
	$
Total Assets	$

Liabilities	Amount
	$
	$
	$
	$
	$
	$
	$
	$
Total Liabilities	$

Additional Information

Section 4 - Signatures

Signature of proposed insured/applicant	Date signed
X	
Signature of other proposed insured	Date signed
X	

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Supplement to Application for Insurance

Aviation, Racing and Avocation Questionnaire

Proposed Insured

Name _____

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

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

Type of flying _____ Type of aircraft _____

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

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

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

Do you fly for pay? ☐ Yes ☐ No

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

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

_____

Racing of any kind

Type of racing _____

Type of surface _____

Purpose of activity _____

Location of activity _____

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

Club or organization? ☐ Yes ☐ No

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

_____

Number of times participated in the past 12 months? _____

Number of times estimated in the next 12 months? _____

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

Type of activity _____

Typical height/depth _____

Maximum height/depth _____

Location of activity _____

Number of times participated in the past 12 months? _____

Number of times estimated in the next 12 months? _____

Certification? ☐ Yes ☐ No

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

_____

Agreements and Signatures

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

Signed in the state of _____

Signature of proposed insured _____

Date signed _____

Signature of representative _____

Date signed _____

Print name _____ ID number _____

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Supplement to Application for Insurance

Medical Details - Continuation

Proposed Insured

Name _____

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

Question: Number/Letter _____

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

Date of diagnosis _____ Number of occurrences _____

Date of last visit _____ Date of last occurrence _____

Treatment _____ Ongoing symptoms _____

Prescribed medication(s) currently taking _____

Name of care provider/facility _____

City _____ State _____ Phone _____

Question: Number/Letter _____

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

Date of diagnosis _____ Number of occurrences _____

Date of last visit _____ Date of last occurrence _____

Treatment _____ Ongoing symptoms _____

Prescribed medication(s) currently taking _____

Name of care provider/facility _____

City _____ State _____ Phone _____

Question: Number/Letter _____

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

Date of diagnosis _____ Number of occurrences _____

Date of last visit _____ Date of last occurrence _____

Treatment _____ Ongoing symptoms _____

Prescribed medication(s) currently taking _____

Name of care provider/facility _____

City _____ State _____ Phone _____

Question: Number/Letter _____

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

Date of diagnosis _____ Number of occurrences _____

Date of last visit _____ Date of last occurrence _____

Treatment _____ Ongoing symptoms _____

Prescribed medication(s) currently taking _____

Name of care provider/facility _____

City _____ State _____ Phone _____

Question: Number/Letter _____

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

Date of diagnosis _____ Number of occurrences _____

Date of last visit _____ Date of last occurrence _____

Treatment _____ Ongoing symptoms _____

Prescribed medication(s) currently taking _____

Name of care provider/facility _____

City _____ State _____ Phone _____

Question: Number/Letter _____

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

Date of diagnosis _____ Number of occurrences _____

Date of last visit _____ Date of last occurrence _____

Treatment _____ Ongoing symptoms _____

Prescribed medication(s) currently taking _____

Name of care provider/facility _____

City _____ State _____ Phone _____

Agreements and Signatures

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

Signed in the state of _____

Signature of proposed insured _____

Date signed _____

Signature of representative _____

Date signed _____

Print name _____ ID number _____

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Supplement to Application for Insurance

Prescribed Medication(s) - Continuation

Proposed Insured

Name _____

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

Agreements and Signatures

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

Signed in the state of _____

Signature of proposed insured _____

Date signed _____

Signature of representative _____

Date signed _____

Print name _____ ID number _____

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Supplement to Application for Insurance

Moving Traffic Violations - Continuation

Proposed Insured

Name _____

Type of violation	MPH over	Date

Agreements and Signatures

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

Signed in the state of _____

Signature of proposed insured _____

Date signed _____

Signature of representative _____

Date signed _____

Print name _____ ID number _____

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Certification of Trust

Thrivent ID

No representative of Thrivent and its subsidiaries has authority to analyze trust documents or give advice when completing this form. Consult your attorney with any questions regarding the provisions of the trust.

Section 1 - Identification of Trust

Exact name of existing trust	Date trust established

Name of grantor

Type of trust:

☐ Irrevocable - Trust Employer Identification Number (EIN) - _____

☐ Revocable - By whom

Social Security number of grantor	Date of birth of grantor

A Taxpayer Identification Number (TIN) may be obtained at www.irs.ustreas.gov. Distributions from annuities, settlement options, or Modified Endowments owned by a "Grantor" trust may be subject to premature distribution penalties. See Internal Revenue Code (IRC) §§ 673-677. If the trust is an irrevocable trust which qualifies as a grantor trust, contact the Operations Center for additional instructions.

Section 2 - Identification of Currently Acting Trustee(s) - Complete for all currently acting trustee(s).

Correspondence address for trust - Unless you designate otherwise, the address and phone number for the first currently acting trustee will be used as the correspondence address and phone number for the trust.

Name of currently acting trustee			Social Security number
Address	City		Date of birth
	State	ZIP code	Phone

Name of currently acting trustee			Social Security number
Address	City		Date of birth
	State	ZIP code	Phone

Name of currently acting trustee			Social Security number
Address	City		Date of birth
	State	ZIP code	Phone

Section 3 - Trustee Authorization to Act

☐ Yes ☐ No If there is more than one acting trustee, can co-trustees act independently?

If "no" is selected, indicate the number of **signatures required to transact** - _____

If "no" is selected, but the number of **signatures required to transact** is blank or illegible, or no box is checked, all trustees will be deemed necessary to transact. If more than one signature is required, phone transactions may not be available.

Section 4 - Beneficiary of Trust - Not applicable to Thrivent Funds

Indicate who the beneficiary of the trust is by selecting all that apply.

☐ The spouse, child, parent, or other person related to the insured by blood, marriage, or legal adoption, foster parents of the insured, betrothed to the insured, dependents of the insured, or estate of the insured.
If your state recognizes other relationships, such as civil union or domestic partnership, that receive the same privilege, immunity, right, or benefit of marriage, "Spouse" shall include those relationships.

☐ A church, church organization, educational institution, nonprofit corporation, or any corporation, community chest, fund, or foundation described in Section 501(c)(3) of the IRC of 1954, as amended.

☐ The charitable beneficiary is **irrevocably** named. ☐ The charitable beneficiary is **revocably** named.

☐ Other beneficiary with an insurable interest in the insured - Provide the beneficiary details in Section 6 - Additional Information below.

In order to comply with Internal Revenue Service (IRS) rules for fraternal benefit societies, when the contract is issued by Thrivent Financial for Lutherans, and other state regulations when the contract is issued by Thrivent Financial for Lutherans, the undersigned hereby certify that all of the beneficiaries of the trust now have, and will continue to have, an insurable interest in the insured by virtue of the fact that they are all beneficiaries within at least one of the classes above.

Section 5 - State Requirements

When any currently acting trustee is a resident of one of the following states, you must provide the information requested in the Additional Information section.

Michigan - Provide the date of any amendments to the trust. If no date is provided, it is deemed there are no amendments.
Oregon - Provide the state, country, or other jurisdiction whose laws were used to establish the trust. If no state, country, or other jurisdiction is provided, it is deemed Oregon.
Tennessee - Provide the name(s) of each successor trustee. If no names are provided, it is deemed that no successor trustee(s) exist(s). Thrivent may rely on the authority of one or more successors without proof of succession.
Vermont - Provide the name(s) of each original trustee and information on court supervision. If no names are provided, it is deemed that the trustee(s) named in Section 2 are the original trustee(s). If no court supervision information is provided, it is deemed that the trust is not under court supervision.

Section 6 - Additional Information

Section 7 - Mandatory Cost Basis Reporting Notice - Applicable to Thrivent Funds

Thrivent is required to report cost basis for covered shares that are redeemed from this trust account based on the method elected by the authorized person(s) for the trust. If a method is not elected, the average cost method will be used. The trust is required to use the cost basis information provided by Thrivent for covered shares; this information will also be reported to the IRS on Form 1099-B when shares are redeemed from the account. To help ensure that the cost basis on this account remains as accurate as possible, notify Thrivent of any cost basis adjustments that are needed for the account due to trust activities. Provide notification upon the death of any trust grantor(s) for revocable trusts in order for cost basis to be adjusted. Contact your tax advisor for questions on which cost basis method to select. Neither Thrivent nor its financial representatives can provide tax advice.

Section 8 - Signatures, Indemnification, and Taxpayer Identification

By signing, I agree that: 1) the trust exists; 2) I am authorized under the trust and applicable law to conduct business on those accounts/contracts owned by the trust; 3) I will promptly inform Thrivent of any changes in the representations contained in this certification; 4) all representations made in this certification are true and correct to the best of my knowledge and those representations will remain in full force and effect until Thrivent is notified through written revocation or amendment from the trustee; 5) I authorize Thrivent to rely upon the authority of one or more successors to act without proof of their succession; 6) the trustee shall indemnify and hold harmless Thrivent from and against all losses, claims, and expenses (including attorney's fees) of any kind incurred by relying in good faith upon this certification.
By signing, I also understand that no account/contract will be accepted without a valid TIN. Under penalties of perjury, I certify that: 1) the number shown on this form is the trust's correct TIN (or I am waiting for a number to be issue to the trust); 2) the trust is not subject to backup withholding because either the trust is exempt from backup withholding, has not been notified by the IRS that is is subject to backup withholding as a result of a failure to report all interest or dividends, or the trust has been notified by the IRS that it is no longer subject to backup withholding; and 3) the trust is a U.S. trust.

When **any** currently activing trustee is a resident of **California, Idaho, Iowa, Missouri, Nebraska, Nevada, New Jersey, or Oregon,** all currently acting trustees must sign the Certification of Trust. In all other states, only one trustee's signature is required.

Name of currently acting trustee

Signature of currently acting trustee and date signed

X

Name of currently acting trustee

Signature of currently acting trustee and date signed

X

Name of currently acting trustee

Signature of currently acting trustee and date signed

X

Affix notary stamp here (required when **any** currently acting trustee resides in Idaho, Iowa, Michigan, Minnesota, Nebraska, Nevada, Tennessee, or Vermont)	Affix notary stamp here (required when **any** currently acting trustee resides in Idaho, Iowa, Michigan, Minnesota, Nebraska, Nevada, Tennessee, or Vermont)	Affix notary stamp here (required when **any** currently acting trustee resides in Idaho, Iowa, Michigan, Minnesota, Nebraska, Nevada, Tennessee, or Vermont)

As used in this form, "Thrivent" refers to Thrivent Financial for Lutherans and its subsidiaries, including without limitation Thrivent Funds and Thrivent Financial Investor Services Inc.

thrivent

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Assignment and Agreement for 1035 Exchange

Thrivent ID

Section 1 - General Information

Name of insured/annuitant

Name of insured/annuitant

Name of owner	Social Security number
Name of additional owner	Social Security number

Section 2 - Contract(s) to be Exchanged

Full company name	Company phone

Company service address	City	
	State	ZIP code

Contract number	Contract issue date	Type of contract

From ("Exchanged Contract(s)")	Select One	To ("New Contract" or "Existing Contract")	Type of Exchange	Exchange Frequency
Life Insurance	☐	**New** Life Insurance	Full	
	☐	**New** Nonqualified Annuity	Full	
	☐	**Existing** Nonqualified Annuity Contract number - _____	Full	
	☐	**Existing** Long-Term Care Insurance Contract number - _____	Full	
	☐	**New** Long-Term Care Insurance	Full	

From ("Exchanged Contract(s)")	Select One	To ("New Contract" or "Existing Contract")	Type of Exchange	Exchange Frequency
Nonqualified Annuity	☐	**New** Nonqualified Annuity	☐ Partial $ _____ or ____ % ☐ Full	
	☐	**Existing** Nonqualified Annuity Contract number - _____	☐ Partial $ _____ or ____ % ☐ Full	
	☐	**Existing** Long-Term Care Insurance Contract number - _____	☐ Partial $ _____ or ____ % ☐ Full	☐ One Time Exchange ☐ Recurring Exchanges *(Only available for internal exchanges on an annual frequency)*
	☐	**New** Long-Term Care Insurance	☐ Partial $ _____ or ____ % ☐ Full	☐ One Time Exchange ☐ Recurring Exchanges *(Only available for internal exchanges on an annual frequency)*

Section 3 - Agreements

I, the undersigned owner(s), hereby agree to exchange the above-designated contract(s), (hereinafter "**Exchanged Contract(s)**") to Thrivent pursuant to Section 1035 of the Internal Revenue Code. In consideration of Thrivent assisting me with the exchange:

1. I hereby assign my rights, title, and interest (as indicated above) in the **Exchanged Contract(s)** to Thrivent, including the right to receive its cash surrender value. If requested by Thrivent, I agree to execute a separate assignment form that shall be acceptable to the company that issued the **Exchanged Contract(s)** so that said company will recognize that Thrivent is an owner of the contract(s), or any portion thereof.
2. I understand and agree that Thrivent is not obligated to and will not make any premium payments on the **Exchanged Contract(s)** and I will not hold Thrivent liable if the contract(s) lapse(s) for nonpayment of premiums or any loan balance.
3. I warrant that no other individual, firm, or trustee has any interest in the **Exchanged Contract(s)** and that I have the sole right to surrender **Exchanged Contract(s)** and receive the cash surrender value.
4. I represent and agree that Thrivent is furnishing this assignment form and is participating in this transaction at my request and as an accommodation to me. I represent and agree that Thrivent makes no representations concerning my tax treatment under Section 1035 of the Internal Revenue Code or otherwise. I agree that Thrivent is not responsible or liable for my tax treatment under Section 1035 of the Internal Revenue Code or otherwise.
5. Thrivent agrees to apply all proceeds received from the **Exchanged Contract** as I have requested to the **"New Contract"** for which I have applied, if issued, or to a Thrivent contract I already own **("Existing Contract")** subject to the terms of paragraph (6) of this Agreement. Thrivent agrees that the **New Contract** or **Existing Contract** shall be credited with the cash surrender value received from the **Exchanged Contract(s)**.
6. My obligations and the obligations of Thrivent described in paragraphs (1) and (5) of this agreement are contingent upon Thrivent's approval of the issuance of the **New Contract** or my request to apply a premium to my **Existing Contract**. If Thrivent does not approve the issuance of the **New Contract** or approve my request to apply premium to my **Existing Contract**, my assignment of the **Exchanged Contract** pursuant to paragraph (1) shall be void.
7. Thrivent and I may agree to modify the **New Contract** or my premium request before either is approved by Thrivent. The modification of the **New Contract** or my premium request, by mutual agreement, shall not change the obligations of me or Thrivent under this agreement. If, by the agreement of the parties the **New Contract** or my premium request is modified, the modified contract or request shall become subject to this agreement.
8. I understand the assignment and surrender I am requesting as part of this exchange cannot be reversed once it is processed. I understand that I have no right to the return of the **Exchanged Contract(s)** once such contract(s) have been surrendered - my rights shall be limited to the return of the net surrender value in the **New Contract** under the Right to Cancel provision or the net surrender value in the **Existing Contract** under a surrender/termination provision. Consequently, I also understand that any taxable gain resulting from this exchange cannot be reversed once the distribution is processed even if I request a return of my net surrender value.

9. I agree to destroy my **Exchanged Contract(s)** if this request is for a full 1035 exchange.
10. **Partial Exchanges to Annuities Only** - I fully acknowledge and understand that if I take a distribution from either contract (new or existing) within 180 days after the exchange, the IRS may treat this exchange as a way to avoid tax and I may be assessed with additional taxes, penalties and interest. I understand that Thrivent is unable to predict what regulations or tax requirements, if any, will be issued regarding partial exchanges and the effect those regulations or requirements will have on any contracts involved in a partial exchange.
11. **Exchanges to Long-Term Care Insurance Only** - It is currently unclear what, if any, tax impact the exchange may have on the benefit payments from the long-term care insurance contract. I fully acknowledge and understand that Thrivent is unable to predict what regulations or tax requirements, if any, will be issued regarding exchanges to long-term care insurance and the effect those regulations or requirements will have on any contract involved in the exchange.
12. **For Recurring 1035 Exchange Requests to Long-Term Care Insurance:** I understand that subsequent exchange amounts may vary based on amounts billed for my Long-Term Care Insurance contract and that exchanges will reduce and possibly deplete the value of the Exchanged Contract. I authorize adjustment of the requested 1035 Exchange amount to reflect the premium necessary in subsequent exchanges. Thrivent agrees to provide notice of the necessary 1035 Exchange amount taken each year. For recurring requests, Variable and Multi-Year Guarantee Annuity amounts will be distributed proportionately from each investment option/allocation. For Fixed Indexed Annuities, amounts will be distributed from the Fixed Account first and will only be taken from the Indexed Account when the value in the Fixed Account is insufficient. Amounts removed from the Indexed Account will not receive any interest. Requests are intended for exchanges between Thrivent products. Requests for 1035 Exchanges from external companies may require the completion of annual paperwork.
13. **For ad hoc 1035 Exchange Requests:** You may ask us to distribute the amount from specific investment options/ allocations. If you do not, Variable and Multi-Year Guarantee Annuity amounts will be distributed proportionately from each investment option/allocation. For Fixed Indexed Annuities, amounts will be distributed from the Fixed Account first and will only be taken from the Indexed Account when the value in the Fixed Account is insufficient. Amounts removed from the Indexed Account will not receive any interest.
14. **Exchanged Contract Surrender Charges may apply**
15. **A market value adjustment (MVA)** may apply to exchange amounts from Exchanged Contract with a Fixed Period Allocation.
16. **Impact for an Annuity with Long-Term Care Insurance** - I understand that if a long-term care insurance benefit or rider is present on the contract being exchanged, an exchange request to another annuity will result in termination of my LTC insurance benefits.

I fully acknowledge and understand that by exchanging the contract requested, the following may result:

Taxable Gain - An amount of approximately $ _____ will be reported to the IRS as being taxable in the year the exchange is processed (if nothing will be taxable, enter zero). In certain situations, the tax gain will be greater than estimated above due to previous withdrawals processed.

Penalty Tax - If the exchange results in a taxable distribution, an IRS penalty tax may apply to the taxable portion of the distribution if I am under age 59 1/2 and no other exception applies.

Surrender Charges - A surrender charge of $ _____ will be levied (if no surrender charges, enter zero).

Section 4 - Signatures

Signature of owner/trustee/authorized signer and date signed

X

Title (if applicable)

Signature of owner/trustee/authorized signer and date signed

X

Title (if applicable)

Signature of representative/witness and date signed

X

As used in this form "Thrivent" refers to Thrivent Financial for Lutherans and its subsidiaries without limitation.

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Automated Annuity Withdrawal to Pay Other Thrivent Product Premium/Loan

Thrivent ID	Contract number

Section 1 - General Information

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

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

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

Address	City		
	State	ZIP code	Phone

Section 2 - Premium Payment Request

☐ Pay initial premium and subsequent premium payments

☐ Pay only subsequent premium payments

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

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

Section 3 - Contract(s) to be Paid Information

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 5 - Notification for Federal and State Income Tax Withholding

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

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

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

☐ Do not withhold federal income tax

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

State Tax Withholding:

☐ Do not withhold state income tax*

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

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

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

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

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

Section 6 - Additional Information

Section 7 - Disclosures for Distribution Request

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

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

I fully acknowledge and understand that:

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

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

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

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

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

Withdrawal charges may apply.

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

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

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

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

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

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

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

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

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

Name of employer

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

Signature of authorized representative of employer and date signed

X

Section 9 - Signatures

Signature of owner/controller/assignee* and date signed

X

Title (if applicable)

Signature of owner/controller/assignee* and date signed

X

Title (if applicable)

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

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

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

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

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

Name and code number of representative

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

Fax:
800-225-2264

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Annuity/Settlement Option Surrender Service Request

1. Owner Information

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

Thrivent ID _____ Contract number _____ Email _____

Name _____

2. Surrender Details

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

☐ One-time partial surrender amount

☐ Amount $ _____

☐ Amount that is penalty free

☐ Ongoing Automatic Payout Option (APO)

☐ New ☐ Change ☐ Cancel

Payout frequency

☐ Monthly ☐ Quarterly ☐ Semiannually ☐ Annually

Start date - _____

Automatic payout options (select one)

☐ Interest only

☐ Fixed amount $ _____

☐ Fixed percentage _____ %

3. Specific Subaccount Surrender

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

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

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

4. Delivery of Payment

☐ Check

☐ Direct Deposit

Complete bank information for direct deposit

Full name of bank account owner(s) _____

Full name of bank _____

Account type ☐ Checking ☐ Savings

Routing number _____ Account number _____

☐ Deposit into an existing Thrivent Mutual Fund account _____

☐ Deposit into a new Thrivent Mutual Fund account.

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

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

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

Optional in the state of California.

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

6. Withholding and Charges

Surrender Charges and Tax Withholding Amount

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

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

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

Federal and State Withholding Election

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

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

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

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

7. Additional Information

8. Plan Trustee Certification

For Qualified Retirement Plan Surrenders from Deferred Annuities

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

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

9. Validation (see validation requirements in disclosure section)

Medallion Signature Guarantee Seal or Notary Seal

10. Agreements and Signatures

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

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

Signature of owner/controller/assignee _____

Date signed _____

Title _____

Signature of joint owner/controller/assignee _____

Date signed _____

Title _____

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

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

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

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

Name of employer _____

Name of authorized representative of employer _____

Title of authorized representative of employer _____

Signature of authorized representative of employer _____

Date signed _____

Send completed form to:

Thrivent
PO Box 8075
Appleton WI 54912-8075

Fax: 800-225-2264

Disclosures

Surrender Details

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

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

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

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

Surrender charges may apply.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Disclosure and Important Information Regarding Qualified Charitable Distributions (QCD)

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

Specific Subaccount Surrender

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

Delivery of Payment

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

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

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

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

Withholding and Charges

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

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

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

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

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

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

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

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

Plan Trustee Certification

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

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

Generic Notices Available:

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

Validation

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

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

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

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

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

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

Agreements and Signatures

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

THRIVENT FINANCIAL®

Connecting faith & finances for good.®

BUILD AND SHARE WEALTH

With a modified endowment contract

You've worked hard to provide for your loved ones. You've also worked hard to build assets over and above what you need for your day-to-day living expenses. If you have a need for life insurance coverage, you may want to consider using those assets to fund a type of life insurance called a modified endowment contract, or MEC. When premiums paid into a life insurance contract exceed certain Internal Revenue Code limitations, the contract is considered a MEC. When this happens, any distributions you take during your lifetime may be taxable.

However, since a MEC is a life insurance contract, it provides these important life insurance benefits:

- A death benefit to your beneficiaries that is generally free from income taxation.[1]
- The potential for income tax-deferred growth of cash value.
- Death proceeds paid to a beneficiary other than the estate generally avoid probate.
- The means to leave a lasting legacy to help the people and the causes that matter to you.

As long as you do not take money out of the contract, the tax implications of a MEC may not apply to you, potentially allowing you to transfer more of your assets to your beneficiaries.

Protection for your estate—and for future generations

Funding life insurance as a MEC may make sense for you and your family if you:

- ✔ Have substantial assets that are not needed for living or long-term care expenses.
- ✔ Believe you won't likely need these funds in the near future.
- ✔ Want the potential for tax-deferred growth of cash value.
- ✔ Would like to provide your loved ones with a legacy that has income tax advantages.
- ✔ Care about making a charitable bequest using life insurance.

Thrivent Financial pyramid

The Thrivent Financial pyramid offers a four-step road map to help you achieve your financial goals.

[1]State and/or federal inheritance and/or estate taxes may apply.

What you need to know about MECs

If you are thinking about purchasing a life insurance contract that could become classified as a modified endowment contract, consider these possibilities:

- Dividends, while not guaranteed, are payable if they are earned. They also may be taxable.
- All MECs issued to the same contract owner in the same calendar year are treated as one contract for purposes of determining gains on the distributions.
- Exchanging a MEC for another contract does not eliminate its MEC status.

How MECs differ from other insurance contracts

Your life insurance contract will be treated as a MEC for income tax purposes if you fund it in a way that the IRS considers too rapid, typically with a large premium payment. This helps prevent individuals from using their life insurance contracts as short-term, income tax-free investment vehicles instead of a means to financially protect their loved ones.

Although still considered life insurance, MECs can lose the income tax advantages that normally apply to any cash value taken out of the contract. For example:

- MEC distributions, such as withdrawals, loans and loan interest, automatic premium loans, collateral assignments, and certain dividends, are treated as receiving the gain in the contract first. For non-MEC contracts, distributions are generally treated as receiving the investment in the contract first. In either case, you'll normally pay ordinary income tax on any gain distributed.
- A standard 10% penalty tax will apply to the taxable portion of any MEC distribution taken prior to the contract owner reaching age 59½, unless an exception applies.

It's important to note that if you don't expect to take distributions from the contract, a MEC can offer a means to transfer significant assets to the next generation, or to a charity, as described in the section below.

Tax advantages of using life insurance for charitable giving

While the primary purpose of life insurance is to protect your loved ones when you die, life insurance funds can also be used to leave a meaningful legacy to organizations or causes you care about. Using life insurance as part of your charitable giving strategy may allow you to give back while receiving tax advantages when you:

- **Name a charity as the contract's beneficiary.** Your estate may be entitled to an estate tax charitable deduction for the proceeds. However, you won't be entitled to an income tax deduction for the gift. This strategy is appropriate if you want to maintain control of the contract during your lifetime while still being able to leave the death benefit proceeds to charity.
- **Gift the contract to charity.** When you gift a contract to charity, the charity becomes its owner and beneficiary. You no longer have control over the contract. By doing this, you may qualify for an income tax deduction for a portion of the gift's value. If you continue to gift future premiums, you may qualify for an income tax deduction for the amount of premium gifted.

Compare a MEC to other product types

Before funding a life insurance contract as a MEC, you need to understand the consequences and implications of doing so. You should also compare alternative solutions before purchasing a life insurance contract that could become a MEC.

The products described in the chart below are quite different, each having unique strengths and weaknesses. Review the options carefully to help determine which product is best suited for your overall financial needs. This comparison assumes that the annuity, mutual fund and CD are not tax-qualified accounts.

	Life Insurance as a MEC	Deferred Fixed Annuity	Mutual Fund	CD
Primary purpose	Death benefit protection.	Long-term retirement income with guarantees.[1]	Long-term growth potential.	Long-term FDIC-insured investment.[2]
Premiums/funding	Single or periodic.	Single or flexible.	Single or flexible.	Single.
Growth and income taxation	Cash value grows tax-deferred.	Tax-deferred.	Short- and long-term capital gains and dividends taxed annually.	Taxed annually.
Cash availability	Loans and withdrawals available. Tax and surrender fees may apply.[3,4]	Withdrawals available. Tax and surrender fees may apply.	Withdrawals available. Tax and sales charges may apply.	Early surrender penalties or interest charges may apply.
Income tax treatment of withdrawals	Gain taxed first; then basis recovered.[4]	Gain taxed first; then basis recovered.	Investment gains are subject to tax upon withdrawal.	Interest taxed annually; no tax at withdrawal.
Taxation of loans and withdrawals taken prior to age 59½	Regular income tax plus 10% penalty (unless exception applies).[4]	Regular income tax plus 10% penalty (unless exception applies).	N/A	N/A
Income tax treatment for amount paid at death	Death benefit generally income tax-free to beneficiaries.	Current cash value or death benefit guarantee option[1];gain generally taxable to beneficiaries as ordinary income.	Current account value. Step up in basis to beneficiary.	Current account value generally income tax-free to beneficiaries.
Evidence of insurability required	Yes	No	No	No
Fees and expenses	Fees and expenses apply that affect the cash value.	Fees and expenses apply and affect the value returned.	Fees and expenses apply and affect the value returned. Potential loads on purchases may also apply.	Fees and expenses apply and affect the value returned.
Other considerations	Must have an insurance need to purchase; contract could lapse if cash value depleted.	Low yields.	Potential loss of value.	Relatively low yields.

Investing in a mutual fund involves risks, including the possible loss of principal. The prospectus contains more complete information on the investment objectives, risks, charges and expenses of the fund, which investors should read and consider carefully before investing.

[1]Guarantees are backed by the financial strength and claims-paying ability of the issuing insurance company.

[2]For deposits at FDIC-insured institutions as of Jan. 1, 2014, the standard insurance amount will return to $100,000 per depositor for all account categories except for IRAs and certain other retirement accounts, which will remain at $250,000 per depositor.

[3]Distributions may reduce the contract death benefit and the cash value available to pay insurance costs, and may cause the contract to lapse. There may be tax consequences if the contract lapses or terminates.

[4]Loans and partial surrenders on contracts classified as modified endowment contracts (MECs) are taxed on a gain-out first basis and may be subject to a 10% penalty tax if made prior to age 59½.

Strong and stable

When you do business with Thrivent, you can take comfort in knowing you have a solid partner on your side. Independent insurance analysts A.M. Best and Fitch Ratings give us high marks for our financial strength and ability to pay claims.[1]

A++ A.M. Best — **Superior** May 2017 Highest of 16 ratings

AA+ Fitch Ratings — **Very Strong** December 2016 Second highest of 19 ratings

[1]Ratings reflect Thrivent Financial's overall financial strength and claims-paying ability but do not apply to the investment performance of investment products.

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Thrivent Financial was named one of the "World's Most Ethical Companies" by Ethisphere Institute for our leadership in promoting ethical business standards and introducing innovative ideas to benefit the public. "World's Most Ethical Companies" and "Ethisphere" names and marks are registered trademarks of Ethisphere LLC. For details, visit Ethisphere.com.

Find out more!

Talk to your financial representative for more information and to help you develop a charitable giving strategy. If appropriate to your situation, your financial representative will also work with InFaith Community Foundation to help you achieve your planned giving goals.

Team Photo
4 x 5 aspect ratio

[Team Name]
[Team Email Address]
[Team Webpage]
[Street Address]
[City, State, ZIP]
[Phone Number(s)]
[AR License ######]
[CA Insurance #######]

[Not all Thrivent Financial representatives are authorized to provide all products and services. Not all products are available in all states.]

This is a solicitation for insurance. A Thrivent Financial representative may contact you.

The information contained herein provides only a basic discussion of each charitable giving tool described and its advantages. For more details, contact your tax and legal advisors.

Please note that Thrivent Financial and its representatives and employees cannot provide legal, accounting, or tax advice or services. The brief discussion of taxes in this brochure is not intended to be comprehensive and is subject to change at any time. Tax laws and regulations are complex and depend on individual circumstances. For complete details, consult your attorney, accountant and tax advisor. Your Thrivent Financial representative can work with your attorney and tax professional to implement the appropriate charitable giving option.

Insurance products issued or offered by Thrivent Financial, the marketing name for Thrivent Financial for Lutherans, Appleton, WI. Not all products are available in all states. Securities and investment advisory services are offered through Thrivent Investment Management Inc., 625 Fourth Ave. S., Minneapolis, MN 55415, a FINRA and SIPC member and a wholly owned subsidiary of Thrivent. Thrivent Financial representatives are registered representatives of Thrivent Investment Management Inc. They are also licensed insurance agents/producers of Thrivent. For additional important information, visit Thrivent.com/disclosures.

InFaith Community Foundation is a public charity serving donors and the community through charitable funds. InFaith Community Foundation is independent of Thrivent Financial and its financial representatives.

THRIVENT FINANCIAL®

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

inFaith COMMUNITY FOUNDATION®
InFaithFound.org • 800-365-4172

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thrivent

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

Beneficiary Provisions

Thrivent Financial for Lutherans is a fraternal benefit society. All beneficiaries must be eligible as required in the Society's bylaws.

The contract will control if any Beneficiary Provision(s) conflict.

Neither Thrivent nor its affiliates or representatives provide legal or tax advice. Where appropriate, you should consult with an attorney or tax advisor for advice.

Beneficiary Shares

CLASS: Examples of CLASSES of beneficiaries are primary, contingent, second contingent or First Beneficiary, Second Beneficiary, Contingent Beneficiary. Your contract may use different terminology which has the same meaning.

Beneficial Shares: Death proceeds will be paid in equal shares to all beneficiaries of the same CLASS who survive the insured. Instead of equal shares, specific dollar or percentages are permitted with approval.

- **Specific Dollar Amount:**
  - Specified dollar amounts shall be deducted first from death proceeds. Remaining proceeds shall be paid to other beneficiaries of the same CLASS in equal shares unless a different percentage is designated.
  - If proceeds are insufficient to pay all specified amount designations in a CLASS, amounts paid will be in pro rata shares.
- **Percentages:** If a beneficiary predeceases the insured(s), shares will be split pro rata between the remaining beneficiaries of the same CLASS. If beneficiaries of the same CLASS are named to share in a percentage, for example, 25% to John and Jane Doe, the percentage will be paid to the survivor(s) before death proceeds are paid to the CLASS.

Proceeds will be paid to the next CLASS of beneficiaries if all beneficiaries of the same CLASS predecease the insured(s).

If no beneficiary in any CLASS survives the insured, proceeds shall be paid to the owner or owner's estate as required by your contract.

Spousal Consent

You should consider whether to obtain your spouse's or ex-spouse's (herein “SPOUSE's”) signature if you are or ever have been married.

Your SPOUSE's signature may be required in circumstances such as the following:

- You live or have lived in a community property state;
- You have a divorce decree which ordered you to maintain life insurance; or
- You have or ever had a marital property agreement.

It is your sole responsibility, and not that of Thrivent, to determine whether your SPOUSE's signature should be obtained.

If your SPOUSE's signature was required but not obtained:

- If your SPOUSE believes s/he has a claim to proceeds, Thrivent must receive notice of that claim no later than the date it pays the contract proceeds; or
- You agree to hold Thrivent harmless for accepting your beneficiary designation and payment of any proceeds without your SPOUSE's consent.

Trust Beneficiaries

Trust Owned Contracts: If a contract is owned by a trust, naming a beneficiary other than the trust may cause legal and/or tax issues. Naming a beneficiary other than the trust may prevent the payment of proceeds according to the objectives of the trust.

Trust Beneficiaries: Trust beneficiaries must qualify as eligible beneficiaries under the bylaws of Thrivent, if applicable, at the time a claim is paid. Proceeds cannot be paid to the trust if its beneficiaries are ineligible under the bylaws of Thrivent when a claim is submitted.

Miscellaneous Provisions

Charity as Beneficiary: Thrivent may have the contractual right to prohibit annuitization elected by a charity at time of claim.

Final Services Funding: Thrivent may accept designations to name an entity which will provide for reimbursement to a state recovery program for services or for final services. An example of a state recovery program is Medicaid Estate Recovery. Examples of final services include, but are not limited to, funeral, mortuary, cemetery, cremation, and funeral trust. Any state recovery program or final services entity is permitted to receive only those proceeds necessary to reimburse for services received by the insured or pay the insured's final expenses. Verification of final expenses or reimbursement is required prior to payment of any claim. The balance of any proceeds shall be paid according to the beneficiaries you name. If there are no named beneficiaries, then the balance of any proceeds shall be paid to the insured's estate.

Irrevocable Beneficiary: To designate a primary or contingent beneficiary as irrevocable, indicate "irrevocable" in the beneficiary designation. After an irrevocable beneficiary is named any changes to the contract can only be made with the consent of the irrevocable beneficiary. These changes include beneficiary changes, loans, withdrawals, contract surrender,dividend option changes, and long-term care claim payments for Care Forward contracts

Minor Beneficiaries

When Naming a Custodian: You may wish to direct payment of proceeds to minor beneficiaries by naming a custodian. You may designate: a custodian who will control property until it is transferred to the beneficiary. These designations will be administered under the Uniform Transfers to Minors Act (or similar law) of the state where the minor resides unless another state is designated.

When Not Naming a Custodian: If any proceeds are payable to a person under age 18 at the time of claim and you did not designate a custodian, you are deemed to elect to use the state where the minor resides on the date of the insured's death to administer the property under the Uniform Transfers to Minors Act (or similar state law). Thrivent may pay, as custodian, any adult family member with whom the client resides.

Simultaneous Death

A beneficiary will be treated as having predeceased the insured if: 1) that beneficiary dies at the same time as the insured; or 2) within 15 days of the insured.

This provision shall not apply if the proceeds have already been paid to the beneficiary.

Your contract may contain a 15 day survival provision. If your contract contains this provision, that provision will control.

Group Designations

Thrivent strongly encourages individuals to be named, as this can clarify your intent with regards to beneficiary designations.

Thrivent will only approve the following Group Designations: 1) children; 2) sons; 3) daughters; 4) brothers; 5) sisters; 6) half-brothers; 7) half-sisters; 8) grandchildren; 9) great-grandchildren; 10) granddaughters; and 11) grandsons.

Unless you specify otherwise, group designations shall only include naturally born or legally adopted members of that group. For example, step-children who you have not legally adopted will not be included in a group designation of Children.

Per Stirpes

Per Stirpes is a stipulation directing that proceeds pass to the children of a beneficiary if that beneficiary pre-deceases the insured. If none survive the insured, proceeds will pass according to the instructions outlined in the Beneficiary Shares provision.

This stipulation may be added to any group or individual with approval from Thrivent. All provisions outlined under Group Designations will also apply to a Per Stirpes stipulation.

Signature - A signature is only required for new business applications in the state of New York.

By signing this form, I certify that I have read and agree to all the provisions on this form.

Signature of owner/controller and date signed

X

thrivent

Thrivent Financial for Lutherans
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Trusted Contact Person Designation

Trusted Contact Person shall mean a person who has been designated by you as a person Thrivent may contact. This applies to all products.

Section 1 - General Information

*Name of client (print first, middle, last name and suffix, as applicable)	*Thrivent ID

Section 2 - Authorization Information

You may not list a Thrivent Professional as your Trusted Contact Person.

*Name of Trusted Contact Person (print first, middle, last name and suffix, as applicable)		*Phone	
*Address	*City	*State	*ZIP code
Email	Relationship	Date of birth	

*These fields must be completed

This request will replace any Trusted Contact Person currently on file, if applicable.

Section 3 - Acknowledgement, Disclosures and Signature

I understand that I am able to designate one person age 18 or older to be listed as my Trusted Contact Person. This authorization is not allowed for contracts owned by a company/corporation/church or partnership. I authorize Thrivent and its applicable subsidiaries** to contact my Trusted Contact Person and disclose information to address possible financial exploitation, or to confirm the specifics of my current contact information, health status or the identity of any legal guardian, executor, trustee or holder of a power of attorney. I understand that health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient, and may no longer be protected under federal law. This authorization is not a general or limited power of attorney or a trading authorization and, therefore, does not allow any purchase, sale or other transaction to be entered into by the identified individual for my benefit with Thrivent without my prior written authorization.

I understand that I can revoke this contract authorization at any time by notifying Thrivent in writing at the address shown below. I further understand that this authorization will stay in effect and may be relied upon by Thrivent until I revoke it, or upon my death, whichever is sooner.

I understand that this authorization does not supersede any Power of Attorney, Guardianship or Conservatorship legal document. Failure to designate a Trusted Contact Person does not disqualify me from being eligible for products or services offered by Thrivent.

By signing below, I and my heirs, hold Thrivent harmless if they act, or fail to act, on my stated preferences based upon their best judgement. Also, by signing this form I certify that I have read and agree to the disclosures contained in this form, and have been provided a copy.

☐ I do not elect to designate a Trusted Contact Person or update my Trusted Contact Person at this time.

Signature of client	Date signed
X	

Send completed form to: Thrivent
PO Box 8074
Appleton WI 54912-8074

Fax: 800-225-2264

**This form may be used for Thrivent Investment Management Inc. (Minneapolis, MN 55415), a wholly owned subsidiary of Thrivent Financial for Lutherans. If used in this form “Thrivent” refers to Thrivent Financial for Lutherans.”

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.

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Important Privacy Choices for Consumers

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

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

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

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

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

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

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

Other important information

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

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

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

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

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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.

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

Understanding the Underwriting Process

Life and Disability Income Insurance

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

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

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

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

Tips to help your examination go smoothly:

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

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

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

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

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

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

Thank you for considering Thrivent for your insurance needs.

thrivent

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

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.