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The Virtual Advice Team is a team of licensed financial advisors and professionals available to assist you during designated business hours. Our team offers a full variety of products and services. If you prefer to meet with a local financial advisor or professional, our team can connect you with someone in your area. Whether you work with the Virtual Advice Team, or with a local Thrivent financial advisor or professional, there will generally be no difference in the fees and expenses you will incur.

Insurance products, securities and investment advisory services are provided by appropriately appointed and licensed financial advisors and professionals. Only individuals who are financial advisors are credentialed to provide investment advisory services. Visit Thrivent.com or FINRA's Broker Check for more information about our financial advisors.

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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, LLC, 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, LLC

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 your agent, so that they can assist with processing your transactions and service your policy or account. If your agent is part of a team, your information may also be shared amongst team members.
- 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, LLC;
- 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, LLC; 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, LLC by Thrivent Financial is disputed by you, Thrivent Financial will notify MIB, LLC of such dispute.

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

Information regarding your insurability will be treated as confidential. Thrivent Financial, or its reinsurers may, however make a brief report thereon to MIB, LLC which operates an information exchange on behalf of insurance companies that are members of MIB Group Inc. If you apply to another MIB, LLC Member Company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, LLC, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB, LLC will arrange disclosure of any information it may have in your file. Please contact MIB, LLC at 866 692-6901. If you question the accuracy of information in MIB, LLC's file, you may contact MIB, LLC and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB, LLC'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, LLC may be obtained on its website at www.mib.com.

Information obtained from a report prepared by MIB, LLC may be retained by MIB, LLC 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:

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

Death Benefit Option ☐ Option 1 - Level ☐ Option 2 - Variable

Disability Waiver of Monthly Deductions ☐ Yes ☐ No

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

Life Insurance Qualification Test

☐ Cash Value Accumulation Test (CVAT) ☐ Guideline Premium Test (GPT)

6. Dividend Options

Term Product

☐ Cash ☐ Reduce Premium/Excess to Cash

Whole Life Product

☐ Paid in Cash ☐ Reduce Premium/Buy Paid-Up Additions

☐ Buy Paid-Up Additions ☐ Reduce Debt/Buy Paid-Up Additions

☐ Reduce Premium ☐ 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 Individual 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, LLC. 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, LLC.

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, LLC. 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 benefits.

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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HIV Test Informed Consent

Insurer : Thrivent Financial for Lutherans
Appleton, WI

In order for us to evaluate your eligibility for insurance coverage, we request that you provide a blood or other bodily fluid sample for HIV testing and analysis. The test that will be performed will determine the presence of antibodies to the HIV virus. By signing and dating this form, you agree that the HIV antibody test may be performed on your blood or other bodily fluid sample and that underwriting decisions may be based on the test results. A positive test result will adversely affect your insurance application. It also may result in uninsurability for life, health, or disability insurance for which you may apply in the future.

Human Immunodeficiency Virus (HIV)

The HIV virus causes a life-threatening disorder of the immune system called Acquired Immune Deficiency Syndrome (AIDS). Antibodies to HIV are found in the blood and other bodily fluids of people who have been exposed to the virus. You do not have to have AIDS to have antibodies against HIV. The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion), or from an infected mother to her new-born infant.

The HIV antibody test is actually a series of tests performed upon your blood or other bodily fluid sample by a medically accepted procedure which is extremely reliable. The testing will be performed by a licensed laboratory.

Pre-testing Consideration

Many public health organizations have recommended that before taking an HIV virus antibody test a person seek counseling to become informed about the implications of such tests. You may wish to consider counseling, at your expense, prior to being tested.

Disclosure of Test Results

All test results are confidential, except as provided by law. State law requires that the laboratory notify the Ohio Department of Health of positive test results.

The results of the test will be reported to Thrivent. Thrivent may not by law, release positive test results except as provided below:

If your HIV antibody test result is normal (negative), you will not be notified. You will be notified of an abnormal (positive) test result if you indicate that you desire a positive result be made known to you. You may also identify another person to whom you want the positive results released.

If you want a physician or other health care provider to be notified of an abnormal HIV antibody test result, you must indicate the name and address of that physician or provider.

Abnormal test results may be disclosed to persons hired by Thrivent who participate in medical underwriting decisions of Thrivent. Abnormal test results may also be disclosed to affiliates of Thrivent who require the result for medical underwriting purposes.

In addition, if your HIV antibody test is abnormal, a generic code signifying a non-specific blood, oral fluid (saliva), or urine abnormality may be made known to MIB Group, Holdings Inc. (MIB). The MIB is an organization of life and health insurance companies which operates as an information exchange on behalf of its members. There will be no record with The MIB, that you had a positive HIV antibody test; however, there will be a record at The MIB, that you have some blood, oral fluid, or urine abnormality. If you apply to another MIB member company for life or health insurance coverage, The MIB, upon request, will supply the information on you in its file to that member.

Test Results

While a positive test result does not necessarily mean that you have AIDS, it does mean that you are at a greater risk of developing AIDS or AIDS-related conditions if you do not take appropriate medications. If you are infected with HIV you are infectious to others. You should seek medical follow-up care with your personal health care provider.

HIV test results are highly reliable but not 100% accurate. If the test gives a positive result you should consider retesting in order to confirm the result. If the test gives a negative result, there is still a small possibility you may be infected with HIV. This is most likely to happen in recently infected persons. It takes at least 4 to 12 weeks for a positive test result to develop after a person is infected, and may take as long as 6 to 12 months.

Other Sources of Information
For more information about HIV or AIDS you may ask a doctor, a nurse, a counselor, or call the Ohio AIDS Hotline at 800-332-AIDS (2437). The hotline is a free call.

Consent for HIV Testing
I have read and I understand this HIV Test Informed Consent form. I voluntarily consent to the withdrawal of blood or to the providing of another bodily fluid sample, the testing of my blood or other bodily fluid for HIV antibodies, and the disclosure of the test results as described above. I will be given a copy of this form. This consent is valid for ninety (90) days from the date of my signature below. Thrivent agrees to complete testing and provide the authorized notifications, as appropriate, within 90 (ninety) day period.

Thrivent is the marketing name for Thrivent Financial for Lutherans and Thrivent Life Insurance Company (a wholly owned subsidiary of Thrivent Financial for Lutherans).

In the event of a positive test result:

☐ Send the results to me at:

Address	City	
	State	ZIP code

☐ I authorize Thrivent to send the result to another person:

Name

Address	City	
	State	ZIP code

☐ I authorize Thrivent to send the result to the following physician or health care provider:

Name

Address	City	
	State	ZIP code

Authorization

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

Signature of proposed insured and date signed

X

Signature of legal guardian, if any, and date signed

X

Signature of person obtaining consent 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 *(If no box is checked, the distribution will be sent via check)*

☐ 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

☐ **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

If no box is checked, 10% federal income tax will be withheld and State withholding will occur as required by your state of residence.

Federal Tax Withholding:

☐ Do not withhold federal income tax

☐ Withhold federal income tax amount of 10%

☐ Other federal withholding - Complete and submit to Thrivent IRS form W-4R.

State Tax 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 and authorized signature
For Medallion Signature Guarantee, seal and signature and original document must be mailed. Fax will not be accepted.

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 corrections are made to my financial institution account. This authorization shall remain in full force and effect until I revoke it by giving 10 days prior notice to Thrivent.
When providing bank information on this form, you authorize Thrivent to use a Third-Party Service Provider to verify account and account owner information. Account and/or account owner information that cannot be verified may result in a delay in processing. This Third-Party Service Provider is a consumer reporting agency under the Fair Credit Reporting Act. By signing this form, you understand and agree that a consumer report, including credit reports, criminal records and driving records, among other forms of information obtained from private and public record sources, may be obtained on you as part of this transaction.

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

Notification of Withholding and Surrender 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. 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.

Form W-4R can be found on Thrivent Online Forms Utility or www.irs.gov/formsinstructions

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.

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 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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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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Accelerated Death Benefit for Terminal Illness Disclosure Statement

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

The Accelerated Death Benefit for Terminal Illness Rider allows you to receive benefits of your life insurance contract that would otherwise be payable upon the death of the Insured. IF WE PAY YOU AN ACCELERATED BENEFIT, THE AMOUNT OF INSURANCE AND THE CASH/ACCUMULATED VALUE OF THE CONTRACT WILL BE REDUCED OR ELIMINATED.

RECEIPT OF ACCELERATED DEATH BENEFITS MAY AFFECT ELIGIBILITY FOR MEDICAID OR OTHER PUBLIC ASSISTANCE PROGRAMS AND MAY, IN LIMITED SITUATIONS, BE TAXABLE. PRIOR TO APPLYING FOR BENEFITS, YOU SHOULD CONSULT A QUALIFIED TAX ADVISOR.

Accelerated Benefits are available if the Insured has an illness or physical condition that can reasonably be expected to result in death in 24 months or less.

We will determine the amount available as an Accelerated Benefit. You may elect to receive all or part of the available amount as an Accelerated Benefit. If you elect to receive the entire amount, the contract will terminate. If you elect to receive only a portion of the available amount as an Accelerated Benefit, the contract will remain in force. THE AMOUNT OF INSURANCE, LOAN AMOUNT AND CASH/ACCUMULATED VALUE OF THE CONTRACT WILL BE REDUCED BY THE SAME PERCENTAGE AS THE PERCENTAGE OF THE AVAILABLE AMOUNT THAT YOU ELECT TO RECEIVE AS AN ACCELERATED BENEFIT. THE NEW PREMIUM OR COST OF INSURANCE WILL BE DETERMINED BASED ON THE REDUCED AMOUNT OF INSURANCE. Insurance not included in the determination of the available amount is not affected.

If a rider on the contract provides life insurance on a person who is not the Insured under the contract, the insurance under the rider may be used to provide an Accelerated Benefit on that person subject to the same provisions and conditions as for the Insured.

There is no additional premium charged for this rider. However, we will charge an administrative fee if you elect to receive an Accelerated Benefit. The fee of $150 will be deducted to determine the Accelerated Benefit payable.

If you elect to receive an Accelerated Benefit, we will give you a notice showing the amount of the benefit and the effect that payment of the Accelerated Benefit will have on the contract's death benefit, loan amount, cash/accumulated value and premium.

THIS RIDER WILL TERMINATE UPON TERMINATION OR MATURITY OF THE CONTRACT.

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

Example of Accelerated Death Benefit for Terminal Illness

Contract:	$100,000 Life Paid-Up at Age 65
Issue Age:	Age 40
Dividend Option:	Paid in Cash
Annual Premium:	$1,850.00

If the Insured qualifies for an Accelerated Benefit 10 years after the date of issue, the amount available as an Accelerated Benefit would be $86,576.08 (maximum amount available). You may elect to have all or part of this amount paid as an Accelerated Benefit provided that (1) the benefit payable must be at least $10,000 or, if smaller, the entire available amount and (2) if you elect only part of the available amount, the amount of insurance remaining in force after payment of the benefit must be at least $10,000 or, if greater, the minimum amount of insurance, if any, stated in the contract. If a 50% Accelerated Benefit were elected, contract values before and after acceleration would be:

	Before Election of Accelerated Benefit	After Payment of Accelerated Benefit
Accelerated Benefit	---	$43,288.04
Face Amount	$100,000.00	50,000.00
Death Benefit	100,000.00	50,000.00
Available Amount	86,576.08	43,174.13
Cash/Accumulated Value	14,300.00	7,150.00
Available Loan	13,240.74	6,620.37
Annual Premium	1,850.00	945.00

Please keep this form with your contract.

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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

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

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

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

Name of primary health care provider _____

City _____ State _____ Phone _____

Date of last visit _____ Reason for last visit _____

Treatment _____

Prescribed Medication(s) _____

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

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

_____

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

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

_____

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

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

_____

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

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

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

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

***If yes**, list below*

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

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

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

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

Disease or disorder	Relation to proposed insured	Age of onset

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

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

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

_____

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

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

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

_____

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

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

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

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

_____

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

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

Question: Number/Letter _____

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

Date of diagnosis _____ Number of occurrences _____

Date of last visit _____ Date of last occurrence _____

Treatment _____ Ongoing symptoms _____

Prescribed medication(s) currently taking _____

Name of care provider/facility _____

City _____ State _____ Phone _____

Question: Number/Letter ____________

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

Date of diagnosis ____________ Number of occurrences ____________

Date of last visit ____________ Date of last occurrence ____________

Treatment ____________ Ongoing symptoms ____________

Prescribed medication(s) currently taking ____________

Name of care provider/facility ____________

City ____________ State ______ Phone ____________

Question: Number/Letter ____________

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

Date of diagnosis ____________ Number of occurrences ____________

Date of last visit ____________ Date of last occurrence ____________

Treatment ____________ Ongoing symptoms ____________

Prescribed medication(s) currently taking ____________

Name of care provider/facility ____________

City ____________ State ______ Phone ____________

Question: Number/Letter ____________

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

Date of diagnosis ____________ Number of occurrences ____________

Date of last visit ____________ Date of last occurrence ____________

Treatment ____________ Ongoing symptoms ____________

Prescribed medication(s) currently taking ____________

Name of care provider/facility ____________

City ____________ State ______ Phone ____________

4. Additional Underwriting Information

5. Agreements and Signatures

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

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

Signed in the state of _____

Signature of proposed insured _____

Date signed _____

Signature of representative _____

Date signed _____

Print name _____ ID number _____

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Supplement to Application for Insurance

Medical Details - Continuation

Proposed Insured

Name ____________________

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

Question: Number/Letter ________

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

Date of diagnosis ____________________ Number of occurrences ____________

Date of last visit ____________________ Date of last occurrence ____________

Treatment ____________________ Ongoing symptoms ____________

Prescribed medication(s) currently taking ____________________

Name of care provider/facility ____________________

City ____________________ State ______ Phone ____________

Question: Number/Letter ________

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

Date of diagnosis ____________________ Number of occurrences ____________

Date of last visit ____________________ Date of last occurrence ____________

Treatment ____________________ Ongoing symptoms ____________

Prescribed medication(s) currently taking ____________________

Name of care provider/facility ____________________

City ____________________ State ______ Phone ____________

Question: Number/Letter ________

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

Date of diagnosis ____________________ Number of occurrences ____________

Date of last visit ____________________ Date of last occurrence ____________

Treatment ____________________ Ongoing symptoms ____________

Prescribed medication(s) currently taking ____________________

Name of care provider/facility ____________________

City ____________________ State ______ Phone ____________

Question: Number/Letter ____________

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

Date of diagnosis ____________ Number of occurrences ____________

Date of last visit ____________ Date of last occurrence ____________

Treatment ____________ Ongoing symptoms ____________

Prescribed medication(s) currently taking ____________

Name of care provider/facility ____________

City ____________ State ______ Phone ____________

Question: Number/Letter ____________

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

Date of diagnosis ____________ Number of occurrences ____________

Date of last visit ____________ Date of last occurrence ____________

Treatment ____________ Ongoing symptoms ____________

Prescribed medication(s) currently taking ____________

Name of care provider/facility ____________

City ____________ State ______ Phone ____________

Question: Number/Letter ____________

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

Date of diagnosis ____________ Number of occurrences ____________

Date of last visit ____________ Date of last occurrence ____________

Treatment ____________ Ongoing symptoms ____________

Prescribed medication(s) currently taking ____________

Name of care provider/facility ____________

City ____________ State ______ Phone ____________

Agreements and Signatures

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

Signed in the state of ______

Signature of proposed insured ____________

Date signed ____________

Signature of representative ____________

Date signed ____________

Print name ____________ ID number ____________

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Supplement to Application for Insurance

Moving Traffic Violations - Continuation

Proposed Insured

Name _____

Type of violation	MPH over	Date

Agreements and Signatures

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

Signed in the state of _____

Signature of proposed insured _____

Date signed _____

Signature of representative _____

Date signed _____

Print name _____ ID number _____

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Supplement to Application for Insurance

Prescribed Medication(s) - Continuation

Proposed Insured

Name _____

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

Agreements and Signatures

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

Signed in the state of _____

Signature of proposed insured _____

Date signed _____

Signature of representative _____

Date signed _____

Print name _____ ID number _____

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Supplement to Application for Insurance

Aviation, Racing and Avocation Questionnaire

Proposed Insured

Name _____

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

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

Type of flying _____ Type of aircraft _____

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

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

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

Do you fly for pay? ☐ Yes ☐ No

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

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

_____

Racing of any kind

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

Type of surface _____

Purpose of activity _____

Location of activity _____

Club or organization? ☐ Yes ☐ No

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

_____

Number of times participated in the past 12 months? _____

Number of times estimated in the next 12 months? _____

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

Type of activity _____

Typical height/depth _____

Maximum height/depth _____

Location of activity _____

Number of times participated in the past 12 months? _____

Number of times estimated in the next 12 months? _____

Certification? ☐ Yes ☐ No

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

_____

Agreements and Signatures

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

Signed in the state of _____

Signature of proposed insured _____

Date signed _____

Signature of representative _____

Date signed _____

Print name _____ ID number _____

Form **W-9**
(Rev. March 2024)
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.

Before you begin. For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

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

1 Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)

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

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

☐ Individual/sole proprietor ☐ C corporation ☐ S corporation ☐ Partnership ☐ Trust/estate

☐ LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) . . . . .

Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner.

☐ Other (see instructions)

3b If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions . . . . . ☐

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

Exempt payee code (if any)

Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any)

(Applies to accounts maintained outside the United States.)

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. See also *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*.

What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3. See the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they

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-NEC (nonemployee compensation).

• 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), and 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.

Caution: If you don't 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; and

4. Certify to your non-foreign status for purposes of withholding under chapter 3 or 4 of the Code (if applicable); and

5. 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).

Establishing U.S. status for purposes of chapter 3 and chapter 4 withholding. Payments made to foreign persons, including certain distributions, allocations of income, or transfers of sales proceeds, may be subject to withholding under chapter 3 or chapter 4 of the Code (sections 1441–1474). Under those rules, if a Form W-9 or other certification of non-foreign status has not been received, a withholding agent, transferee, or partnership (payor) generally applies presumption rules that may require the payor to withhold applicable tax from the recipient, owner, transferor, or partner (payee). See Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities.

The following persons must provide Form W-9 to the payor for purposes of establishing its non-foreign status.

• In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the disregarded 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 grantor trust.

• In the case of a U.S. trust (other than a grantor trust), the U.S. trust and not the beneficiaries of the trust.

See Pub. 515 for more information on providing a Form W-9 or a certification of non-foreign status to avoid withholding.

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 (under Regulations section 1.1441-1(b)(2)(iv) or other applicable section for chapter 3 or 4 purposes), do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Pub. 515). If you are a qualified foreign pension fund under Regulations section 1.897(l)-1(d), or a partnership that is wholly owned by qualified foreign pension funds, that is treated as a non-foreign person for purposes of section 1445 withholding, do not use Form W-9. Instead, use Form W-8EXP (or other certification of non-foreign status).

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 their 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 their 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, but are not limited to, 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, as described in item 4 under "*By signing the filled-out form*" 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.

See also *Establishing U.S. status for purposes of chapter 3 and chapter 4 withholding*, earlier.

What Is FATCA Reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all U.S. account holders that are specified U.S. 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 are no longer 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.

• **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 for 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 you filed with your application.

• **Sole proprietor.** Enter your individual name as shown on your Form 1040 on line 1. Enter your business, trade, or "doing business as" (DBA) name on line 2.

• **Partnership, C corporation, S corporation, or LLC, other than a disregarded entity.** 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.

• **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. Enter any business, trade, or DBA name on line 2.

• **Disregarded entity.** In general, a business entity that has a single owner, including an LLC, and is not a corporation, is disregarded as an entity separate from its owner (a disregarded entity). See Regulations section 301.7701-2(c)(2). A disregarded entity should check the appropriate box for the tax classification of its owner. Enter the owner's name on line 1. The name of the owner 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. 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, enter it on line 2.

Line 3a

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

IF the entity/individual on line 1 is a(n) . . .	THEN check the box for . . .
• Corporation	Corporation.
• Individual or • Sole proprietorship	Individual/sole proprietor.
• LLC classified as a partnership for U.S. federal tax purposes or • LLC that has filed Form 8832 or 2553 electing to be taxed as a corporation	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 3b

Check this box if you are a partnership (including an LLC classified as a partnership for U.S. federal tax purposes), trust, or estate that has any foreign partners, owners, or beneficiaries, and you are providing this form to a partnership, trust, or estate, in which you have an ownership interest. You must check the box on line 3b if you receive a Form W-8 (or documentary evidence) from any partner, owner, or beneficiary establishing foreign status or if you receive a Form W-9 from any partner, owner, or beneficiary that has checked the box on line 3b.

Note: A partnership that provides a Form W-9 and checks box 3b may be required to complete Schedules K-2 and K-3 (Form 1065). For more information, see the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

If you are required to complete line 3b but fail to do so, you may not receive the information necessary to file a correct information return with the IRS or furnish a correct payee statement to your partners or beneficiaries. See, for example, sections 6698, 6722, and 6724 for penalties that may apply.

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 on 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 territory, 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 territory.

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 as defined under section 581.

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 Information, 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) entered 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 territory, 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, enter "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 ITIN. Enter it in the entry space for the Social security number. 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). 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 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/EIN*. 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 Form SS-4 mailed to you within 15 business days.

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and enter "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, you will generally 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. See also *Establishing U.S. status for purposes of chapter 3 and chapter 4 withholding*, earlier, for when you may instead be subject to withholding under chapter 3 or 4 of the Code.

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 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))**	The grantor*
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 Form 1041 or under the Optional Filing Method 2, requiring Form 1099 (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 on line 1, and enter your business or DBA name, if any, on line 2. 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.)

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

** For more information on optional filing methods for grantor trusts, see the Instructions for Form 1041.

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 return 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 a questionable credit report, contact the IRS Identity Theft Hotline at 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 877-777-4778 or TTY/TDD 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 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.

Go to *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 territories for use in administering their laws. The information may also 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, payors must generally withhold a percentage of taxable interest, dividends, and certain other payments to a payee who does not give a TIN to the payor. Certain penalties may also apply for providing false or fraudulent information.

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Understanding the underwriting process

Thank you for submitting your application to Thrivent. Now your application will go through underwriting. Underwriting is the process of collecting and assessing your information to determine whether you qualify for coverage, and if so, what premium is needed to pay for that coverage. We strive to make the underwriting process as easy as possible for you.

The underwriting process can be as short as a day or could take longer depending on your age, type and amount of coverage you are applying for, the complexity of your health history, 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 you can.

Helpful tips

- Have a government issued picture ID (preferably a driver's license) available.
- Have a list of the medications and doses 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.

How the information is used

After the underwriter receives all of the information, a decision will be made regarding your insurability. One of the following may happen:

- Your coverage may cost the same as what was shown to you by your financial advisor.
- Your coverage may cost less than what was shown to you by your financial advisor.
- Your coverage may cost more or be modified from what was shown to you by your financial advisor. Your financial advisor 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 financial advisor 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 financial advisor 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.

What may be needed

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.	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.	20 to 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. Your blood pressure, pulse, height and weight will also be taken.	20 to 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.	10 minutes
Face-to-face assessment Additional questions and activities conducted during the paramedical exam to assess mobility and memory.	15 to 20 minutes

If a paramedical exam, blood and urine sample and/or a Face-to-Face Assessment are needed, an examiner will contact you to schedule an appointment to complete the services.

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 clarification 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.

Your insurance needs are important to Thrivent.
Responding to any requests as soon as possible can help ensure the timely processing of your application.

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Thrivent Financial for Lutherans
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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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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

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Thrivent Funds
Non-Retirement Redemption Request

Thrivent ID

*To request a redemption due to the death of an account owner, please complete form MF34914

Section 1 - General Information

This section is required. Provide the names of the account owners for the account that you wish to redeem.

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

Joint account owner (print first, middle, last name and suffix, as applicable)

Section 2 - Redemption Amount

This section is required. Provide the amount that should be redeemed from the account. To close an account, indicate the fund/account and enter ALL under shares.

Fund/Account Number	Dollar Amount		Percentage		Shares
	$	or	%	or	
	$	or	%	or	
	$	or	%	or	
	$	or	%	or	
	$	or	%	or	

Section 3 - Cost Basis Override for Transaction

This section is optional. The cost basis method elected for your account will be used on the redemption unless you indicate otherwise. If average cost, you cannot override the cost basis method on a transaction basis.

Fund Name (Indicate "ALL" if election applies to all accounts.)	First-In, First-Out (FIFO)	Last-In, First-Out (LIFO)	High Cost	Low Cost	Gain/Loss Utilization
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐

Section 4 - Distribution Options

This section is required. Select the method in which the funding should be sent. Please only select one option.
If a distribution option is not selected we will send a check to the address of record for the account.

☐ **Distribute by electronic funds transfer**

☐ Direct Deposit to a bank

☐ Wire to a bank - A fee will be charged against your account.

Is bank information on file?

☐ Yes Name of bank and account number - _____

☐ No Complete bank information below - Signature validation may be required in Section 5, see Disclosures for additional details:

Financial institution name

Financial institution account owner

Financial institution joint account owner

Routing number	Account number	Type of account ☐ Checking ☐ Savings

Include a copy of a voided check or letter on Bank letterhead that includes bank registration, routing number, and account number

I authorize Thrivent Financial Investor Services Inc. 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 Funds; 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 or amount changes; 5) release any and all information related to this authorization to the third party account/contract owner, and 6) act upon electronic deposit instructions I provide to my representative.

☐ **Distribute by check to registered account address**

☐ Overnight delivery Available when distributing to registered account address or other payee. (A fee will apply.)

☐ Yes ☐ No Is a signature upon receipt of overnight delivery required?

☐ **Distribute by check to other payee -** Signature validation required in Section 5, see Disclosures page for details

Name (print first, middle, last name and suffix, as applicable)	Contract/Account number

For the benefit of (print first, middle, last name and suffix, as applicable)

Address	City	
	State	ZIP code

☐ **Distribute to another Thrivent Financial product**

Contract Number/ Financial Planning Agreement Number	Premium	Loan Repayment	For IRA Contributions, Must Provide a Tax Year
	$	$	
	$	$	

Section 5 - Signature Validation

Certain cash distributions require signature validation. Please see Disclosures for additional information.

Medallion Signature Guarantee Seal or Notary Seal

Section 6 - Agreements and Signatures

This section is required. Signatures of at least one account owner is required.

I certify I have received, read, and agree to the Disclosures (page 4 of this form) and any other disclosures contained in this form.

Signature of primary account owner/conservator/guardian/custodian/trustee/authorized person — Date signed

X _____

Signature of joint owner/additional conservator/additional trustee/additional authorized person — Date signed

X _____

Signature of additional joint owner/additional trustee/additional authorized person — Date signed

X _____

Signature of additional joint owner/additional trustee/additional authorized person — Date signed

X _____

Mail completed form to:

Regular Mail:
Thrivent Funds
PO Box 219348
Kansas City, MO 64121-9348

Express Mail:
Thrivent Funds
430 W 7th St
Kansas City, MO 64105

Fax:
866-278-8363

Phone:
800-847-4836

Disclosures

For Internal Product-to-Product Transfers Only

Unless otherwise indicated herein, I intend the requested transfer(s) from the distributing accounts(s) to become effective only if and when:

- Thrivent Financial (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 Financial (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.

Distribution Options

If a distribution option is not selected we will send a check to the address of record on the account. For Proceeds from Broker and Barter Exchange Transactions (IRS Form 1099-B) reportable accounts cost basis will be applied to the transaction and fees associated with expedited distribution methods.

Signature Validation

For your protection, validation of your identity is requested.

Redemption/disbursement transactions:

a. Greater than $499,999 will require a Medallion Signature Guarantee.
b. Greater than $99,999 and up to $499,999 will require one of the following forms of validations:
    · Attestation by a Thrivent Financial representative
    · A Notary Public
    · A Medallion Signature Guarantee
c. Greater than $9,999, 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 Financial representative.
d. Greater than $9,999, 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 Financial 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 account, 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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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
- ☐ Maximum Partial Surrender

☐ 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 *(If no box is checked, the distribution will be sent via check.)*

☐ 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

Select one:

- ☐ **NET Request:** *You will receive the amount requested. Your account balance will be reduced by this amount plus any applicable surrender charges and tax withholding.*
- ☐ **GROSS Request:** *You will receive the amount requested less any applicable surrender charges and tax withholding.*

If neither is checked, the default is NET Request.

Federal and State Withholding Election

If no box is checked, 10% federal income tax will be withheld and State withholding will occur as required by your state of residence.

For 403(b) or qualified Retirement plan please review Mandatory Tax listed in the Disclosure Section.

Federal Tax Withholding:

- ☐ Do not withhold federal income tax
- ☐ Withhold federal income tax amount of 10%
- ☐ Other federal withholding - Complete and submit to Thrivent IRS form W-4R.

State Tax 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 and authorized signature

For Medallion Signature Guarantee, seal and signature and original document must be mailed. Fax will not be accepted.

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 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 certify the distributable event is financial hardship.

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 - If you have a GLWB rider and a withdrawal results in a GLWB Excess Surrender as defined by the GLWB rider, all GLWB guaranteed values will be reduced. Please see the prospectus for details.

For Income Builder GLWB Rider Only: Be advised that the first withdrawal will set your withdrawal percentage.

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.

When providing bank information on this form, you authorize Thrivent to use a Third-Party Service Provider to verify account and account owner information. Account and/or account owner information that cannot be verified may result in a delay in processing. This Third-Party Service Provider is a consumer reporting agency under the Fair Credit Reporting Act. By signing this form, you understand and agree that a consumer report, including credit reports, criminal records and driving records, among other forms of information obtained from private and public record sources, may be obtained on you as part of this transaction.

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. 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.

Form W-4R can be found on Thrivent Online Forms Utility or www.irs.gov/formsinstructions

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.

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Automated Payment of a Thrivent Product

Thrivent ID	Contract/agreement/account number

Section 1 - General Information

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

Section 2 - Contract(s) to be Paid Information

The start date is not available when a new settlement option/immediate annuity is paying for premium or loan. The start date is determined at the time of issue of the settlement option/immediate annuity.

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

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

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

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

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

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

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

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

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

Section 3 - Notification for Federal and State Income Tax Withholding

For settlement option/immediate annuity withholding changes, the federal W-4P form and/or the Certification of Voluntary Withholding of State Income Tax from Pension and Annuity Payments (form 20017) must be used.

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

Federal Tax Withholding:

☐ Do not withhold federal income tax

☐ Other federal withholding - Complete and submit to Thrivent IRS form W-4R, search W-4R here: www.irs.gov/forms-instructions

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.

Section 4 - Additional Information

Section 5 - 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 6 - Agreements and Signatures

I authorize Thrivent to process the requested transaction and I certify I have received, read and agree to the Disclosures (pages 3-4 of this form) and any other disclosures contained in this form.

Signature of owner/controller/assignee/payor/authorized person/trustee and date signed

X

Title (if applicable)

Signature of owner/controller/assignee/payor/authorized person/trustee and date signed

X

Title (if applicable)

Name and code number of representative

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

Fax:
800-225-2264

Disclosures

Section 3 - Notification for Federal and State Income Tax Withholding

You are liable for state income tax, where applicable, on the taxable portion of your distribution even if you elect no withholding. Except where prohibited by state law, you can elect: 1) no withholding; 2) withholding at the minimum 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. You may change your withholding election for future distributions by contacting Thrivent. Check with your tax advisor to determine if withholding is necessary.

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

Additional Disclosures

I fully acknowledge and understand that:

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.

Impact of withdrawal - The withdrawal from my annuity or mutual fund will occur approximately 10 days before the payment due date.

The payments to the recipient contract are withdrawals from my annuity, mutual fund or settlement option/immediate 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 or mutual fund contract. Subject to availability.

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.

Annuity

- 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.
- Withdrawal charges may apply.
- A market value adjustment (MVA) may apply to distributions from a Fixed Period Allocation.
- If I am under age 59 1/2, a 10% premature distribution tax penalty may apply.

Impact of withdrawal on Guaranteed Living 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 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.

Settlement Option/Immediate Annuity - Cancellation of other Thrivent products will not negate the settlement option/immediate annuity agreement.

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)

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.

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

Trusted Contact Person Authorization Form

STEP 1 - Client information, review acknowledgments and disclosures

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

I understand and agree that:

- By completing this form, I designate the person(s) below as my trusted contact person(s) ("Trusted Contact");
- I am able to designate anyone age 18 or older as my Trusted Contact(s);
- I understand this applies to all products.
- Thrivent and its subsidiaries** are authorized, but not obligated, to contact my Trusted Contact(s) and disclose information to address possible financial exploitation, to confirm the specifics of my current contact information, health status, and/or the identity of any legal guardian, executor, trustee or power of attorney;
- This authorization is not a general or limited power of attorney or trading authorization and does not allow any purchase, sale or other transaction to be entered into by the Trusted Contact without my prior written authorization;
- I can change my Trusted Contact(s) at any time by completing a new Trusted Contact Person Authorization form;
- I understand this authorization will stay in effect until I revoke it. I can revoke this authorization at any time by notifying Thrivent in writing at the address below.

STEP 2 - Check one box

☐ I choose to designate a Trusted Contact Person(s) - continue to Step 3

☐ I do **not** wish to designate or update my Trusted Contact Person(s) at this time - skip to Step 4

STEP 3 - Designate one or more Trusted Contact Person(s) - You may not list a Thrivent Financial Professional

This designation will replace any Trusted Contact Person(s) currently on file, if applicable.

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	

Trusted Contact Person (Optional)			
*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

STEP 4 - Sign, then return completed form to Thrivent

I certify that I have read and agree to the acknowledgments contained in this form, and have been provided a copy.

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."

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Privacy of Information About Your Health

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

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

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

Uses and disclosures of information about your health without your authorization

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Uses and disclosures of information about your health with your authorization

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

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

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

Your rights regarding information about your health

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Our duties regarding information about your health

We are required by law to:

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

Changes to this notice

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

For more information or to file a complaint

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

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

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

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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 inform new clients, as well as current clients annually, 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 third parties, such as insurance agents, financial advisors and 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

- Log in to your thrivent.com account and go to **Profile and Settings**.
- Call 800-847-4836 between 7 a.m. and 6 p.m. Central time, Monday through Friday.
- 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 new, current or former client who has previously provided us with sharing preferences, your preferences have not been changed; they will remain as is, unless we receive instruction to change them. For all others, including former clients, 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 Cash Management Trust, Thrivent Education Funding, LLC, and Thrivent ETF Trust.

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 California, Massachusetts, Minnesota, New Mexico, North Dakota and Vermont 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.
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.

Please note that if your insurance agent or financial advisor is part of a team, your information may also be shared amongst team members.

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.