Declaration of Insurability
(Age 16 or Over)

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

Section 1 - Proposed Insured Information

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

Section 2 - Declaration of Insurability

Name of primary health care provider - Indicate if none.

Date last consulted	Reason last consulted	
Type of treatment	Medication prescribed	Recovery date

Yes No

☐ ☐ 1. Within the past two years, have you participated in any of the following:

- ☐ Pilot, copilot, student pilot, or crew member
- ☐ Ballooning
- ☐ Skin / Scuba diving
- ☐ Auto racing
- ☐ Motorcycle racing
- ☐ Powerboat racing
- ☐ Mountain climbing
- ☐ Sky diving
- ☐ Hang gliding
- ☐ Other avocation - Provide details in Additional Underwriting Information section.

☐ ☐ 2. Within the past five years, have you had a driver's license suspended or had a moving traffic violation?

Type of Violation	MPH Over	Date

☐ ☐ 3. Within the past six months, have you had a life application declined, postponed, rated, modified or withdrawn?

Application Action	Company Name	Date	Reason

☐ ☐ 4. Have your biological parents, brothers, or sisters ever had cancer (internal or melanoma), coronary artery disease or Huntington's disease?

Disease or Disorder	Relationship to Proposed Insured	Age at Onset	Current Age	Age at Death

Place details for all 'Yes' answers for questions five through 11 in Section 3.

Yes No

☐ ☐ 5. Within the past 10 years, have you had, been diagnosed or been treated by a physician or other member of the medical profession, chiropractor, counselor or any other health care provider for any of the following:

(a) disease or disorder of the heart, circulatory, blood or immune system (excluding Human Immunodeficiency Virus (HIV))?

If high blood pressure:

Last blood pressure reading - _____/_____ Date of last blood pressure reading - _____

☐ ☐ (b) abnormal growth, cyst, tumor or cancer?

☐ ☐ (c) disease or disorder of the respiratory system?

☐ ☐ (d) disease or disorder of the digestive system (e.g., stomach, intestines, rectum, liver, gallbladder, esophagus)?

☐ ☐ (e) disease or disorder of the urinary system, (e.g., kidneys, bladder)?

☐ ☐ (f) disease or disorder of the endocrine / hormone system (e.g., diabetes)?

☐ ☐ (g) disease or disorder of the nervous system, including psychological and psychiatric care?

☐ ☐ (h) disease or disorder of the muscle, skin, bone or joint?

☐ ☐ (i) disease or disorder of the reproductive system?

☐ ☐ (j) disease or disorder of the eyes, ears, nose or throat?

☐ ☐ 6. Within the past 10 years, have you been advised to seek treatment or counseling, been treated for or received counseling or joined Alcoholics Anonymous, Narcotics Anonymous, or other support organization for the use of alcohol or controlled substances?

☐ ☐ 7. Within the past 10 years, have you used or are you currently using, except as prescribed by a physician, controlled substances such as cocaine, marijuana, amphetamines or narcotics?

☐ ☐ 8. Are you currently disabled?

Date disability began - _____ Reason for disability -_____

☐ ☐ Are disability benefits being filed for or received from Social Security or from another source?

9. Other than reported above, within the past 10 years, have you:

☐ ☐ (a) consulted or been advised to consult a physician or other member of the medical profession, chiropractor, psychiatrist, psychologist or counselor for any reason?

☐ ☐ (b) been medically treated or evaluated at a hospital, clinic or other facility or been medically advised to have any treatment, test, surgery, biopsy or hospitalization not yet completed?

☐ ☐ (c) been advised by a physician, or other member of the medical profession, chiropractor or medical therapist to restrict or avoid normal activities due to illness or injury?

☐ ☐ (d) taken any other prescription drugs?

Prescription Drug Used	Date Last Used	Reason for Use

☐ ☐ 10. Within the past 10 years, have you been treated for, or been diagnosed by a physician or other member of the medical profession as having Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)?

☐ ☐ 11. Other than reported above, have you been under the care of a physician or other member of the medical profession or are you scheduled to see a physician or other member of the medical profession?

Section 3 - Details for questions answered 'Yes'

Question: No/Ltr	Type of disease, disorder, injury, test, care, controlled substance			Date of diagnosis
Date of onset	Number of occurrences	Treatment		Number of times treated
Last occurrence date	Time lost from work / school	Recovered ☐ Yes ☐ No	Recovery date	Date substance last used
Last consultation date	Date of last hospitalization	Surgery date	Medication(s) currently taking	
Residuals		Care provider / Facility with records if other than primary care provider		

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Section 3 - Details for questions answered 'Yes' (continued)

Question: No/Ltr	Type of disease, disorder, injury, test, care, controlled substance			Date of diagnosis
Date of onset	Number of occurrences	Treatment		Number of times treated
Last occurrence date	Time lost from work / school	Recovered ☐ Yes ☐ No	Recovery date	Date substance last used
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Additional Underwriting Information

Section 4 - Agreement and Signature

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 at _____ _____
City State

Signature of proposed insured / Date signed (mm/dd/yyyy)	Signature of representative / Date signed (mm/dd/yyyy)

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Thrivent.com · 800-THRIVENT (800-847-4836)

Physician/Paramedical Exam

Complete only this form. No additional tests are to be performed unless specifically requested by Thrivent Financial for Lutherans.

Name of proposed insured (first, middle, last)			Date of birth (mm/dd/yyyy)	Application number
1. Height without shoes	Weight (clothed) without shoes	BMI	Measured and weighed by you? ☐ Yes ☐ No	
Weight loss within last year lbs	Reason		Abdomen, at umbilicus	Hips, greatest circumference

2. Urinalysis:	Albumin	Sugar	Other
3. Blood pressure (record two sitting readings):	Systolic / Diastolic		Systolic / Diastolic
4. Pulse (at rest):	Rate (recheck at end of exam if over 100)		Irregularities per minute

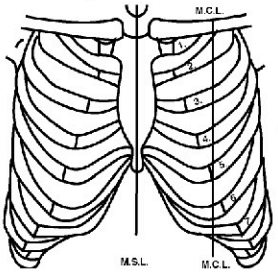
5. Heart: Any murmur(s)? ☐ Yes ☐ No If yes, describe below. If more than one, describe separately.

Interspace	First Murmur	Second Murmur
Right	☐	☐
Left	☐	☐
Constant	☐	☐
Inconstant	☐	☐
Transmitted	☐	☐
Localized	☐	☐

	First Murmur	Second Murmur
Systolic	☐	☐
Presystolic	☐	☐
Diastolic	☐	☐
Soft (Gr 1-2)	☐	☐
Mod. (Gr 3-4)	☐	☐
Loud (Gr 5-6)	☐	☐

With Valsalva:	First Murmur	Second Murmur
Increased	☐	☐
Absent	☐	☐
Unchanged	☐	☐
Decreased	☐	☐

Use these symbols to record findings:



Murmur
- X Position of apex beat
- ☐ Area of distribution
- ○ Point of greatest intensity
- > Direction of transmission

Is there hypertrophy? ☐ Yes ☐ No
☐ Slight ☐ Moderate ☐ Marked
Is there evidence of:
- ☐ Yes ☐ No a. congestive heart failure?
- ☐ Yes ☐ No b. dyspnea?
- ☐ Yes ☐ No c. cyanosis?
- ☐ Yes ☐ No d. edema?
- ☐ Yes ☐ No e. arteriosclerosis?
- ☐ Yes ☐ No f. pericarditis?

6. On examination, is there any abnormality of the following:
- ☐ Yes ☐ No a. respiratory system?
- ☐ Yes ☐ No b. gastrointestinal system (including liver)?
- ☐ Yes ☐ No c. genitourinary system (including breasts and prostate)?
- ☐ Yes ☐ No d. nervous system (including tremor, reflexes, gait and paralysis)?
- ☐ Yes ☐ No e. endocrine system?
- ☐ Yes ☐ No f. musculoskeletal system (including spine, joints, amputations, deformities)?
- ☐ Yes ☐ No g. lymph nodes?
- ☐ Yes ☐ No h. skin (including scars)?
- ☐ Yes ☐ No i. circulatory system?
- ☐ Yes ☐ No j. femoral and/or carotid bruits?
- ☐ Yes ☐ No k. Are you aware of any additional medical history, habits or other factors affecting insurability?

Details for questions answered "Yes"

☐ Yes ☐ No **Does the proposed insured currently use, or within the past 10 years have they used, tobacco or other nicotine products?**

Type of Tobacco/Nicotine Product	Quantity	Frequency	Date Last Used

How do you know the person examined? ☐ First meeting ☐ Personal acquaintance ☐ Patient

Signature of medical examiner and date signed (mm/dd/yyyy)	**If desired, a confidential supplementary report may be sent to Thrivent Financial Medical Director.**