

**Declaration of Insurability  
(Age 16 or Over)**



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:			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Pilot, copilot, student pilot, or crew member	<input type="checkbox"/> Auto racing	<input type="checkbox"/> Sky diving	
		<input type="checkbox"/> Ballooning	<input type="checkbox"/> Motorcycle racing	<input type="checkbox"/> Hang gliding	
		<input type="checkbox"/> Skin / Scuba diving	<input type="checkbox"/> Powerboat racing	<input type="checkbox"/> Other avocation - Provide details in Additional Underwriting Information section.	
		<input type="checkbox"/> Mountain climbing			
<input type="checkbox"/>	<input type="checkbox"/>	2. Within the past five years, have you had a driver's license suspended or had a moving traffic violation?			
		<b>Type of Violation</b>	<b>MPH Over</b>	<b>Date</b>	
<input type="checkbox"/>	<input type="checkbox"/>	3. Within the past six months, have you had a life application declined, postponed, rated, modified or withdrawn?			
		<b>Application Action</b>	<b>Company Name</b>	<b>Date</b>	<b>Reason</b>
<input type="checkbox"/>	<input type="checkbox"/>	4. Have your biological parents, brothers, or sisters ever had cancer (internal or melanoma), coronary artery disease or Huntington's disease?			
		<b>Disease or Disorder</b>	<b>Relationship to Proposed Insured</b>	<b>Age at Onset</b>	<b>Current Age</b>

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

Yes	No													
<input type="checkbox"/>	<input type="checkbox"/>	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 - _____												
<input type="checkbox"/>	<input type="checkbox"/>	(b) abnormal growth, cyst, tumor or cancer?												
<input type="checkbox"/>	<input type="checkbox"/>	(c) disease or disorder of the respiratory system?												
<input type="checkbox"/>	<input type="checkbox"/>	(d) disease or disorder of the digestive system (e.g., stomach, intestines, rectum, liver, gallbladder, esophagus)?												
<input type="checkbox"/>	<input type="checkbox"/>	(e) disease or disorder of the urinary system, (e.g., kidneys, bladder)?												
<input type="checkbox"/>	<input type="checkbox"/>	(f) disease or disorder of the endocrine / hormone system (e.g., diabetes)?												
<input type="checkbox"/>	<input type="checkbox"/>	(g) disease or disorder of the nervous system, including psychological and psychiatric care?												
<input type="checkbox"/>	<input type="checkbox"/>	(h) disease or disorder of the muscle, skin, bone or joint?												
<input type="checkbox"/>	<input type="checkbox"/>	(i) disease or disorder of the reproductive system?												
<input type="checkbox"/>	<input type="checkbox"/>	(j) disease or disorder of the eyes, ears, nose or throat?												
<input type="checkbox"/>	<input type="checkbox"/>	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?												
<input type="checkbox"/>	<input type="checkbox"/>	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?												
<input type="checkbox"/>	<input type="checkbox"/>	8. Are you currently disabled? Date disability began - _____ Reason for disability - _____												
<input type="checkbox"/>	<input type="checkbox"/>	Are disability benefits being filed for or received from Social Security or from another source?												
<input type="checkbox"/>	<input type="checkbox"/>	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?												
<input type="checkbox"/>	<input type="checkbox"/>	(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?												
<input type="checkbox"/>	<input type="checkbox"/>	(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?												
<input type="checkbox"/>	<input type="checkbox"/>	(d) taken any other prescription drugs?												
<table border="1"> <thead> <tr> <th>Prescription Drug Used</th> <th>Date Last Used</th> <th>Reason for Use</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>			Prescription Drug Used	Date Last Used	Reason for Use									
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<input type="checkbox"/>	<input type="checkbox"/>	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 Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?												
<input type="checkbox"/>	<input type="checkbox"/>	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'**

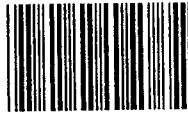
Question: No/Ltr	Type of disease, disorder, injury, test, care, controlled substance		Date of diagnosis
Date of onset	Number of occurrences	Treatment	Number of times treated
Last occurrence date	Time lost from work / school	Recovered <input type="checkbox"/> Yes <input type="checkbox"/> No	Recovery date 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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# Physician/Paramedical Exam

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

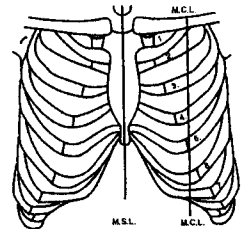
Name of proposed insured (First, Middle, Last) \_\_\_\_\_ Date of birth (mm/dd/yyyy) \_\_\_\_\_

1. Height without shoes	Weight (clothed) without shoes	BMI	Measured and weighed by you? <input type="checkbox"/> Yes <input type="checkbox"/> 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 - Describe below. If more than one, describe separately.  No

	First Murmur	Second Murmur	Systolic Presystolic Diastolic Soft (Gr 1-2) Mod. (Gr 3-4) Loud (Gr 5-6)	First Murmur	Second Murmur	With Valsalva: Increased Absent Unchanged Decreased	First Murmur	Second Murmur
	Interspace							
Right	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Left	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Constant	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Inconstant	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Transmitted	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Localized	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

Use these symbols to record findings.



- X** Position of apex beat
- Area of distribution
- O** Point of greatest intensity
- >** Direction of transmission

Yes <input type="checkbox"/>	No <input type="checkbox"/>	Is there hypertrophy? <input type="checkbox"/> Slight <input type="checkbox"/> Moderate <input type="checkbox"/> Marked
<input type="checkbox"/>	<input type="checkbox"/>	Is there evidence of:
<input type="checkbox"/>	<input type="checkbox"/>	a. congestive heart failure?
<input type="checkbox"/>	<input type="checkbox"/>	b. dyspnea?
<input type="checkbox"/>	<input type="checkbox"/>	c. cyanosis?
<input type="checkbox"/>	<input type="checkbox"/>	d. edema?
<input type="checkbox"/>	<input type="checkbox"/>	e. arteriosclerosis?
<input type="checkbox"/>	<input type="checkbox"/>	f. pericarditis?

6. On examination, is there any abnormality of the following:

Yes <input type="checkbox"/>	No <input type="checkbox"/>	a. respiratory system?
<input type="checkbox"/>	<input type="checkbox"/>	b. gastrointestinal system (including liver)?
<input type="checkbox"/>	<input type="checkbox"/>	c. genitourinary system (including breasts and prostate)?
<input type="checkbox"/>	<input type="checkbox"/>	d. nervous system (including tremor, reflexes, gait and paralysis)?
<input type="checkbox"/>	<input type="checkbox"/>	e. endocrine system?
<input type="checkbox"/>	<input type="checkbox"/>	f. musculoskeletal system (including spine, joints, amputations, deformities)?
<input type="checkbox"/>	<input type="checkbox"/>	g. lymph nodes?
<input type="checkbox"/>	<input type="checkbox"/>	h. skin (including scars)?
<input type="checkbox"/>	<input type="checkbox"/>	i. circulatory system?
<input type="checkbox"/>	<input type="checkbox"/>	j. femoral and/or carotid bruits?
<input type="checkbox"/>	<input type="checkbox"/>	k. Are you aware of additional medical history, habits or other factors affecting insurability?

**Details for questions answered 'Yes'**

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.