Application For: Medicare Supplement Coverage

Thrivent Financial for Lutherans

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

Service Center
PO Box 14008
Clearwater, FL 33766-4008

Writing Agent Name	Writing Agent #

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

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

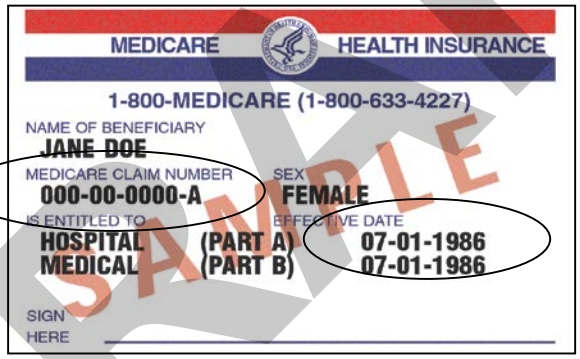
NOTE: If more than 1 applicant, complete Applicant B sections.

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

SECTION 2. APPLICANT INFORMATION – PLEASE ANSWER ALL QUESTIONS COMPLETELY

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

SECTION 2. APPLICANT INFORMATION, CONTINUED – PLEASE ANSWER ALL QUESTIONS COMPLETELY	
Home Phone No. (_____) _____-_____ (area code)	Home Phone No. (_____) _____-_____ (area code)
Best Time to Contact:	Best Time to Contact:
Current Age_____ Date of Birth_____/_____/_____ mo / day / yr	Current Age_____ Date of Birth_____/_____/_____ mo / day / yr
☐ Male ☐ Female State of Birth _____	☐ Male ☐ Female State of Birth _____
Social Security No. _____-_____-_____	Social Security No. _____-_____-_____
Have you used tobacco in any form in the past 12 months?..... ☐ Yes ☐ No	Have you used tobacco in any form in the past 12 months?..... ☐ Yes ☐ No
Please reference your Medicare Card to complete this section.	



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

SECTION 3: HOUSEHOLD PREMIUM DISCOUNT INFORMATION.		
You may be eligible for a contract with a lower premium rate based on your answers to the questions in this section. 1. Do you currently have a household resident (at least one, no more than 3) with whom you have continuously resided for the last 12 months and who is age 50 or older; or who is your legal spouse, including validly recognized civil union and domestic partners? 2. If you answered "YES" to Question 1 above, please fill out the following information about the household resident, except if both applicants are applying for coverage on this application.	**Applicant** ☐ Yes ☐ No	**Applicant B** ☐ Yes ☐ No
Name (First/Middle/Last)		
Street Address		
City/State/Zip		
Name (First/Middle/Last)		
Street Address		
City/State/Zip		
Name (First/Middle/Last)		
Street Address		
City/State/Zip		

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

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy or certificate, or that you had certain rights to buy such a policy or certificate, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application.

PLEASE ANSWER ALL QUESTIONS. Please mark "YES" or "NO" with an "X" to the questions below.

To the Best of Your Knowledge:	**Applicant A**	**Applicant B**
1. Are you applying during a guaranteed issue period? ..... **(NOTE: If the answer above is "YES," please attach proof of eligibility.)**	☐ Yes ☐ No	☐ Yes ☐ No
2. Do you have another Medicare Supplement or Medicare Select insurance policy or certificate in force? ..... (a) If "YES," with what company, and what plan do you have?	☐ Yes ☐ No	☐ Yes ☐ No
Applicant A	**Applicant B**	
Name of Company	Name of Company	
Plan	Plan	
Effective Date ____/____/_____	Effective Date ____/____/_____	
	Applicant A	**Applicant B**
(b) If "YES," do you intend to replace your current Medicare Supplement policy/certificate with this policy?.....	☐ Yes ☐ No	☐ Yes ☐ No
(c) If "YES," indicate termination date.....	____/____/_____	____/____/_____
(d) If "YES," have you received a copy of the replacement notice?	☐ Yes ☐ No	☐ Yes ☐ No
(e) NOT INCLUDING Medicare Supplement, have you had before or do you now have any other Medicare plan coverage as referenced below? ..... If you answer "NO" skip to question #4 below. If you answer "YES," please complete questions 3 (a-g) below.	☐ Yes ☐ No	☐ Yes ☐ No
3. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates. If you are still covered under this plan, leave "END" blank……	Start ____/____/_____ End ____/____/_____	Start ____/____/_____ End ____/____/_____
(a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?.....	☐ Yes ☐ No	☐ Yes ☐ No
(b) If "YES," have you received a copy of the replacement notice?.....	☐ Yes ☐ No	☐ Yes ☐ No
(c) Reason for termination/disenrollment?	_____ Applicant A	_____ Applicant B
(d) Planned date of termination/disenrollment?	____/____/_____ Applicant A	____/____/_____ Applicant B

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

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

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

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

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

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

Applicant A	Applicant B

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Are you applying during Open Enrollment or a Guaranteed Issue period? If yes, SKIP SECTION 5 and GO TO SECTION 6

SECTION 5. HEALTH QUESTIONS

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

Applicant A	Applicant B
Height: ___ Ft _____ In Weight: _____ Lbs	Height: ___ Ft _____ In Weight: _____ Lbs

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

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

SECTION 5. HEALTH QUESTIONS, CONTINUED

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

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

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

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

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SECTION 7. METHOD OF PAYMENT – PLEASE COMPLETE ALL QUESTIONS

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

THE FIRST PREMIUM WILL BE WITHDRAWN FROM YOUR ACCOUNT IMMEDIATELY

WHEN YOUR CONTRACT IS ISSUED.

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

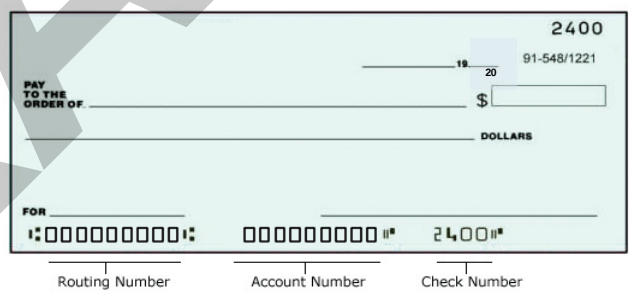
I authorize Thrivent Financial for Lutherans to withdraw funds from my account for my initial and/or monthly renewal premiums and understand that the amounts may differ. I understand my rights and responsibilities with each electronic payment will be the same as if personally paid by me. I understand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

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

Checking ☐
Please attach a voided check

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

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



(9 digits)

Financial Institution Name: Phone #:

Financial Institution Address:

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

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SECTION 7. AUTHORIZATION AND ACKNOWLEDGEMENT

IMPORTANT STATEMENTS TO BE READ BY APPLICANT

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

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

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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

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

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

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SECTION 7. AUTHORIZATION AND ACKNOWLEDGEMENT, CONTINUED

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

_____
PRODUCER NUMBER

X_____ _____
(Signature of Licensed Producer) Date

SECTION 8. FOR ADDITIONAL COMMENTS

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

THRIVENT FINANCIAL®

Membership Application

4321 N. Ballard Road, Appleton, WI 54919-0001
Thrivent.com · 800-THRIVENT (800-847-4836)

Congratulations and Welcome! You are joining a unique membership-owned organization of Christians. At Thrivent Financial for Lutherans (Thrivent), you are more than a consumer of financial products and services; you also join millions of other members who want to be wise with money, live generously, and by doing so, strengthen Christian communities.

Member Protection, Community Support. Thrivent is a special not-for-profit organization. When you buy a Thrivent insurance or annuity product, you gain more than financial protection for you and your family -- you also help strengthen Christian communities. The tax exemption we receive as a fraternal benefit society allows us to direct money we would otherwise pay in taxes to support Thrivent's local chapters and our members' efforts as they give back to their communities.

Our Common Bond. Essential to Thrivent's structure is our common bond among members. More than 100 years ago, our Lutheran founders created an organization called to help members support one another and their communities. We honor our heritage and welcome Christians* seeking to live out their faith.

*For more information on Thrivent's Christian Common Bond, visit Thrivent.com/christiancalling.

Statement of Christian Common Bond:

I am age 16 or older and am applying for membership with Thrivent and a local Thrivent chapter or member network, or I am age 18 or older and applying for membership on behalf of a youth under age 16.

Name of person applying for membership (print first, middle, and last name)

Street (address correction requested)	City		
	State	ZIP code	Phone number
Email address*	Date of birth		Gender ☐ Male ☐ Female

**Email address is required for authentication when applying online for membership. Email address is optional for any other membership application submission.*

Select one of the following:

- ☐ 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.

The Thrivent Way. We are a membership organization of Christians, and our members are our owners. Our purpose is to serve our members and society by guiding both to be wise with money and live generously. We believe that all we have is a gift from God and that generosity is an expression of faith. We succeed when our members, their families and their communities thrive.

I agree to support and further *The Thrivent Way,* and 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 and date signed (mm/dd/yyyy)