

REPORT OF DISABILITY

The furnishing of this form is neither an admission of coverage or liability by the Company nor a waiver of any rights or defenses.

INSTRUCTIONS:

After you have been continuously disabled beyond your required waiting period, please complete the following steps:

- Step 1 - Provide your Loan Information in Part I of this report
This must include the mailing address for the Lending Institution where the payment is made, and the loan/account number.
- Step 2 - Attach a copy of your monthly loan statement or payment coupon.
- Step 3 - You complete Part II below.
- Step 4 - Have your Employer complete the Employer's Statement or if you are self-employed, you complete the Self-Employed Statement. These statements are in Part III on Side 2 of this Report.
- Step 5 - Have the Physician who first treated you for this condition complete Part IV on Side 2 of this Report.
- Step 6 - Complete and sign the separate Authorization to Disclose Personal Information.
- Step 7 - Return the following items in the enclosed envelope:
- (1) completed Report of Disability
 - (2) completed Authorization to Disclose Personal Information
 - (3) a copy of your monthly loan statement or payment coupon.

Check when completed

UNLESS ALL STATEMENTS ARE COMPLETED, FURTHER CONSIDERATION MAY BE DELAYED.

We suggest that you keep in touch with your Lending Institution and make sure you keep your account current.

PART I

LOAN INFORMATION

Lending Institution Name and Address:	
Loan Number/Monthly Loan Payment	Be sure to attach a copy of your monthly loan statement or payment coupon.

PART II

INSURED'S STATEMENT

Insured's Full Name		M	F	Date of Birth		
		Mo.	Day	Year		
Certificate/Policy Contract Number	Social Security Number					
Have you had any previous loans covered by CSO insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No						
If yes, please provide Certificate/Policy Contract Number(s): _____						
Occupation/Duties	Name and Address of Employer					
On what date did the first symptoms of this sickness appear/or date of accident?	What sickness or injury was suffered? If injury, describe accident.					
Date: _____, _____						
Date first unable to work entirely because of present disability.	Have you been able to return to work in any capacity? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Date: _____, _____	If yes, list dates you were able to do some work _____					
Please indicate your next scheduled appointment date along with the name and address of the Doctor you will be seeing: Appt. Date: _____						
Doctor's Name and Address: _____						

WARNING: Any person who knowingly files a statement of claim containing false, incomplete or misleading information may be subject to criminal and civil penalties.

The information provided herein is true and correct to the best of my knowledge.

Date _____ Insured's Signature **X** _____ Phone _____

Street Address _____ City and State _____ Zip Code _____

Mailing Address (if different) _____

PART III

EMPLOYER'S STATEMENT

SIDE 2

EMPLOYEE NAME _____	When did employee first cease work entirely? _____
Please attach: <input type="checkbox"/> copy of employee's job description, or <input type="checkbox"/> a statement which details the employee's job duties	On what date did employee resume any part of his/her work, supervisory or otherwise? Date: _____
Was injury or sickness covered under Workmen's Compensation? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when was injury or sickness? _____, _____ Name and address of Workmen's Compensation carrier: _____ _____	Did employee work <input type="checkbox"/> full or <input type="checkbox"/> part time at the onset of disability? Hire Date _____ If part time, how many hours a week _____ Does your company allow light duty? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date _____, _____ Signed _____ Company Name and Authorized Signature _____ (Phone) _____ _____ (Street and No.) (City or Town) (State) (Zip)	

SELF-EMPLOYED STATEMENT

Name and Address of Business _____		
Website Address / E-mail Address _____	Business Phone Number _____	
Type of Business _____	What date did you start your business? _____	How many hours a week did you work prior to your total disability? _____
Have you returned to your regular, full-time job? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, on what date? _____	If no, is the business still operational? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, in what capacity? _____
Have you returned to work part-time or with restrictions? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how many hours per week? _____	What restrictions? _____
Date _____, _____ Your Signature _____		

PART IV ATTENDING PHYSICIAN'S STATEMENT (Statement to be provided without charge to CSO)

1. Patient's Name _____	Age _____	2. Diagnosis (if surgery, describe and provide date of surgery) _____
3. Date symptoms began _____	When did patient first consult you for this condition? _____	4. Give all dates of treatment _____
5. If hospitalized, give name and address of hospital: _____		Dates of confinement: _____
6. Has any other Physician seen patient for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No Physician's Name: _____		If yes, please provide: Address: _____ Phone No.: _____
7. Please indicate the patient's next scheduled appointment date along with the name and address of the Physician the patient will be seeing: Appointment Date: _____ Physician's Name and Address: _____		
8. Patient is / was: <input type="checkbox"/> Totally Disabled? (Unable to work their own occupation) <input type="checkbox"/> Partially Disabled (Light duty own occupation) From _____ through _____ From _____ through _____		
Please list restrictions: _____		
Estimated future disability Weeks _____ Months _____ Date you anticipate patient returning to work _____		
9. Have you treated this patient for any other conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No Diagnosis: _____		If yes, please give diagnosis and treatment dates. Treatment Dates: _____
Date _____, _____ Phone _____ Fax _____		
Attending Physician's Signature and Typed/Printed Name _____ _____ (Address) (City or Town) (State) (Zip Code)		

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION

I hereby authorize any Medical Persons and Entities to use or disclose Personal Information/Medical Records to Central States Health & Life Co. of Omaha (CSO) and any other entities acting on behalf of CSO regarding:

Patient's Full Name: _____

Other names by which the patient may have been known by: _____

Date of Birth: _____ If deceased, Date of Death: _____

Patient's Address: _____

The Personal Information being disclosed may be used to determine eligibility for insurance, resolve or contest any issues of incomplete, incorrect or misrepresented information on the application; or determine eligibility for benefits.

Information to be released can be mailed or faxed to:

ATTN Claims Department
 Central States Health & Life Co. of Omaha
 PO Box 34350 Omaha, NE 68134-0350

or

ATTN Claims Department
 Secure Fax: 1-800-325-9116

Meanings of Terms

"Medical Persons and Entities" means: all physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations, all other providers of medical or dental services, Central States Health & Life Co. of Omaha and other insurance companies.

"Personal Information" means: all health information, such as medical history, entire medical records, mental and psychiatric records (excluding psychotherapy notes), prescription drug records, drug and alcohol use records and other information such as finances, occupation, general reputation and insurance coverage and claims information, about the patient. It may also include information, which may be considered a communicable or a sexually transmitted disease, which may include, but are not limited to diseases such as Hepatitis, Syphilis, Gonorrhea, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) and HIV infection.

Potential of Rediscovery

If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information would then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations.

I Can Refuse to Sign - Consequences

I understand that I may refuse to sign this authorization. I realize that refusal to sign this authorization may result in the lack of necessary information needed to issue the insurance being applied for, or to process the claim being presented.

Expiration and Revocation

Unless revoked earlier, this authorization will remain in effect for the earlier of the duration of the claim or for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to: ATTN: Legal Department, Central States Health & Life Co. of Omaha, P.O. Box 34350, Omaha, NE 68134-0350, and the entity that was authorized to disclose the information. The revocation is not effective until it is received by the entity that was previously authorized to disclose the information.

I realize that my right to revoke this authorization is limited to the extent that CSO has taken action in reliance on the authorization or the law provides CSO with the right to contest the policy itself.

Copy

I understand that I have a right to receive a copy of the signed authorization. I also understand that a copy of this authorization is as valid as the original.

 Patient Signature (if living), otherwise signature of Personal Representative / Next of Kin _____
Date

 If patient is deceased, printed Name of Personal Representative / Next of Kin _____
Relationship to Patient

 Address City, State and Zip Phone No.

List names of physician(s)/health care provider(s) who have treated the patient within the last 3 years, including the names of all pharmacies used in the last 3 years. Attach additional sheet if necessary.			
Primary Physician	Address	Phone No.	Dates of Treatment
Physician/Health Care Provider/Pharmacy	Address	Phone No.	Dates of Treatment
Physician/Health Care Provider/Pharmacy	Address	Phone No.	Dates of Treatment
Physician/Health Care Provider/Pharmacy	Address	Phone No.	Dates of Treatment
Physician/Health Care Provider/Pharmacy	Address	Phone No.	Dates of Treatment