



P.O. Box 34350 • Omaha, NE 68134-0350
 1-800-826-6587 • Fax: 1-888-748-3033

Central States Health & Life Co. of Omaha

When faxing forms, please follow up with originals by mail.

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

REPORT OF DEATH

INSTRUCTIONS:

- (1) Creditor complete Report of Death
 - (2) Submit a certified copy of the Death Certificate with this Report of Death.
- The furnishing of this form is neither an admission of coverage or liability by the Company nor a waiver of any rights of defenses.*

CREDITOR'S STATEMENT

Name of Insured in full _____

Address _____

LOAN OR CONTRACT INFORMATION	INSURANCE INFORMATION
Date of Note: _____	Effective Date of Policy: _____
Has note been refinanced since above date? _____	_____
If yes, when? _____	Policy Number: _____
Amount of Note: _____	_____
Term of Note: _____	Original Amount of Life Insurance: _____
First Payment Due Date: _____	_____
Last Payment Due Date: _____	Term of Policy (months): _____
Amount Paid Prior to Death: _____	_____
Date of Last Payment: _____	
Outstanding Balance (including fees): _____	

PAYOFF INFORMATION

NOTE: There is no life premium refund given on a life claim. Please remember to include the Life Premium back into the Net Pay-Off Balance. (Does not apply in North Carolina, South Carolina and Wyoming).

Pay-Off Balance (principal only)*: + _____ As of date of death: _____

Interest accrued up to filing date: + _____

PLUS Credit Life Premium Refund (as of date of death): + _____

EQUALS Total Amount of Pay-Off: _____

Interest Charged per day: _____

Is Account Delinquent? Yes No How long? _____ Amount? _____

I hereby certify that the answers given above are full and true:

Signed: _____ Date: _____

Official Position: _____

Financial Institution Name: _____

Address: _____

Phone Number: _____ Account Number: _____

*NOTE: Be sure that you have complied with applicable State Laws in computing Net Pay-Off Balance. If policy provides for a Second Beneficiary participation in death proceeds, the benefits in excess of amount paid Creditor will be allowed according to Insurance Statutes.

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION

I, _____ (Name), 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 the deceased _____ (Name)

This Personal Information is being disclosed for the purpose of processing a claim and to determine eligibility for benefits, including review of benefit eligibility, determination of benefit amount and review of representations made in connection with claims for insurance benefits.

Patient's full name _____

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

Date of birth _____ Date of death _____

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) or HIV infection.

Potential of Redisclosure

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 if I refuse to sign, CSO may be unable to process my claim due to lack of necessary information.

Expiration and Revocation

Unless revoked earlier, this authorization will remain in effect for the duration of the claim or 24 months from the date I sign it, whichever occurs first. 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.

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 a claim under the policy or 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.

Date _____

Signature of Co-Borrower or Estate Executor (relationship to insured)

Witness _____

Address _____

Telephone Number _____

Form 815A 2nd Rev.

12-04

ADDITIONAL INFORMATION

Name and address of Insured's personal physician treating Insured within the last two years: _____

Give names and addresses of all hospitals and physicians treating Insured within the last two years: _____