



**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 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 the following steps should be followed:

- (1) Lending Institution complete Part I below.
- (2) This Report will be returned if account number is not provided.
- (3) In lieu of Lending Institution completion attach a copy of payment coupon.
- (4) You complete Part II below.
- (5) Have your Employer complete Part III on the reverse side.
- (6) Have physician who first treated you for this condition complete Part IV on Side 2.
- (7) Return the completed Report in the enclosed envelope.
- (8) We suggest you keep in contact with your Lending Institution and make sure your account remains current.

**PART I**

**CREDITOR'S STATEMENT**

NAME OF INSURED	CERTIFICATE NO.	AGENT NO.
Initial amount of life insurance \$ _____ Mo. Benefit \$ _____ Effective Date: _____ Term: _____		
Has Insured had a previous loan with CSO Insurance Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No CERTIFICATE NO _____		
NAME OF LENDING INSTITUTION		
ADDRESS OF LENDING INSTITUTION		
City	State	Zip
LOAN/ACCOUNT NUMBER MUST BE COMPLETED _____		
Date _____	Signed _____	Phone ( ) _____

**PART II**

**INSURED'S STATEMENT**

Insured's Full Name	M	F	Date of Birth	Occupation/Duties	Name & Address of Employer
			Mo. Day Year		
On what date did the first symptoms of this sickness appear/or date of accident? Date: _____			What sickness or injury was suffered? If injury, describe accident.		
Date first unable to work entirely because of present disability. Date: _____			Have you been able to return to work in any capacity? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list dates you were able to do some work _____		
List names of primary physician and other physician(s) who have treated you within the last 3 years. Attach additional sheet if necessary.					
		ADDRESS(ES):		PHONE NO.	DATE(S) OF TREATMENT:
<input type="checkbox"/> Primary Physician: _____					
<input type="checkbox"/> Physician treating disability: _____					

**AUTHORIZATION TO OBTAIN INFORMATION**

**UNLESS ALL STATEMENTS ARE COMPLETED FURTHER PAYMENT MAY BE DELAYED.**

I HEREBY AUTHORIZE ANY PHYSICIAN OR PRACTITIONER OF THE HEALING ARTS WHO HAS EXAMINED OR TREATED ME, AND ALL HOSPITALS, CLINICS OR MEDICALLY RELATED FACILITIES, INSURANCE COMPANIES, HEALTH MAINTENANCE ORGANIZATIONS, MEDICAL INFORMATION BUREAU, GOVERNMENT ENTITY (FEDERAL, STATE OR LOCAL) OR OTHER ORGANIZATION, INSTITUTION OR PERSON, THAT HAS ANY INFORMATION, RECORDS OR KNOWLEDGE OF ME OR MY HEALTH, PAST OR PRESENT, TO FURNISH TO THE CENTRAL STATES HEALTH & LIFE CO. OF OMAHA (OR ITS REPRESENTATIVES) AND TO PERMIT THEM TO EXAMINE AND COPY ANY SUCH INFORMATION. I UNDERSTAND THAT THE CENTRAL STATES HEALTH & LIFE CO. OF OMAHA MAY DISCLOSE THE INFORMATION TO THE MEDICAL INFORMATION BUREAU, OR REINSURERS, OR AGENTS, EMPLOYEES AND OTHERS WHO HAVE A LEGITIMATE BUSINESS INTEREST IN OBTAINING THE INFORMATION IN CONNECTION WITH UNDERWRITING OR CLAIMS PROCESSING WITH THE COMPANY.

SUCH RELEASE MAY INCLUDE INFORMATION WHICH MAY BE CONSIDERED A COMMUNICABLE OR VENEREAL 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. THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS INVOLVING PSYCHIATRIC, DRUG ABUSE, AND/OR ALCOHOLISM.

A COPY OF THIS AUTHORIZATION, OR THE ORIGINAL, SHALL BE VALID FOR THE DURATION OF THE CLAIM FROM THE DATE SIGNED. I ACKNOWLEDGE THAT I HAVE A RIGHT TO A COPY OF THIS AUTHORIZATION UPON REQUEST.

Date \_\_\_\_\_ Insured's Signature **X** \_\_\_\_\_  
 Phone Number \_\_\_\_\_ Social Security Number \_\_\_\_\_  
 Street Address \_\_\_\_\_ City and State \_\_\_\_\_ Zip Code \_\_\_\_\_

