CSO Family of Companies
P.O. Box 641668 • Omaha, NE 68164-7668
1-888-453-5125 • Fax: 1-800-325-9116

SIDE 1

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

REPORT OF DISABILITY

The furnishing of this form is neither an admission of protection or liability by the Financial Institution or a waiver of any rights or defenses.

INSTRUCTIONS:

After you have been continuously and totally disabled beyond your required waiting period, the following steps should be followed:

(1) Part 1 is to be completed by the Financial Institution. An Addendum or loan / line of credit (LOC) number is required to consider benefits.
(2) Part 2 is to be completed by the Protected Borrower.
(3) Part 3 is to be completed by the current Employer or; if you are self-employed, you complete the Self-Employment statement.
(4) Part 4 is to be completed by the Physician who first treated you for this condition.
(5) The separate Authorization to Disclose Personal Information is to be competed by the Protected Borrower.
(6) Return the completed Report of Disability, and the completed Authorization to Disclose Personal Information in the enclosed envelope or send to CSO at the address shown above.

Unless all statements are completed, further consideration may be delayed.
We suggest that you keep in contact with your Financial Institution and make sure your account remains current.

PART 1 FINANCIAL INSTITUTION - LOAN / LOC INFORMATION

(If LOC, submit loan history for 2 months prior to the date of loss)

Financial Institution Name: ______________________________
(Where the borrower sends their loan / LOC payments.)

Address (street, city, state, zip):______________________ Phone Number:____________

Addendum Number: ____________ Effective Date of Protection:____________ Term:__________

Loan / LOC Number: ____________ Effective Date of the Loan / LOC:____________ Term: __________
(If different from Addendum Number)

Have loan extensions been granted on this Loan? ☐Yes ☐No

If Debt Cancellation Protection was offered through a dealer, please provide the Dealer's Name and a copy of the loan statement or payment coupon.

Dealer Name:______________________________

Financial Institution Officer's Signature:____________________ Date: ____________

Printed Name: ______________________________

PART 2 PROTECTED BORROWER INFORMATION:

Name: ______________________________ Phone Number: ____________

Social Security Number: ____________________ Date of Birth: ____________

Occupation: ____________________ Job Duties: ____________________

Are you a seasonal worker (a person whose occupation can be carried on only during certain seasons or fairly definite portions of the year)?
☐Yes ☐No

Name of Current Employer:____________________ Date of Hire: ____________

Employment information at time of loan:

Employed By:____________________
From ____________ to ____________
Address: ____________________
Phone Number:____________________

Employment information at time of sickness or accident:

Employed By: ____________________
From____________ to ____________
Address:____________________
Phone Number: ____________________

Date of first symptoms or date of accident: ____________ Date first unable to work____________

If disability is due to an accident, describe how accident occurred and provide a copy of the accident or police report (if any), and provide the complete name and address of the Medical Provider who first treated you: ______________________________
____

Have you been able to return to work in any capacity? ☐Yes ☐No If Yes, list dates: ____________

Please indicate your next scheduled appointment date along with the name and address of the Doctor you will be seeing:

Appointment Date:____________ Doctor's Name & Address:____________________

WARNING: Any person who knowingly submits a request for benefits containing a false or deceptive statement is guilty of fraud and may be subject to criminal penalties.

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

Date: ____________________ Protected Borrower's Signature: ____________________

Date of Birth: ____________ Address: ____________________

Mailing Address (if different) ______________________________

PART 3 EMPLOYER'S STATEMENT

(To be completed by Employee's current Employer)

Employee's Name:________________

Does your company allow light duty? ☐ Yes ☐ No

Date employee stopped work entirely due to disability:________________

Has employee resumed duties, light or otherwise? Date:________________

List employee's job duties or attach a copy of the job description: ________________

Is the employee a seasonal worker (a person whose occupation can be carried on only during certain seasons or fairly definite portions of the year)? ☐ Yes ☐ No

At the onset of disability, was the employee gainfully employed (actively working for wages or profit) for at least 30 hours per week? ☐ Yes ☐ No

How long prior to the date of disability was the employee gainfully employed (actively working for wages or profit) for at least 30 hours per week?________________

Employee's date of hire:________________

If employed part-time, how many hours per week?________________

If disability is due to an injury, date of injury:________________

If disability is due to a work related accident, please provide a copy of the accident report.

Did Workmen's Compensation cover disability? ☐ Yes ☐ No

If so, name and address of Workmen's Compensation carrier:

____

Signature: ________________ Date: ________________

Printed Name: ________________ Title:________________

Address: ________________ Phone Number:________________

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? ________________

Number of hours worked per week prior to total disability: ________________

Have you returned to your regular, full-time job? ☐ Yes ☐ No If yes, on what date? ________________

If no, is the business still operational? ☐ Yes ☐ No If yes, in what capacity? ________________

Have you returned to work part-time or with restrictions? ☐ Yes ☐ No If yes, how many hours per week?________________

What are the restrictions? ________________

Signature: ________________ Date: ________________

PART 4 ATTENDING PHYSICIAN'S STATEMENT

(Statement to be provided without charge to CSO)

Patient's Name: ________________ Date of Birth: ________________

Diagnosis, if surgery describe and provide date of surgery: ________________

Is the disability a result of an accident? ☐ Yes ☐ No

Date symptoms began or date of accident: ________________ Date first consulted for this condition: ________________

All dates of treatment: ________________

Please indicate the patient's next scheduled appointment date along with the name and address of the Doctor the patient will be seeing:

Appointment Date:________________ Doctor's Name & Address: ________________

Has any other Physician treated this patient for this condition? ☐ Yes ☐ No If yes, physician's name, address and phone number:

Name:	Address:	Phone Number:

Have you treated this patient for any other conditions? ☐ Yes ☐ No If yes, provide diagnosis and treatment dates:

Diagnosis:	Treatment Dates:

If hospitalized, name and address of hospital:________________

Dates of confinement: ________________

Patient is:
☐ Totally Disabled (unable to work their own occupation) From________________ Through ________________
☐ Partially Disabled (Light duty their own occupation) From________________ Through ________________

Please list restrictions:________________

Attending Physician's Signature, printed name, date, address and phone number:

____
Physician's Signature | Printed Name | Date

____
Address | City or Town | State | Ziip | Phone Number

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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) as Administrator for my financial institution 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 protection, 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
CSO Family of Companies
PO Box 641668 Omaha, NE 68164-7668

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 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 refusal to sign this authorization may result in the lack of necessary information needed to issue the protection being applied for, or to process the benefit request being presented.

Expiration and Revocation

Unless revoked earlier, this authorization will remain in effect for the earlier of the duration of the benefit request 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: CSO Family of Companies, P.O. Box 641668, Omaha, NE 68164-7668, 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 the Protected Borrower's financial institution has taken action in reliance on the authorization or the law provides the financial institution with the right to contest a request for benefits or the Addendum 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