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.

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.

REPORT OF UNPAID FAMILY LEAVE

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 on Unpaid Family Leave 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 3 is to be completed by the Protected Borrower.
(3) Part 2 is to be completed by the Protected Borrower's Employer.
(4) Return the completed Report of Unpaid Family Leave in the enclosed envelope or send to CSO at the address shown above.

We suggest that you keep in contact with your Financial Institution and make sure your account remains current.

PART I - FINANCIAL INSTITUTION - LOAN / LOC INFORMATION: (If LOC, submit loan history for 3 months prior to the date of loss)

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

Address: _____ Phone Number: _____
(Street, City, State, Zip)

Addendum Number: _____ Effective Date of Protection: _____ Term: _____

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

Scheduled Minimum Monthly Payment _____

If Debt Cancellation Protection was offered through a dealer, please provide the Dealer's Name and Account Number.

_____ _____
(Dealer Name) (Dealer Account Number)

_____ _____
(Financial Institution Officer's Signature) (Date)

Printed Name: _____ Title: _____

PART 2 - EMPLOYER'S STATEMENT

Employee's Name: _____

The information in Section 3 (on back) agrees completely with our records except as follows: _____

_____

Employee's Date of Hire: _____ Does Employee Work ☐ full or ☐ part-time? If part-time, how many hours per week? ____

Please provide the following dates:

Date employee's absence from work began: _____

Date employee's income stopped as a result of their absence from work: _____

Date returned to work: _____

Signature: _____ Date: _____

Printed Name: _____ Title: _____

Address: _____ Phone Number: _____

PART 3 - PROTECTED BORROWER INFORMATION:

Name: _____ Phone Number: _____

Address: _____
(Street, City, State, Zip)

Social Security Number: _____ Date of Birth: _____

Occupation: _____ Name of Employer: _____

Please provide the following dates:

Date your absence from work began: _____

Date income stopped as a result of your absence from work: _____

Date returned to work: _____

Reason for Unpaid Family Leave:

☐ Caring for your newborn or adopted child. Date of birth or adoption: _____ **Include proof of birth or adoption**.

☐ Caring for a Family Member who has a serious medical condition.

Name of Family Member being cared for: _____ Relationship to Family Member: _____

Medical Condition: _____ Date condition began: _____

Attending Physician's Name: _____ Phone No.: _____

Attending Physicians Address: _____

☐ Principal residence is in a Federally Declared Disaster Area.

Date of disaster: _____ Description of disaster: _____

Please provide address at time of disaster **if different** from current mailing address shown above:

_____

☐ Jury Duty. **Include a copy of your summons for duty**

☐ Mandatory recall to active Military Service. **Include a copy of Your Military Orders.**

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AUTHORIZATION TO OBTAIN INFORMATION
UNLESS ALL STATEMENTS ARE COMPLETED, FURTHER CONSIDERATION MAY BE DELAYED

The information stated above is true and correct. I hereby authorize any employer, insurance company, government entity (federal, state or local) or other organization, institution or person, that has any information, records, or knowledge of me, past or present, to furnish this information to Central States Health & Life Co. of Omaha (CSO) as Administrator for my financial institution (or its representatives) and to permit them to examine and copy any such information. I understand that CSO may disclose the information to business partners who have a legitimate business need to obtain the information in connection with underwriting or benefits processing with the company. I also authorize CSO to have access to the account for which the request for benefits is being made.

A copy of this authorization, or the original, shall be valid for the duration of the benefits from the date signed. I acknowledge that I have a right to a copy of this authorization upon request.

Date: _____ Protected Borrower's Signature: _____

Date of Birth: _____ Address: _____