CSO P.O. Box 34350 • Omaha, NE 68134-0350
1-800-826-6587 • Fax: 1-800-325-9116
Central States Health & Life Co. of Omaha
Credit Insurance Administrator for First National Life Insurance Company *of the* USA

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

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:

Check when completed

- ☐ 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.

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? ☐ Yes ☐ 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? 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? ☐ Yes ☐ No 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: ☐ copy of employee's job description, or ☐ 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? ☐ No ☐ Yes If yes, when was injury or sickness? ______ , ______ Name and address of Workmen's Compensation carrier: ______ ______	Did employee work ☐ full or ☐ part time at the onset of disability? Hire Date ______ If part time, how many hours a week______ Does your company allow light duty? ☐ Yes ☐ 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? ☐ Yes ☐ No	If yes, on what date?	If no, is the business still operational? ☐ Yes ☐ No If so, in what capacity?
Have you returned to work part-time or with restrictions? ☐ Yes ☐ 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? ☐ Yes ☐ No If yes, please provide:

Physician's Name: 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: ☐ Totally Disabled? (Unable to work their own occupation) ☐ 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? ☐ Yes ☐ No If yes, please give diagnosis and treatment dates.

Diagnosis: Treatment Dates:

______ ______

______ ______

______ ______

Date ______ , ______ Phone______ Fax ______

Attending Physician's Signature and Typed/Printed Name ______

______

(Address) (City or Town) (State) (Zip Code)

This form cannot be laser printed or reproduced without prior approval from CSO.