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 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) Return the completed Report of Disability 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 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:_____

List names of primary physician and other physician(s) who have treated you within the last 2 years. Attach additional sheet if necessary.

ADDRESS(ES): PHONE NO.: DATE(S) OF TREATMENT:

Primary Physician:_____

_____

Physician treating disability:_____

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 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, 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 this information to Central States Health & Life Co. of Omaha as the Administrator for my Financial Institution (or its representatives) and to permit them to examine and copy any such information. I understand that the Administrator 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 the Administrator to have access to my account for information that is necessary to process my request for benefits.

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 benefits or 24 months from the date signed, whichever occurs first. I acknowledge that I have a right to a copy of this authorization upon request.

Date: _____ Protected Borrower's Signature: _____

Date of Birth: _____ Address: _____

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**

Patient's Name: _____ Date of Birth: _____

Diagnosis, if surgery describe: _____

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

Date of Onset/Injury: _____ Date first consulted for this condition: _____

Dates of all 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