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.

POLICYOWNER'S PROGRESS REPORT

Claim No._____ Date _____

Full Name _____ Social Security No. _____

Do you remain totally disabled and unable to work? ☐ Yes ☐ No If yes, please indicate your next scheduled appointment along with the name and address of the Doctor you will be seeing: Appointment Date _____

Physician's Name & Address_____

If no, on what date were you able to do any part of your work, supervisory or otherwise? _____

What are your current job duties? _____

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: _____ Policyowners Signature: _____

Phone: _____ Street Address: _____
CITY OR TOWN STATE ZIP CODE

Mailing Address (if different from street address): _____

ATTENDING PHYSICIAN'S PROGRESS STATEMENT

(Statement to be provided without charge to CSO)

(UNLESS BOTH STATEMENTS ARE COMPLETED FURTHER PAYMENT MAY BE DELAYED)

I hereby certify that _____
PATIENT'S NAME

☐ Continues to be totally disabled from _____ and is still being regularly treated by
CAUSE OF DISABILITY INCLUDING ANY COMPLICATIONS

me. I last examined the patient on _____. The next scheduled appointment date is:_____ .
DATE DATE

Please list restrictions: _____

☐ Is being referred to _____ for additional treatment on _____
PHYSICIAN'S NAME AND ADDRESS APPOINTMENT DATE

☐ Is partially disabled beginning_____ through _____ _____
CAUSE OF DISABILITY INCLUDING ANY COMPLICATIONS

Please list restrictions: _____

Probable further total disability should not exceed 1 2 3 4 5 6 7 8 9 Weeks ☐
Months ☐
Permanent ☐

☐ RELEASED to return to work on_____ , _____

I certify that the above information is correct.

X _____
ATTENDING PHYSICIAN'S SIGNATURE AND TYPED NAME

_____ , _____ _____ _____
MONTH / DAY YEAR PHONE NUMBER FAX NUMBER

_____
ADDRESS CITY OR TOWN STATE ZIP CODE