CSO P.O. Box 34350 • Omaha, NE 68134-0350
1-800-826-6587 • Fax: 1-888-748-3033
Central States Health & Life Co. of Omaha

SIDE 1
When faxing forms, please follow up with originals by mail.

WARNING: Any person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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 the following steps should be followed:

(1) Lending Institution complete Part I below.
(2) **This Report will be returned if account number is not provided.**
(3) **In lieu of Lending Institution completion attach a copy of payment coupon.**
(4) You complete Part II below.
(5) Have your Employer complete Part III below.
(6) Have physician who first treated you for this condition complete Part IV on Side 2.
(7) Return the completed Report in the enclosed envelope.
(8) We suggest you keep in contact with your Lending Institution and make sure your account remains current.
(9) When faxing your claim form, please follow up with an original by mail.

PART I — CREDITOR'S STATEMENT

NAME OF INSURED	CERTIFICATE NO.	AGENT NO.
Stacy D. Orchard	20-053-919	1195402

Initial amount of life insurance $ 1,053.11 Mo. Benefit $ 96.18 Effective Date: 12/06/07 Term: 11M 22 D

Has Insured had a previous loan with CSO insurance Coverage? ☒ Yes ☐ No CERTIFICATE NO 20-053-376

NAME OF LENDING INSTITUTION
First State Bank Southwest

ADDRESS OF LENDING INSTITUTION
202 2nd Ave. SE, PO Box 68 City Pipestone State MN Zip 56164

LOAN/ACCOUNT NUMBER MUST BE COMPLETED

Date 1-23-08 Signed [signature] Phone (507) 825-0055

PART II — INSURED'S STATEMENT

Insured's Full Name	M	F	Date of Birth Mo.	Day	Year	Occupation/Duties	Name & Address of Employer
Stacy Dianne Orchard		Y	2	17	70	assembly	CMC of Pipestone

On what date did the first symptoms of this sickness appear/or date of accident?	What sickness or injury was suffered? If injury, describe accident.
Date: Nov. 10th, 2007	depression / Anxiety / Hospitalized
Date first unable to work entirely because of present disability. Date: Dec. 5th 2007	Have you been able to return to work in any capacity? ☒ Yes ☐ No If yes, list dates you were able to do some work 1-21-08 4 hrs

List names of primary physician and other physician(s) who have treated you within the last 3 years. Attach additional sheet if necessary.

	ADDRESS(ES):	PHONE NO.	DATE(S) OF TREATMENT:
☐ Primary Physician: Dr. Greg Cooper	Pipestone	825-5700	Nov, Dec, Jan
☐ Physician treating disability: Dr. Heather Chester-Adams		605-322-4030	Dec, Jan

AUTHORIZATION TO OBTAIN INFORMATION

UNLESS ALL STATEMENTS ARE COMPLETED FURTHER PAYMENT MAY BE DELAYED.

THIS AUTHORIZATION DOES NOT INCLUDE ANY INFORMATION DETERMINING THE PRESENCE OF A BLOODBORNE PATHOGEN, HUMAN IMMUNODEFICIENCY VIRUS (HIV), OR HEPATITIS B (HBV) OR C (HCV) VIRUS, OBTAINED FROM TEST RESULTS ADMINISTERED TO A CRIMINAL OFFENDER OR A CRIME VICTIM AS A RESULT OF A CRIME THAT WAS REPORTED TO THE POLICE; TO A PATIENT WHO RECEIVED THE SERVICES OF EMERGENCY MEDICAL SERVICES PERSONNEL AT A HOSPITAL OR MEDICAL CARE FACILITY; OR TO AN EMERGENCY MEDICAL SERVICES PERSON WHO WAS TESTED AS A RESULT OF PERFORMING EMERGENCY MEDICAL SERVICES. THE TERM "BLOODBORNE PATHOGENS" MEANS PATHOGENIC MICROORGANISMS THAT ARE PRESENT IN HUMAN BLOOD AND CAN CAUSE DISEASE IN HUMANS. THESE PATHOGENS INCLUDE, BUT ARE NOT LIMITED TO, HEPATITIS B VIRUS (HBV), HEPATITIS C VIRUS (HCV), AND HUMAN IMMUNODEFICIENCY VIRUS (HIV). THE TERM "EMERGENCY MEDICAL SERVICES PERSON" MEANS: AN INDIVIDUAL EMPLOYED OR RECEIVING COMPENSATION TO PROVIDE OUT-OF-HOSPITAL EMERGENCY MEDICAL SERVICES SUCH AS A FIREFIGHTER, PARAMEDIC, EMERGENCY MEDICAL TECHNICIAN, LICENSED NURSE, RESCUE SQUAD PERSON, OR OTHER INDIVIDUAL WHO SERVES AS AN EMPLOYEE OR VOLUNTEER OF AN AMBULANCE SERVICE, OR A MEMBER OF AN ORGANIZED FIRST RESPONDER SQUAD FORMALLY RECOGNIZED BY A POLITICAL SUBDIVISION IN THE STATE, WHO PROVIDES OUT-OF-HOSPITAL EMERGENCY MEDICAL SERVICES DURING THE PERFORMANCE OF THE INDIVIDUAL'S DUTIES; AN INDIVIDUAL EMPLOYED AS A LICENSED PEACE OFFICER; AN INDIVIDUAL EMPLOYED AS A CRIME LABORATORY WORKER WHILE WORKING OUTSIDE THE LABORATORY AND INVOLVED IN A CRIMINAL INVESTIGATION; ANY INDIVIDUAL RENDERING EMERGENCY CARE OR ASSISTANCE AT THE SCENE OF AN EMERGENCY OR WHILE AN INJURED PERSON IS BEING TRANSPORTED TO RECEIVE MEDICAL CARE AND WHO IS ACTING AS A GOOD SAMARITAN; AND ANY INDIVIDUAL WHO MAY HAVE EXPERIENCED A SIGNIFICANT EXPOSURE TO A SOURCE INDIVIDUAL WHILE IN THE PROCESS OF EXECUTING A CITIZEN'S ARREST. THE TERM "SIGNIFICANT EXPOSURE" MEANS CONTACT LIKELY TO TRANSMIT A BLOODBORNE PATHOGEN, IN A MANNER SUPPORTED BY THE MOST CURRENT GUIDELINES AND RECOMMENDATIONS OF THE US PUBLIC HEALTH SERVICE AT THE TIME AN EVALUATION TAKES PLACE, THAT INCLUDES: (1) PERCUTANEOUS INJURY, CONTACT OF MUCOUS MEMBRANE OR NON INTACT SKIN, OR PROLONGED CONTACT OF INTACT SKIN; AND (2) CONTACT, IN A MANNER THAT MAY TRANSMIT A BLOODBORNE PATHOGEN, WITH BLOOD, TISSUE, OR POTENTIALLY INFECTIOUS BODY FLUIDS. THE TERM "SOURCE INDIVIDUAL" MEANS AN INDIVIDUAL, LIVING OR DEAD, WHOSE BLOOD, TISSUE, OR POTENTIALLY INFECTIOUS BODY FLUIDS MAY BE A SOURCE OF BLOODBORNE PATHOGEN EXPOSURE TO AN EMERGENCY MEDICAL SERVICES PERSON. EXAMPLES INCLUDE, BUT ARE NOT LIMITED TO, A VICTIM OF AN ACCIDENT, INJURY, OR ILLNESS OR A DECEASED PERSON.

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, MEDICAL INFORMATION BUREAU, 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 TO THE CENTRAL STATES HEALTH & LIFE CO. OF OMAHA (OR ITS REPRESENTATIVES) AND TO PERMIT THEM TO EXAMINE AND COPY ANY SUCH INFORMATION. I UNDERSTAND THAT THE CENTRAL STATES HEALTH & LIFE CO. OF OMAHA MAY DISCLOSE THE INFORMATION TO THE MEDICAL INFORMATION BUREAU, OR REINSURERS, OR AGENTS, EMPLOYEES AND OTHERS WHO HAVE A LEGITIMATE BUSINESS INTEREST IN OBTAINING THE INFORMATION IN CONNECTION WITH UNDERWRITING OR CLAIMS PROCESSING WITH THE COMPANY.

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 EXCEPT AS RESTRICTED ABOVE. 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 CLAIM FROM THE DATE SIGNED. I ACKNOWLEDGE THAT I HAVE A RIGHT TO A COPY OF THIS AUTHORIZATION UPON REQUEST.

Date 1-24-08 Insured's Signature X Stacy Orchard

Phone Number 562-0432 Social Security Number 476-06-4278

Street Address 1105 5th Ave SW City and State Pipestone, MN Zip Code 56164

PART III EMPLOYER'S STATEMENT SIDE 2

EMPLOYEE NAME	On what date did employee resume any part of his/her work, supervisory or otherwise? Date:
When did employee first cease to stop work entirely? Date:	
List job duties of employee occupation	Classification: Light ____ Medium ____ Heavy ____
Was injury or disease covered under Workmen's Compensation? ☐ No ☐ Yes If yes, when was injury? ____ 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 lite duty? ____

Date ____ Signed ____
Company Name and Authorized Signature (Phone)
(Street and No.) (City or Town) (State) (Zip)

PART IV ATTENDING PHYSICIAN'S STATEMENT

1. Patient's Name Stacy Orchard Age 37

2. Diagnosis
If surgery, describe Major Depressive Disorder
Panic Disorder

3. Date of Onset
Date December 26, 2007
When did patient first consult you for this condition?
Date December 26, 2007

4. Give dates of all treatment
December 26, 2007 → current
Estimated future disability
____ weeks ____ months
If disability continues what date do you anticipate your patient returning to work? Date ____

5. Has any other Physician seen patient for this condition? ☐ Yes ☐ No
Physician's Name: Address: Phone No.:
Dr. Umesh Rao Chakurta MD Psychiatric Resident 605-322-5700
Dr. H. Chester-Adem MD
4400 West 69th St. Suite 1500
Sioux Falls, S.D. 57108

6. Have you treated this patient for any other conditions? If yes, please give diagnosis and treatment dates.
Diagnosis: Date:
NO

7. If hospitalized give name and address of hospital: Date of Confinement: Not continuous -
Avera McKennan Behavioral Health Center 12-26-07 - present

8. Is this patient: Totally Disabled? (Unable to work–own occupation)
From 12-26-07 Through present
Partially Disabled? (Lite duty–own occupation)
From ____ Through ____

Date 1-25-08 Phone 605-322-5700

Scott Ruge CNP MSN
Attending Physician Signature and Typed Name

4400 W. 69th St. Sioux Falls S.D. 57108
(Address) (City or Town) (State) (Zip Code)

Form 687 13th Rev. MN 12-04

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