Underwritten by
Mutual of Omaha Insurance Company
3300 Mutual of Omaha Plaza | Omaha, NE 68175

Claimant's Statement for Critical Illness Insurance Benefits

Claim Number: **Policy Number:**

1. Owner's Name (First)_____ (Last)_____

2. Claimant's Name (First)_____ (Last)_____Date of Birth _____/____/____
Month Day Year

   Claimant's Address (Street)_____(City)_____(State)____(Zip Code)_____

   Social Security Number _____-_____-_____ Telephone Number (____) _____ - _____

3. Please describe the nature and extent of your Critical Illness:_____

   _____

4. On what date was your medical condition diagnosed or surgical procedure performed? ____/____/____

5. On what date did symptoms first begin? _____/_____/_____

6. Please describe these symptoms:_____

   _____

7. On what date did you first consult a medical practitioner in connection with your medical condition? __/__/__

   Please indicate the name and address of the medical practitioner seen:

   Name_____ Phone Number (____) _____ - _____

   Address (Street) _____(City) _____ (State)_____ (Zip Code)_____

8. Have you undergone any tests or investigations related to the diagnosis? If yes, please provide details and dates:

   _____

   _____

9. Have you previously suffered from, or received treatment for, a similar or related medical condition? If yes, please provide details:_____

   _____

10. Please provide the Name and Address of your personal physician:

    Name_____ Phone Number (____) _____ - _____

    Address (Street) _____ (City) _____ (State) _____ (Zip Code)_____

Policy Number:

11. Please provide details of any other medical practitioners or specialists who have been consulted in connection with your medical condition:

Name	Address	Dates Seen
_____	_____	_____
_____	_____	_____

12. If you have been treated at a hospital or another facility, please supply the following information:

Name of Hospital/Facility	City/State	Dates of Confinement
_____	_____	_____ - _____
_____	_____	_____ - _____

13. What other treatments have you received or are you currently receiving in connection with your medical condition? (medications, therapy, etc.):

Types of Treatment	Institution/Prescribing Physician	Dates
_____	_____	_____
_____	_____	_____

14. Are you insured for benefits related to this condition from another company? If yes, please indicate:

Name of Insurer	Type of Benefit	Amount of Benefit	Has a Claim Been Filed?
_____	_____	_____	_____

15. Do you smoke or use tobacco products? No ( ) Yes ( )

    If "Yes", please indicate type and amount per day:_____

    If "No", did you previously use tobacco products? No ( ) Yes ( ) On what date did you quit? _____/_____/_____

16. Please provide any further information that you think might be helpful in support of your claim._____

    _____

I declare the above statements are accurate and complete.

Date_____, 20_____ Claimant's Signature _____

Date_____, 20_____ Owner's Signature _____