MUTUAL of OMAHA INSURANCE COMPANY
Mutual of Omaha Plaza
Omaha, NE 68175
1 800 775 1000
mutualofomaha.com

POLICYOWNER'S CONTINUANCE OF DISABILITY REPORT

Claim No. **Date of last report** _____
Policy Number:

1. Policyowner's full name	Weight _____ Age_____
2. Give dates physician treated you since last report.	Office_____ Therapy_____ Hospital_____
3. If confined in a hospital since last report, give hospital and period covered	Hospital and address From _____ to _____
4. What are your activities and how do you spend your time?	
5. Describe any change in your condition.	
6. Have you resumed any duties?	No _____ Yes _____ Date you resumed work_____
7. Number of Hours Worked: _____	This Months Earnings _____ (Attach Earnings Documents)

As part of our claims procedure, a consumer report may be secured through personal interviews with third parties, which may include information as to your character, reputation, mode of living, etc. You have the right to make written request within a reasonable period of time, concerning the nature and scope of this investigation.

Pursuant to New York Insurance Statutes and Regulations. "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

Date _____ Policyowner's Signature _____

Address _____
Number and Street City or Town State ZIP Code

Please check if this is a new address. ( )

Phone No. _____ Policy No. _____
Area Code Exchange Number

Is the change:
Permanent ( )
Temporary ( )

M20410 NY Rev. 2-2013

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Policy Number:

ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT

1) Patient's name	
2) Diagnosis	
3) Describe any complications or other diseases affecting present condition.	
4) Give dates of treatments (Since last report)	Office_____ Diagnostic Tests_____ Hospital_____
5) Is patient still under your care for this condition? If discharged, give date.	Yes_____ No_____ Date_____
6) How long was or will patient be unable to work?	From _____ through _____
7) How long was or will patient be partially disabled?	From _____ through _____
8) List Restrictions	_____

Date _____

_____
Physician's Name (Print)

_____
Degree

Individual Practitioner's - SS#: _____-_____-_____
All Others - Employer I.D.#: _____-_____

Must be furnished under authority of law

_____ Phone No. _____
Physician's Signature Area Code Exchange Number

_____
Street Address City or Town State or Province ZIP Code