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Proofs of Death — Physician Statement

The Claimant is Responsible for any Fee for the completion of this Form.

Full Name of Deceased

Policy Number(s)

Address at the time of Death
Street

City

Province

Postal Code

Occupation

Age at Death or Date of Birth (D D / M M / Y Y Y Y)

Date of Death (D D / M M / Y Y Y Y)

Place of Death

(If Hospital or Institution, Give Name.)

Immediate Cause of Death (That is, the disease, injury or complication which caused death.)

What was the date of onset of the first symptom or sign according to the clinical history? (D D / M M / Y Y Y Y)

How long in your opinion did the disease or impairment exist?

Other significant conditions: (Contributing to the death but not related to the disease or condition causing death.)

If death was due to accident, suicide or homicide, specify which. Describe briefly.

Was an inquest held? ☐ Yes ☐ No

Was an autopsy performed? ☐ Yes ☐ No

If so, by whom and with what findings?

Was the Deceased known to be a cigarette smoker?
☐ Yes ☐ No If Yes, furnish information below.

Have you treated or advised the Deceased during the last 5 years, prior to last illness?
☐ Yes ☐ No If Yes, furnish information below.

Did the Deceased, to your knowledge, receive treatment during the last 5 years from any other physician, or in any hospital or institution?
☐ Yes ☐ No If Yes, furnish information below.

If "Yes", to above questions, please furnish the following

Name of Physician	Address	Nature of Illness or Injury	Date
			(D D / M M / Y Y Y Y)
			(D D / M M / Y Y Y Y)

Physician's Name (Please Print)

Phone Number

Address
Street

City

Province

Postal Code

Signature MD

Date Signed (D D / M M / Y Y Y Y)