500-5000 Yonge Street
Toronto, ON M2N 7J8
Telephone: 1-800-846-5970
Fax: 416-883-5715

Physician's Statement Proof of Death

THE CLAIMANT IS RESPONSIBLE FOR ANY FEE FOR THE COMPLETION OF THIS FORM **PLEASE PRINT**

Policy Number(s): _____

The Medical Certification follows the recommendation of The World Health Assembly made in Geneva on July 24, 1948. It has been accepted by all states in the United States and all provinces in Canada. In the interest of accurate vital statistics, please conform to the international list of causes of death.

Full Name of Deceased: _____

Place of Death: *(if hospital or institution, give name)* _____

Date of Birth: D D / M M / Y Y Y Y Date of Death: D D / M M / Y Y Y Y

Cause of death *(enter only one cause for each of a, b and c).* Disease or condition directly leading to death: This does not mean the mode of dying, such as heart failure, asthenia etc. It means disease, injury or complication which caused death.

		DATE OF DIAGNOSIS	DATE PATIENT ADVISED
a)	_____	a) D D / M M / Y Y Y Y	D D / M M / Y Y Y Y
Due to b)	_____	b) D D / M M / Y Y Y Y	D D / M M / Y Y Y Y
Due to c)	_____	c) D D / M M / Y Y Y Y	D D / M M / Y Y Y Y

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

_____

_____

Was the deceased a smoker? ○ Yes ○ No If ***"Yes"***, please indicate how long the deceased smoked: _____

Date of first attendance for last illness:: D D / M M / Y Y Y Y Date of last attendance for last illness: D D / M M / Y Y Y Y

If death was due to accident, suicide or homicide, specify which and describe briefly:

_____

_____

Was an inquest held? ○ Yes ○ No Was an autopsy performed? ○ Yes ○ No

If ***"Yes"***, by whom and with what findings? _____

Did you treat or advise the deceased during the last 5 years, prior to last illness? ○ Yes ○ No

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"***, to either question, please furnish the name(s):

Name: _____ Nature of illness or injury _____ Date: D D / M M / Y Y Y Y

Name: _____ Nature of illness or injury _____ Date: D D / M M / Y Y Y Y

Your Name and Address: _____

_____

_____ Date: D D / M M / Y Y Y Y
Signature