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: DD / MM / YYYY   Date of Death: DD / MM / YYYY

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) DD / MM / YYYY	DD / MM / YYYY
Due to b)	____________________	b) DD / MM / YYYY	DD / MM / YYYY
Due to c)	____________________	c) DD / MM / YYYY	DD / MM / YYYY

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:: DD / MM / YYYY   Date of last attendance for last illness: DD / MM / YYYY

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: DD / MM / YYYY

Name: ____________________ Nature of illness or injury ____________________ Date: DD / MM / YYYY

Your Name and Address: ____________________

____

____________________ Date: DD / MM / YYYY
Signature

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