



THE CLAIMANT IS RESPONSIBLE
FOR ANY FEE
FOR THIS INFORMATION

Death claim Physician's Statement

Completed by: (Please print name) _____

Policy No.: _____

Full name of Deceased			
Date of Death		Date of Birth or Age at Death	
Place of Death (if Hospital or Institution give name and address)			
Residence at Death			

1 Cause of Death	a) Immediate cause – State the disease, injury or complications which caused death, not the mode of dying such as heart failure, asphyxia, asthenia, etc.	Interval between onset and death
	b) Is this the first occurrence of the disease, if NO , provide dates. <input type="checkbox"/> Yes <input type="checkbox"/> No	
	c) Other significant conditions: (contributing to the death but not related to the disease or condition causing death)	

2 Was death due to AIDS or an AIDS Related disease? Yes No

3 a) Date of first attendance in last illness.	a)
b) Date of last attendance in last illness.	b)

4 Was death due to suicide, homicide or accident? If so, which? Describe briefly.

5 a) Was an inquest held? Yes No

b) Was an autopsy performed? Yes No

c) If yes, state by whom and with what findings. Yes No

6 To the best of your knowledge, did the deceased use tobacco in any form? Yes No If yes, provide details.

7 a) Have you treated or advised the deceased during the last 5 years prior to the last illness Yes No

b) 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

c) If "yes" to either a) or b), give the following details:

Name of Physician, Hospital or etc.	Address	Nature of Illness or Injury

These statements are complete and true to the best of my knowledge and belief.

Date _____ Signature of Physician _____

Address _____
