Equitable™

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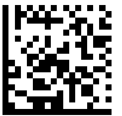
equitable.ca



PROOF OF DEATH – PHYSICIAN'S STATEMENT

To be completed by the coroner or last physician in attendance.

Note: The Medical certification follows the recommendations of the World Health Assembly made in Geneva on July 24th 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 the Causes of Death. Incomplete responses or missing information will cause delays in the assessment and handling of this file.

The Claimant is responsible for the charges incurred for the completion of this form.

Policy Number: ____________ First and Last name of deceased: ____________

Date of death: dd/mm/yyyy Residence at death: ____________

Place of death: ____________ Age at death/date of birth: ______ / dd/mm/yyyy

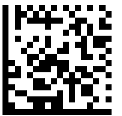
If hospital or institution, give name

Cause of Death (Enter only one cause for each of a, b, c)

Disease or condition directly leading to death (This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury or complication which caused death:	**Date of onset? (dd/mm/yyyy)**
a)	a)
Antecedent causes (Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.):	
Due to: b)	b)
Due to: c)	c)
Other significant conditions (contributing to the death but not related to the disease or condition causing death:	
Was the deceased unable to work from the onset of disability? If not, when did they cease working?	

Date of First Attendance in Last Illness:

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 what are the findings?



PROOF OF DEATH – PHYSICIAN'S STATEMENT

Have you treated or advised the deceased during the last three years, prior to last illness: ☐ Yes ☐ No

Did the deceased, to your knowledge, receive treatment during the
last three years from any other physician, or any Hospital or Institution: ☐ Yes ☐ No

If Yes to either question above, please furnish the following:

Name: ______________________________

Address: ______________________________

Nature of Illness or Injury: ______________________________ Dates: ______________

To your knowledge, was the deceased a smoker? ☐ Yes ☐ No

If yes, please indicate the length of time (approx.) please check one: ☐ Cigarettes ☐ Pipes ☐ Cigars ☐ Marijuana ☐ Other ______________

Last name of physician completing this form: ______________ First Name: ______________

☐ Family Doctor ☐ Specialist (indicate specialty): ______________

Physician's address (street number and name): ______________ Apartment or suite: ______________

City/Town: ______________ Province: ______________

Postal code: ______________ Telephone number: ______________

Signature: ______________________________

Date ______________________________

Fax this completed form to **519 883 7404**

or or email Individual Claims: individualclaims@equitable.ca

or mail to **(do not use staples)**

Equitable
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Please keep a copy of this form for your records.

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