Equitable Life of Canada®

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Group Disability Claims Department
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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 Company is not responsible for any fee for this information.

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

Date of death: _____ (mm/dd/yyyy) Residence at death: _____

Place of death: _____ (If Hospital or Institution, give name) Age at death/date of birth: _____/_____ (mm/dd/yyyy)

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:	**Interval between onset and death:**
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 he/she cease working?	
Date of First Attendance in Last Illness:	**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?

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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 1.888.505.4373
or mail to (do not use staples):

Equitable Life of Canada
Group Disability Claims Department
One Westmount Road North
P.O. Box 1603 Stn Waterloo, Waterloo Ontario N2J 4C7

Please keep a copy of this form for your records.

Please note: Equitable Life cannot ensure the privacy and confidentiality of any information sent through the internet because e-mail may be vulnerable to interception. As a result, Equitable Life is not responsible for any loss or damages you may incur if your information is intercepted and misused. If you would prefer to submit your information by another means, please contact us at 1.800.265.4556.