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INSURANCE AND FINANCIAL SERVICES INC.

PACIFIC ™

PROOF OF DEATH
ATTENDING PHYSICIAN'S STATEMENT

NOTE — ANY CHARGES FOR COMPLETING THIS FORM ARE THE RESPONSIBILITY OF THE CLAIMANT.

Last and first name of the deceased	Date of death (Y M D)

Residence at death	Place of death

Date of birth (Y M D)		If death occurred in a hospital or institution, give the name of the establishment.

CAUSE OF DEATH

Enter only one cause for each of A ■ B ■ and C ■

A ■ Disease, injury or condition which directly caused death

A ■ Date illness started (Y M D)

B ■ Antecedent causes
(Morbid conditions having eventually given rise to the above cause.)

B ■ Date illness started (Y M D)

C ■ Disease or condition provoked by or resulting from

C ■ Date illness started (Y M D)

OTHER SIGNIFICANT CONDITIONS (Contributing to the death, but not related to the disease or condition causing death.)

FOR MOST RECENT ILLNESS	Date of **first** consultation (Y M D)	**Specify if death was due to:** ❑ Accident ❑ Suicide ❑ Homicide
	Date of **last** consultation (Y M D)	Describe briefly:

Was an inquest held? ❑ Yes ❑ No

Was an autopsy performed? ❑ Yes ❑ No

If so, by whom and with what findings?

Did you treat the deceased or did he/she consult you during the **5 years preceding** the most recent illness? ❑ Yes Indicate the dates ❑ No	Date(s)	Diagnosis(es) then reached:
	Y M D	
	Y M D	
	Y M D	

To your knowledge, did the deceased receive treatment from any other physician, or in any hospital or other institution **during the past 5 years**? ❑ Yes ❑ No

Name of physician	Name of hospital or institution
Date (Y M D)	Diagnosis(es):

Name of physician	Name of hospital or institution
Date (Y M D)	Diagnosis(es):

Tobacco use

1. Did the deceased smoke? ❑ Yes ❑ No
2. If not, did he/she ever smoke? ❑ Yes ❑ No
3. If yes, when did he/she quit? (Y M D)

Physician's signature

Date (Y M D)

Name of physician (in block letters)

Address

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