Equitable Life of Canada®

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PROOF OF DEATH - PHYSICIAN'S STATEMENT

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.

Policy Number: ______________________ Full name of deceased: ______________________

Date of death: ______________________ Residence at death: ______________________

Place of death: ______________________ Age at death/date of birth: ______________________
(If Hospital or Institution, give name)

CAUSE OF DEATH (Enter only one cause for each of a, b, c)

Interval between onset and death:

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.)
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:

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If death was due to accident, suicide or homicide, specify which describe briefly.

Was an inquest held: ❑ Yes ❑ No
Was an autopsy performed: ❑ Yes ❑ No

If yes, by whom and what findings?

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, 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

The Company is not responsible for any fee for this information. ______________________ M.D.
Signature

______________________ ______________________
Date: *Address:*

683(2008/01/11)