

Claim #

PROOF OF DEATH

- INSTRUCTIONS: 1. Please attach a certified copy of death certificate
2. Please attach newspaper clippings describing accident
3. Please sign authorization at bottom of this form
4. Please be sure proof of death and physician's statement are complete

Deceased's Full Name	Policy Number(s)	Form Number(s)
_____	a) _____	a) _____
Deceased's Address	b) _____	b) _____
_____	c) _____	c) _____
Date of Birth (MM/DD/YYYY)	Date of Death (MM/DD/YYYY)	d) _____
_____	_____	d) _____
Occupation at Time of Death		

Employer's Name and Address		

Please list names of all other companies with whom deceased carried life accident or health insurance

Please list names of all doctors who treated deceased during last 5 years, including last illness or injury

Date of Accident (MM/DD/YYYY)	Nature of Injuries
Please state exactly where deceased was when accident occurred.	
What was deceased doing when accident occurred?	
Please describe in detail how accident occurred.	

IF DEATH WAS
DUE TO
"ACCIDENT"
PLEASE
COMPLETE

Beneficiary's Full Name and Mailing Address	Date of Birth (MM/DD/YYYY)
_____	_____
Telephone Number	Relationship to Deceased
_____	_____
If you are not named beneficiary, by what right do you claim policy benefits?	

Date	Signature
_____	_____

I HEREBY AUTHORIZE any hospital, physician or other person who has attended or examined _____, now deceased, to disclose when requested to do so by Combined Insurance Company of America, or its representative, any and all the information with respect to any illness or injury, medical history, consultation, examinations or treatment and to furnish copies of all hospital, medical or autopsy records. A photocopy of this authorization shall be considered as effective and valid as the original.

Date (MM/DD/YYYY)	Beneficiary	Nearest Relative
_____	_____	_____

STATEMENT OF ATTENDING PHYSICIAN

Full Name of Deceased (Please Print) _____ Age _____ Gender _____

Residence of Deceased (Street and Number, City/Town, Prov, Postal Code) _____

Date of Death (MM/DD/YYYY) _____ Place of Death (If Hospital or Institution, Please Give Name) _____

Hospitalized From _____ to _____

CAUSE OF DEATH

State the disease, injury or complication which caused death, not mode of dying, such as heart failure, etc. (A) _____
due to _____

Antecedent causes: morbid conditions, if any, giving rise to the above cause (A) stating the underlying cause last. (B) _____
due to _____

Other morbid conditions contributing to death not related to the condition causing death. (C) _____
due to _____

Was there a surgical operation? _____ Date of Operation (MM/DD/YYYY) _____

Major findings of operation? _____

Was there an autopsy? _____

Findings: _____

If death was due to violence, state whether it was an accident, suicide or homicide _____ Date of Injury (MM/DD/YYYY) _____

How are the injuries said to have been caused _____

State nature of injury(ies) _____

What are the names and addresses of other physicians who attended deceased during his(her) final disability _____

The answers I have made to the above questions are true and complete to the best of my knowledge and belief

Date (MM/DD/YYYY): _____ Signature _____ M.D.

Office Address: _____