COMBINED INSURANCE

Canadian Head Office
P.O. Box 3720 MIP, Markham, ON L3R 0X5
LIFE INSURANCE

COMBINED ASSURANCES

Claim #

PROOF OF DEATH

INSTRUCTIONS

1. Please attach a certified copy of death certificate.
2. If death was due to accident, please attach newspaper clippings describing accident.
3. Please sign authorization at bottom of this form.
4. Only one form is necessary for all policies carried by deceased.

Deceased's Full Name		Policy Number(s)	Form Number(s)
Deceased's Address		a) _____ b) _____ c) _____ d) _____ e) _____ f) _____	a) _____ b) _____ c) _____ d) _____ e) _____ f) _____
Deceased's Birthdate (MM/DD/YYYY)	Date of Death (MM/DD/YYYY)		
Employer's Name and Address		Occupation at time of death	

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.

Please complete if death was due to SICKNESS	Date of First Treatment (MM/DD/YYYY)	Had deceased ever had same or similar sickness? ☐ Yes ☐ No If YES, give date (MM/DD/YYYY)	Nature of Sickness
Please complete if death was due to ACCIDENT	Date of Accident (MM/DD/YYYY)	Nature of injuries	Please state exactly where deceased was when accident occurred
	Please describe in detail how accident occurred		What was deceased doing when accident occurred?

Beneficiary's Full Name and address	Birthdate (MM/DD/YYYY)	Relationship to Deceased
	If you are not named beneficiary, by what right do you claim policy benefits?	
	If you are filing claim under a Combined Life Insurance Policy and wish to select one of the settlement options described in that policy, instead of payment of the amount of Life Insurance in one lump sum, sign this section Not applicable to accident policies	
	Date (MM/DD/YYYY)	Signature - Beneficiary

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

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PHYSICIAN'S STATEMENT OF DEATH

Deceased's Full Name	Date of Death (MM/DD/YYYY)	Place of Death	Age

Address	Date of first treatment for last illness or injury (MM/DD/YYYY)
	Date of last treatment for last illnessor injury (MM/DD/YYYY)

If deceased was hospitalized for last illness or injury, please give Hospital's Name and Address	From (MM/DD/YYYY)
	To (MM/DD/YYYY)

Causes of DEATH (Please list only one cause per line a, b and c)	Immediate Cause of Death / Duration
	a)_____ a)_____
	Antecedent Causes
	b)_____ b) _____
	c)_____ c) _____
	Other significant diseases (Conditions contributing to death, but not related to disease or condition causing death).
	Was autopsy performed? If YES, please give name and address of Doctor who performed it. ☐ Yes ☐ No

If death followed an ACCIDENT please complete	Date of Accident (MM/DD/YYYY)	History given as to how accident occurred
	Upon first examination, did you observe any signs of injury? If YES, please describe. ☐ Yes ☐ No	
	Were the injuries sustained by the deceased, independent of all other causes, sufficient to cause death? ☐ Yes ☐ No	

Please list names and addresses of all other doctors who treated deceased during terminal illness.

Please list below all conditions for which you treated deceased in five years immediately preceding death.

DATE (MM/DD/YYYY)	Diagnosis	Duration	Recovery

REMARKS

Physician's Name (please print)	Physician's Address

Signature	Date (MM/DD/YYYY)
_____	