COMBINED INSURANCE

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

COMBINED ASSURANCES

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 _____

Deceased's Address _____

Date of Birth (MM/DD/YYYY) _____ Date of Death (MM/DD/YYYY) _____

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 _____

Policy Number(s)	Form Number(s)
a) _____	a) _____
b) _____	b) _____
c) _____	c) _____
d) _____	d) _____

IF DEATH WAS DUE TO "ACCIDENT" PLEASE COMPLETE

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. _____

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
_____	_____	_____

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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: _____