PROOF OF DEATH – PHYSICIAN'S STATEMENT

The Claimant is responsible for the charges incurred for the completion of this form.
Original signatures must be submitted to Empire Life.

1. Information about the Deceased

Name of Deceased (first, middle, last)			Policy/contract number(s)
Date of birth (dd/mmm/yy)	Date of death (dd/mmm/yy)	Place of death (If hospital or institution, give name)	
Residence at death (number and street)	City	Province	Postal code

To the best of your knowledge, did the deceased ever smoke or use any cigarettes, cigarillos, more than 12 large cigars, small cigars hashish, chewing tobacco, nicotine substitute, snuff, marijuana, betel nuts or pipes? ◯ yes ◯ no ◯ unknown

If yes, please indicate amount per day: Cigarettes _________ Pipe/cigar _________ Marijuana _________ Other products __________

How long did the deceased use the product(s)? ____

Did the deceased ever stop smoking/using the product(s)? ◯ yes ◯ no ◯ unknown – if yes, specify when and for how long:

2. Cause of Death (enter only one cause each for questions a, b and c)

a) Specify the disease or condition directly leading to death
(Not the mode of dying such as heart failure, asthenia, etc., but the disease, injury or complication that caused death.)

Disease/condition	Date of onset (dd/mmm/yy)

b) Specifiy the antecedent cause (the morbid condition (if any) that caused te disease or condition noted above)

Cause	Date of onset (dd/mmm/yy)
c) Due to, or as a consequence of:	Date of onset (dd/mmm/yy)

Other significant conditions:

Date of first consultation for the most recent Illness (dd/mmm/yy)	Date of last consultation for the most recent Illness (dd/mmm/yy)
Date of diagnosis (dd/mmm/yy)	Date the deceased was informed of the illness (dd/mmm/yy)

Was death was due to ◯ accident ◯ suicide ◯ homicide?

Describe briefly:

Was an inquest held? ◯ yes ◯ no Was an autopsy performed? ◯ yes ◯ no - If yes to either question, specify the findings:

Policy/contract number(s)

3. Treatment Information

Have you treated or advised the deceased during the last 5 years, prior to the last illness? ◯ yes ◯ no
Did the deceased, to your knowledge, receive treatment during the last 5 years from any other physician, or in a Hospital or Institution?
◯ yes ◯ no – If yes to either question please provide the following:

Name of physician/hospital/Institution	Address	Nature of Illness/Injury	Date(s)

4. Physician Signature

Signature X		Date (dd/mmm/yy)	
Name (please print)	Telephone	Degree	
Address (number and street)	City	Province	Postal code

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