HUMANIA ASSURANCE MD®

# PROOF of DEATH
## Physician statement

For information, please contact us at:
**Individual Insurance**: Téléphone : 450 773-7170 / 514 489-8404 / Toll free: 1 800 773-8404
**Group Insurance**: Téléphone :450 773-7236 / 514 485-7236 / Toll free: 1 800 818-7236
Fax: 450 778-2519 / E-mail: presentations@humania.ca / **Web site**: www.humania.ca
Our address: 1555 Girouard Street West, Saint-Hyacinthe, Quebec J2S 2Z6

Policy Nº_____

The Medical Certification follows the recommendation of The World Health Assembly made in Geneva on July 24, 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 causes of death.

**The claimant is responsible for any fees for this information**

| Full name of deceased | Date of death |
|---|---|
| Residence at death | Place of death |
| Age at death or date of birth | If hosptial or institution, give name |

**Cause of death (Enter only one cause for each of a, b, and 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 disease, injuring or complication which caused death.)

a) _____ a) _____

Antecedent causes. (Morbid condtions, 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.): _____

❑ Smoker ❑ Non-smoker If yes : Since when ? _____ If you stop : Since when ? _____

| Date of first attendance in last illness | Date of last attendance in last illness |
|---|---|

If death was due to accident, suicide or homicide, specify wich. Describe briefly?

Was an inquest held? ❑ Yes ❑ No

Was an autopsy performed? ❑ Yes ❑ No

If so, by whom and with what findings?

Have you treated or advised the deceased during the last 3 years, prior to last illness? ❑ Yes ❑ No

Did the deceased, to your knowledge, receive treatment during the last 3 years from any ohter physician, or in any hospital or institution? ❑ Yes ❑ No

If "Yes", to either question, please furnish the following:

| Name | Address | Nature of illness or injury | Dates |
|---|---|---|---|
| | | | |

_____ 20 _____ _____ M.D.
Date Signature

_____ _____
Please print (write in blocks capitals) Address