HUMANIA ASSURANCE MD®

PROOF OF DEATH
Physician Statement

For information, please contact us at: Telephone :1-877-987-3076 / Fax: 1-877-660-2519
E-mail: Life@humania.ca / Web site : www.humania.ca
Our address: 1555, Girouard Street West, Saint-Hyacinthe, Quebec J2S 2Z6

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.

Part A: Information on the deceased

Last Name:	First Name:
Residence at death:	Policy No:
Date of death (dd/mm/yyyy):	Place of death:
Age at death or date of birth (dd/mm/yyyy)	If hospital 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 cause of death, such as heart failure, asthenia, etc. It, means disease, injury or complication of death.) a) _____	a) _____
Antecedent causes. (Morbid conditions, 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 stopped, since when?
Date of first attendance in last illness (dd/mm/yyyy)	Date of last attendance in last illness (dd/mm/yyyy)

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

Was an inquest held? ☐ Yes ☐ No	Was an autopsy performed? ☐ Yes ☐ No

If so, by whom and with what findings?

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Part A: Information on the deceased (continued)

Have you treated or advised the deceased during the last five (5) years, prior to last illness? ☐ Yes ☐ No

Did the deceased, to your knowledge, receive treatment during the last five (5) years from any other physician, or in any hospital or institution? ☐ Yes ☐ No

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

Name (physician, hospital)	Address	Nature of illness or injury	Dates (dd/mm/yyyy)

Part B: Information on Health Care Professionnal

_____ _____

Name (write in block) Physician's signature

E-mail: _____

_____ _____ ___ ___ ___ ___

Speciality Permit number Date (dd/mm/yyyy)

Clinic /Hospital Name	
Address:	City:
Province:	Postal Code:
Telephone:	Fax:

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