PRINT RESET

Wawanesa Life®

Please return this completed form and supporting documents to:
Group Benefit Services
400-200 Main Street, Winnipeg, MB R3C 1A8
For inquiries, please call 1-800-665-7076

GROUP DEATH BENEFIT PHYSICIAN'S STATEMENT

POLICY #

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 FEE FOR THIS INFORMATION

Full Name of Deceased	Date of Death
Residence at Death	Place of Death
Age at Death or Date of Birth	(If Hospital or Institution, Given Name)

Cause of death (Enter only one cause for each a, b, and c.)
Disease or condition directly leading to death: (This does not mean the mode of dying, such as heart failure, asthenia, etc. It means disease, injury or complication which caused death.)
(a)

INTERVAL BETWEEN ONSET AND DEATH

(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.)

Date of First Attendance in Last Illness	Date of Last Attendance in Last Illness

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?

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 other 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

_____ M.D.
Signature

_____
Date

_____
Address