Print Reset

PROOF OF DEATH
PHYSICIAN'S STATEMENT

POLICY NUMBER(S)

The Medical Certification follows the recommendation of The World Health Assembly made in Geneva on July 24, 1948. It has been accepted by all provinces in Canada and all states in the United States. In the interest of accurate vital statistics, please conform to the international list of causes of death.

PERSONAL DETAILS

FULL NAME OF DECEASED

DATE OF DEATH D M Y

RESIDENCE AT DEATH

PLACE OF DEATH (if hospital or institution, provide the name)

AGE AT DEATH OR DATE OF BIRTH D M Y

CAUSE OF DEATH AND CLAIM DETAILS – Must be completed in full

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):

Interval between onset and death

State the underlying cause(s) of death:

Date of Onset

Due to:

Date of first attendance in last illness

Date of last attendance in last illness

Was death due to: ☐ accident? ☐ suicide? or ☐ homicide? ☐ YES ☐ NO

If YES, specify which and describe briefly.

Was an inquest held? ☐ YES ☐ NO

Was an autopsy performed? ☐ YES ☐ NO

If YES, by whom and with what findings?

Have you treated or advised the deceased during the last 5 years, prior to last illness? ☐ YES ☐ NO

If YES, please provide the nature of illness and the approximate date when the health of the deceased was first affected.

Did the deceased, to your knowledge, receive treatment during the last 5 years from any other physician, or in any hospital or institution? If YES, please complete the following: ☐ YES ☐ NO

Name	Address	Nature of illness or injury	Dates

Please provide details of the deceased's tobacco use including amount per day and date last used.

Please provide any other information that would be helpful in the assessment of this claim.

PHYSICIAN INFORMATION/SIGNATURE

A photocopy or an electronic reproduction of this document will be as valid as the original.

Physician's Name (please print) Physician's Signature Date

Address

THE CLAIMANT IS RESPONSIBLE FOR ANY FEE FOR THIS INFORMATION

PLEASE RETURN FORM TO:
Medical Director, The Wawanesa Life Insurance Company, 400 – 200 Main Street, Winnipeg, MB R3C 1A8, FAX: 1-888-985-3872