beneva

Death
Physician's statement

Instructions

Policy No.: _____

1. Fill out and return to claimant.
2. All costs incurred are at the claimant's expense.

1. Identification of the Deceased Person

Surname and given names of the deceased

Date of death (Y Y Y Y M M D D)

Residence at time of death

Place of death

Age at death

Date of birth (Y Y Y Y M M D D)

If death occurred in a hospital or other institution, please give the name

2. Identification on the Deceased Person

Cause of death – Indicate a single cause for each of paragraphs (a), (b) and (c) below	Interval between the onset of morbidity and death
a) Illness or state of morbidity that caused death directly.	
b) Secondary causes – State of morbidity that led eventually to the precipitate state.	
c) Other major morbid states (that contributed to death but unrelated to the illness or morbid state that caused it).	

Date of initial care for the last illness (Y Y Y Y M M D D)		Date of final care for the last illness (Y Y Y Y M M D D)
Was death due to: ☐ an accident ☐ a murder	Date of event: (Y Y Y Y M M D D)	Describe it briefly
Was there an investigation? ☐ No ☐ Yes ☐	Was there an autopsy? ☐ No ☐ Yes	If yes, indicate by whom and provide the observations

	Yes	No
Have you treated the person mentioned above, or did this person consult you, in the three years preceding the final illness?	☐	☐
To your knowledge, in the final three years, did this person take medication in relation to the final illness?	☐	☐
To your knowledge, in the final three years, was this person treated by other physicians or in a hospital or other institution?	☐	☐

If you have answered yes to any of these questions, give the following details:

Name	Address	Type of illness or injury	Names of medications	Dates
				(Y Y Y Y M M D D)
				(Y Y Y Y M M D D)
				(Y Y Y Y M M D D)
				(Y Y Y Y M M D D)

Does the patient use tobacco products (cigarette, cigar, pipe, cigarillos) or in any other form? ☐ No ☐ Yes

Has the patient ever used tobacco products? ☐ No ☐ Yes | If yes, when did the patient stop? (Y Y Y Y M M D D)

X _____
Signature

Date (Y Y Y Y M M D D)

Licence number

Address _____

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