

## PROOF OF DEATH

- INSTRUCTIONS:**
1. Please attach a certified copy of death certificate
  2. Please attach newspaper clippings describing accident
  3. Please sign authorization at bottom of this form
  4. Please be sure proof of death and physician's statement are complete

Deceased's Full Name	Policy Number(s)	Form Number(s)
Deceased's Address	a) _____	a) _____
Date of Birth (Mo/Day/Yr)	Date of Death (Mo/Day/Yr)	b) _____
Occupation at Time of Death	c) _____	c) _____
Employer's Name and Address	d) _____	d) _____

\_\_\_\_\_  
Please list names of all other companies with whom deceased carried life accident or health insurance

\_\_\_\_\_  
Please list names of all doctors who treated deceased during last 5 years, including last illness or injury

Date of Accident (Mo/Day/Yr)	Nature of Injuries
Please state exactly where deceased was when accident occurred.	
<b>IF DEATH WAS DUE TO "ACCIDENT" PLEASE COMPLETE</b>	What was deceased doing when accident occurred?
	Please describe in detail how accident occurred.

Beneficiary's Full Name and Mailing Address	Date of Birth (Mo/Day/Yr)
Telephone Number	Relationship to Deceased
If you are not named beneficiary, by what right do you claim policy benefits?	

Date \_\_\_\_\_ Signature \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION** I hereby authorize any hospital, physician or other person who has attended or examined \_\_\_\_\_, now deceased, to disclose when requested to do so by Combined Insurance Company of America, or its representative, any and all the information with respect to any illness or injury, medical history, consultation, examinations or treatment and to furnish copies of all hospital, medical or autopsy records. A photocopy of this authorization shall be considered as effective and valid as the original.

Date \_\_\_\_\_ Signature of Beneficiary \_\_\_\_\_ Signature of Nearest Relative \_\_\_\_\_

## STATEMENT OF ATTENDING PHYSICIAN

Full Name of Deceased (Please Print) \_\_\_\_\_

Age \_\_\_\_\_

Gender \_\_\_\_\_

Residence of Deceased (Street and Number, City/Town, Prov, Postal Code) \_\_\_\_\_

Date of Death (Mo/Day/Yr) \_\_\_\_\_

Place of Death (If Hospital or Institution, Please Give Name) \_\_\_\_\_

Hospitalized From \_\_\_\_\_ to \_\_\_\_\_

### CAUSE OF DEATH

State the disease, injury or complication which caused death, not mode of dying, such as heart failure, etc.

(A) \_\_\_\_\_

due to \_\_\_\_\_

Antecedent causes: morbid conditions, if any, giving rise to the above cause (A) stating the underlying cause last.

(B) \_\_\_\_\_

due to \_\_\_\_\_

Other morbid conditions contributing to death not related to the condition causing death.

(C) \_\_\_\_\_

due to \_\_\_\_\_

Was there a surgical operation? \_\_\_\_\_ Date of Operation (Mo/Day/Yr) \_\_\_\_\_

Major findings of operation? \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_

Findings: \_\_\_\_\_

If death was due to violence, state whether it was an accident, suicide or homicide

Date of Injury (Mo/Day/Yr) \_\_\_\_\_

How are the injuries said to have been caused \_\_\_\_\_

State nature of injury(ies) \_\_\_\_\_

What are the names and addresses of other physicians who attended deceased during his(her) final disability \_\_\_\_\_

The answer I have made to the above questions are true and complete to the best of my knowledge and belief

Date: \_\_\_\_\_ Signature \_\_\_\_\_ M.D.

Office Address: \_\_\_\_\_