

PROOF OF DEATH — PHYSICIAN'S STATEMENT

To be obtained by Claimant and submitted to CUMIS Life Insurance Company
NOTE: This medical certification follows the recommendations 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 the Causes of Death.

Credit Union Affiliation _____	CLAIM NO. _____
Full name of deceased _____	Date of death _____
<small>Last</small>	<small>First</small>
<small>Middle</small>	<small>month/day/year</small>
Residence at death _____	Place of death _____
Age at death or date of birth _____	(If hospital or institution, give name) _____

Cause of death (Enter only one cause for each of 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 the disease, injury or complication which caused death.) (a) _____ Antecedent causes. (Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.) Due to (b) _____ Due to (c) _____ Other significant conditions: (Contributing to the death but not related to the disease or condition causing death.) _____	Interval between onset and death (a) _____ (b) _____ (c) _____
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Date of First Attendance in Last Illness _____	Date of Last Attendance in Last Illness _____
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If death was due to accident, suicide or homicide, specify which. Describe briefly: _____	Was an inquest held? Yes <input type="checkbox"/> No <input type="checkbox"/> Was an autopsy performed? Yes <input type="checkbox"/> No <input type="checkbox"/> If so, by whom and with what findings? _____
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Have you treated or advised the deceased during the last 3 years, prior to last illness? Yes <input type="checkbox"/> No <input type="checkbox"/> Did the deceased, to your knowledge, receive treatment during the last 3 years from any other physician, or in any hospital or institution? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes to either question, please furnish the following:					
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">Name</td> <td style="width: 33%;">Address</td> <td style="width: 33%;">Nature of illness or injury</td> <td style="width: 15%;">Dates</td> </tr> </table>	Name	Address	Nature of illness or injury	Dates	
Name	Address	Nature of illness or injury	Dates		

Was the deceased advised of the nature of their illness? Yes No If Yes, when? _____

Date _____, 20_____	Signature _____	M.D.
Address _____		Print or type name _____
Telephone No. (_____) _____		

The information furnished herein will be used by CUMIS for claims administration purposes, and for such other lawful purposes in accordance with applicable federal and provincial laws, as may apply.

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