the co-operators
A Better Place For You®

GROUP BENEFITS PROOF OF DEATH PHYSICIAN STATEMENT

FOR OFFICE USE ONLY

MAILING ADDRESS	INSTRUCTIONS
Mail: Co-operators Life Insurance Company Group Life Claims Department 1920 College Avenue Regina SK S4P 1C4 Fax: 1-866-889-9925	The claimant is responsible for the cost of completing this form.

1. DECEASED INFORMATION

Group ______________ Account ______________ Certificate ______________

Name ______________ (First Name) ______ (Initial) ______________ (Last Name)

Date of Death ______________ (MMM/DD/YYYY) Place of Death (if hospital or institution, provide name) ______________

Date of Birth ______________ (MMM/DD/YYYY)

CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause of death:	
Underlying causes of death:	
Other significant conditions:	

If the deceased's death was not the sole result of an illness or disease, please describe the circumstances of death (e.g., an accident or suicide)

____

____

Was an inquest held? ☐ Yes ☐ No Was an autopsy performed? ☐ Yes ☐ No If yes, by whom ______________

How long have you treated the deceased? ______________

Did the deceased receive treatment during the last 3 years from any other physician, or any hospital or institution? ☐ Yes ☐ No

If yes, provide the following:

Name	Address	Nature of illness or injury	Dates
			MMM/DD/YYYY
			MMM/DD/YYYY

Was the deceased advised of the nature of his/her illness? ☐ Yes ☐ No If yes, when ______________ (MMM/DD/YYYY)

Did the deceased ever use any form of tobacco, marijuana, nicotine products or substitutes (including nicotine patch and gum)? ☐ Yes ☐ No ☐ Unknown

2. PHYSICIAN ACKNOWLEDGEMENT AND AUTHORIZATION

I hereby declare that the answers to the above questions are accurate and complete.

Attending Physician (Please Print) ______________

Certified Speciality ______________ Family Physician ☐ Yes ☐ No

Address ______________ (Street) ______________ (City) ______________ (Province) ______________ (Postal Code)

Phone Number (______) ______________ Fax Number (______) ______________

Physician's Stamp

Physician Signature ______________ Date ______________ (MMM/DD/YYYY)

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