COMBINED[MC]
A Chubb Company

Canadian Head Office
P.O. Box 3720 MIP, Markham, ON L3R 0X5

COMBINED[MC]
Une compagnie de Chubb

Claim #

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)
a) ______ b) ______ c) ______ d) ______

Form Number(s)
a) ______ b) ______ c) ______ d) ______

Deceased's Address ______________________

Date of Birth (MM/DD/YYYY) ______________ Date of Death (MM/DD/YYYY) ______________

Occupation at Time of Death ______________________

Employer's Name and Address ______________________

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 ______________________

IF DEATH WAS DUE TO "ACCIDENT" PLEASE COMPLETE

Date of Accident (MM/DD/YYYY) ______________ Nature of Injuries ______________

Please state exactly where deceased was when accident occurred. ______________________

What was deceased doing when accident occurred? ______________________

Please describe in detail how accident occurred. ______________________

Beneficiary's Full Name and Mailing Address ______________________

Date of Birth (MM/DD/YYYY) ______________

Telephone Number ______________ Relationship to Deceased ______________

If you are not named beneficiary, by what right do you claim policy benefits? ______________________

Date ______________ Signature ______________________

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 (MM/DD/YYYY)	Beneficiary	Nearest Relative

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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 (MM/DD/YYYY) ______________________

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 (MM/DD/YYYY) ______________

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 (MM/DD/YYYY) ______________

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

Date (MM/DD/YYYY): ______________ Signature ______________________ M.D.

Office Address: ______________________