CHUBB®

PROOF OF ACCIDENTAL DEATH
ATTENDING PHYSICIAN'S STATEMENT

Chubb Life Insurance Company of Canada
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PLEASE COMPLETE ALL DATES IN MONTH/DAY/YEAR FORMAT

THE CLAIMANT IS RESPONSIBLE FOR ANY FEE CHARGED FOR THIS INFORMATION

Full Name of Deceased:		
Date of Birth:	**Sex:** ☐ **Male** ☐ **Female**	
Address:		
City:	**Province:**	**Postal Code:**
Date of Death:		
Place of Death (if Hospital or Institution, give name):		

CAUSE OF DEATH

1. State the Disease, Injury or Complication which caused Death, not mode of dying, such as Heart Failure, etc.
2. Antecedent Causes: Morbid Conditions, if any, giving rise to the above cause stating the underlying cause last.
3. Other Morbid Conditions contributing to Death, not related to the condition causing Death.
4. To what extent did any antecedent causes contribute to Death?
5. If Death was due to accident, Suicide or homicide, specify which. Describe briefly and include dates.
6. Was an Inquest held? ☐ Yes ☐ No
Was an Autopsy performed? ☐ Yes ☐ No
If so, by whom and with what findings?
How was this death said to have been caused?

7. When and where did you first attend the Deceased for this matter?
8. Was the injury described above, directly and independently of all other causes, sufficient to produce Death?
9. Have you treated or advised the Deceased during the last 3 years? ☐ Yes ☐ No
Did the Deceased, to your knowledge, receive treatment during the last 3 years from any other Physician, or in any Hospital or Institution? ☐ Yes ☐ No
If "Yes" to either question, please furnish the following:
Name:
Address:
Nature of Illness or Injury:
Date:
Name:
Address:
Nature of Illness or Injury:
Date:

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

Name of Physician completing this form (please print): _____

Signature of Physician completing this form: _____ Date: _____

Office Address:	
Phone #: ( )	**Fax #: ( )**