MEDAVIE BLUE CROSS™

PROOF OF DEATH
PHYSICIAN'S STATEMENT

PO BOX 220
MONCTON NB E1C 8L3
TEL: 1-800-667-4511 FAX: 1-800-644-1722

PO BOX 2000 185 THE WEST MALL SUITE 1200
ETOBICOKE ON M9C 5P1
TELEPHONE: 1-800-355-9133 FAX: (416) 626-0400

If there is a charge for completing this form, it is the responsibility of the individual claiming benefit.

Full name of deceased _____

Residence at death _____

Age at death _____ **OR**

Date of birth (DD / MM / YY) _____

Date of death _____

Place of death (if Hospital or Institution, give name)

_____

_____

Cause of Death *(Enter only one cause for each of a, b and c.)*	Interval between onset and death
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 that caused death.)* (a)	(a)
Antecedent causes. *(Morbid conditions, if any, giving rise to the above cause (a), stating the underlying cause last.)*	
Due to or as a consequence of (b)	(b)
Due to or as a consequence of (c)	(c)
Other significant conditions: *(Contributing to the death but not related to the disease or condition causing death.)*	

Date of first attendance in last illness (DD / MM / YY)	Date of last attendance in last illness (DD / MM / YY)
If death was due to accident, homicide or suicide, specify which. Describe briefly.	Was an inquest held? ❑ Yes ❑ No Was an autopsy performed? ❑ Yes ❑ No If so, by whom and with what findings?

Have you treated or advised the deceased during the last 3 years, prior to last illness? ❑ Yes ❑ No

Did the deceased, to your knowledge, smoke any tobacco or used any tobacco or nicotine in any form (including nicotine replacement products) 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	Dates (DD / MM / YY)

Physician's Full Name (Please Print) _____

Physician's Signature _____ Date _____

Address _____

The 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.