



**SLI**

**SPECIALTY LIFE  
INSURANCE™**

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**PHYSICIAN'S STATEMENT  
FOR LIFE INSURANCE CLAIMS**

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# Physician's Statement Proof of Death

(Claimant is responsible for any fee related to the completion of this form)

Policy number(s)  Full name of deceased

Place of death (if hospital or institution, give name and address)

Date of birth (DD/MM/YYYY)  Date of death (DD/MM/YYYY)

Was the deceased a smoker at time of death?  Yes  No If "Yes" how long did he/she smoke?

## Primary cause of death: (Disease or condition directly leading to death):

(This does not mean the mode of dying, such as heart failure, asthenia, etc. It means disease, injury, or complication which caused death)

a) <input type="text"/>	Date of Diagnosis (DD/MM/YYYY) <input type="text"/>	Date Patient Advised (DD/MM/YYYY) <input type="text"/>
b) <input type="text"/>	Date of Diagnosis (DD/MM/YYYY) <input type="text"/>	Date Patient Advised (DD/MM/YYYY) <input type="text"/>
c) <input type="text"/>	Date of Diagnosis (DD/MM/YYYY) <input type="text"/>	Date Patient Advised (DD/MM/YYYY) <input type="text"/>

## Secondary cause(s) of death: (morbid conditions if any, giving rise to the above cause, may have more than one condition)

### Other significant conditions: (Contributing to the death but not related to the disease or condition causing death)

Date of 1st consultation for the condition which led to death: (DD/MM/YYYY)

Date of the 1st attendance for the last illness: (DD/MM/YYYY)

Date of the last attendance for the last illness : (DD/MM/YYYY)

When did the deceased health begin to deteriorate? (DD/MM/YYYY)

Did you treat or advise the deceased during the last 5 years, prior the last illness?  Yes  No

Explain

Did the deceased to your knowledge, receive treatment during the last 5 years from any other physician, or in any hospital or institution?  Yes  No

If "Yes" please provide the name(s)

Name <input type="text"/>	Nature of illness or injury <input type="text"/>	Date (DD/MM/YYYY) <input type="text"/>
Name <input type="text"/>	Nature of illness or injury <input type="text"/>	Date (DD/MM/YYYY) <input type="text"/>

If death was due to an accident, suicide or homicide, specify which and describe briefly:  an accident  a suicide  a homicide

Explain:

Was an inquest held?  Yes  No Was an autopsy performed?  Yes  No

If so, by whom and with what findings?

I certify that the answers are to the best of my knowledge complete and true.

Your name  Specialty  Permit Number

Address

Phone Number  Fax Number  Email

Date (DD/MM/YYYY)

Signature