Desjardins Insurance
LIFE • HEALTH • RETIREMENT

200, rue des Commandeurs
Lévis (Québec) G6V 6R2

DEATH – CLAIM
PHYSICIAN'S STATEMENT

Fees charged for this statement are to be paid by the claimant.

A. Information about the deceased

Last name	First name	Date of birth
		YYYY-MM-DD

B. Physician's statement

Date of death	Place of death
YYYY-MM-DD	

Residence at death - No., street | City | Province | Postal code

If the deceased died in a hospital or in another institution, give the name:

Age at death: OR Date of birth: YYYY-MM-DD

1. 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 which caused death):	Interval between onset and death
2. Antecedent causes (morbid conditions, if any, giving rise to the above condition) due to or as a consequence of: (a)	
(b)	
3. (a) Other significant conditions (contributing to the death but not related to the disease or condition causing death):	

(b) Was death related to acquired immunodeficiency syndrome? ☐ Yes ☐ No

4. Date of first attendance in last illness	5. Date of last attendance in last illness	6. Date of diagnosis	7. When was the deceased informed the first time about this illness?
YYYY-MM-DD	YYYY-MM-DD	YYYY-MM-DD	YYYY-MM-DD

8. Was the death due to: ☐ accident ☐ suicide ☐ homicide Describe briefly:

9. Was an inquest held? ☐ Yes ☐ No If yes, by whom and with what findings:

10. Was an autopsy performed? ☐ Yes ☐ No If yes, by whom and with what findings:

11. Have you treated or advised the deceased during the last 3 years, prior to last illness? ☐ Yes ☐ No
If yes, please furnish the following:

Nature of illness or injury	Hospital or institution	Address	Date
			YYYY-MM-DD
			YYYY-MM-DD

12. Did the deceased, to your knowledge, receive treatment during the last 3 years of his life from any other physician, or in any hospital or institution? ☐ Yes ☐ No
If yes, please furnish the following:

Nature of illness or injury	Physician, hospital or institution	Address	Date
			YYYY-MM-DD
			YYYY-MM-DD

13. Did the deceased ever use tobacco under any form? ☐ Yes ☐ No	14. When did the deceased start smoking?	15. When did the deceased stop smoking?

16. Specify non-smoking periods:

C. Physician's identification

Last name, first name: _____ Telephone no.: AREA CODE + NO.

License no.: _____ Fax no.: AREA CODE + NO.

General practitioner ☐ Specialist ☐ Specify: _____

Signature: _____ Date: _____