SASKATCHEWAN BLUE CROSS®
516 2nd Avenue North, PO Box 4030
Saskatoon, SK S7K 3T2

PROOF OF DEATH
PHYSICIAN'S STATEMENT

Full Name of Deceased | Residence at Death

Age at Death | Date of birth (YYYY/MM/DD) | Date of Death (YYYY/MM/DD)

Place of Death (If Hospital or Institution, give name)

CAUSE OF DEATH

Cause of Death | Date of first onset of symptoms (YYY/MM/DD)

Disease, injury or condition directly leading to death | Date of first onset of symptoms (YYYY/MM/DD)

Date deceased was advised of disease or condition directly leading to dealth (YYYY/MM/DD)

Have you treated or advised the deceased during the last 5 years, before his/her last illness? ☐ Yes ☐ No

Indicate date you first saw the deceased (YYYY/MM/DD) | Indicate date you last saw the deceased (YYYY/MM/DD)

Give details including **conditions** and **dates** whether or not related to cause of death

Did the deceased receive treatment during the last 5 years, from any other physician, or in any hospital or facility? ☐ Yes ☐ No

If yes, give details including name of doctor, name of hospital or facility, condition and dates whether or not related to cause of death

NOTICE TO PHYSICIAN

The information in this statement will be kept in a life file with the insurer and might be accessible by the beneficiary, the deceased's estate, applicable reinsurers or third parties to whom access has been granted or those authorized by law. By providing the information you confirm the information is correct and complete to the best of your knowledge, and consent to such unedited release of any information contained herein.

Physicians Printed Name | Telephone Number | Fax Number

Physician's Address

Physician's Signature | Date (YYYY/MM/DD)

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.