



**AIG Commercial Insurance
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**PHYSICIAN'S STATEMENT
Proof of Death**

1. A) Full name of the deceased: _____
B) Residence at time of death: _____
2. Date of Birth: _____
3. A) Date of Death: _____
B) Cause of Death: _____
C) Place of Death: _____

4. Cause of Death (Enter only one cause for each a, b. and c.) **Interval between onset and death**

Disease and condition directly leading to death: (This does not mean the mode of dying such as heart failure asthenia etc. It means the disease, injury of complication which caused the death.)

(a) _____ (a) _____

Antecedent causes. (Morbidity conditions, if any, giving rise to the above cause (a) stating underlying causes last.)

Due to (b) _____ (b) _____

Due to (c) _____ (c) _____

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

If death was due to accident, suicide or homicide, specify which. Describe briefly.

5. Was an inquest held? ☐ Yes ☐ No

Was an autopsy performed? If so by whom and with what findings? _____

6. Have you treated or advised the deceased during the last five years, prior to last illness? ☐ Yes ☐ No

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 to either questions, please furnish us with the name of physician, dates and reasons:

These statements are true and complete to the best of my knowledge and belief.

Name of Attending Physician: _____

Address: _____

Signature of Attending Physician _____ Date: _____

Phone Number: _____ Fax Number: _____

The furnishing of forms shall not be an admission of liability by the Company.