SPECIALTY LIFE INSURANCE™

PHYSICIAN'S STATEMENT
FOR LIFE INSURANCE CLAIMS

SLI-PSLIC0418-EN

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) _____ Date of Diagnosis (DD/MM/YYYY) _____ Date Patient Advised (DD/MM/YYYY) _____

b) _____ Date of Diagnosis (DD/MM/YYYY) _____ Date Patient Advised (DD/MM/YYYY) _____

c) _____ Date of Diagnosis (DD/MM/YYYY) _____ Date Patient Advised (DD/MM/YYYY) _____

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 _____ Nature of illness or injury _____ Date (DD/MM/YYYY) _____

Name _____ Nature of illness or injury _____ Date (DD/MM/YYYY) _____

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

All SLi claims will be adjudicated by ivari. All claim forms should be sent to ivari for adjudication at:
ivari - Claims Department, 500-5000 Yonge Street Toronto, Ontario M2N 7J8.