AIG Insurance Company Of Canada
120 Bremner Boulevard, Suite 2200
Toronto, ON M5J 0A8
416-596-4005 | 1-877-317-8060
ahclaimscan@aig.com | www.aig.com

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. (Morbid 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.