

THE FAMILY INDEMNITY PLAN

PROOF OF DEATH FORM
(To be completed by the attending physician)

NOTICE TO PHYSICIAN: To be completed by attending or family physician having knowledge of conditions causing and contributing to death and returned to the Organization below.

NAME OF DECEASED: _____

ADDRESS: _____

DATE OF BIRTH: ____/____/____
DD / MM / YYYY

DATE OF DEATH: ____/____/____
DD / MM / YYYY

CAUSE OF DEATH:	
Principal Cause	Date of Onset
Contributing Cause	Date of Onset
Contributing Cause	Date of Onset

WAS DEATH DUE TO: ACCIDENT SUICIDE HOMICIDE? Please give explanation:

I certify that I attended to the deceased from _____ to _____
and death occurred from the causes listed above.

Physician's Name: _____ Telephone _____

Physician's Address: _____

Physician's Signature and Stamp/Seal _____ Date: _____

CERTIFICATE OF ORGANIZATION	
I hereby certify that the above named deceased was insured under the Family Indemnity Plan with this Organization.	
Organization Name: _____	Telephone _____
Address _____	
Signature of Authorized Organization Officer _____	Date: _____