Desjardins Insurance
Life • Health • Retirement

200, rue des Commandeurs
Lévis (Québec) G6V 6R2
www.desjardinslifeinsurance.com
1-877-938-8191

Death Claim
Physician's Statement

Employee last name		Employee first name	
Contract/Group No.	Account/Division No.	Class	Identification/Certificate No.

⚠ **Fees charged for this statement are to be paid by the claimant.**

A. Information about the deceased

Last name	First name	Date of birth (YYYY-MM-DD)

B. Physician's statement

Date of death (YYYY-MM-DD)	Place of death

Residence at death - No., Street

City	Province	Postal code

If the deceased died in a hospital or in another institution, please provide the name:	Age at death

1. Disease or condition directly leading to death (This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury or complication which caused death):	Interval between onset and death
2. Antecedent causes (morbid conditions, if any, giving rise to the above condition) due to or as a consequence of: (a)	
(b)	
3. Other significant conditions (contributing to the death but not related to the disease or condition causing death):	

4. Date of first attendance in last illness (YYYY-MM-DD)	5. Date of last attendance in last illness (YYYY-MM-DD)	6. Date of diagnosis (YYYY-MM-DD)	7. When was the deceased informed the first time about this illness? (YYYY-MM-DD)

8. Was the death due to: ☐ an accident ☐ a suicide ☐ a homicide	Describe briefly:
9. Was an inquest held? ☐ Yes ☐ No	If yes, by whom and what were the findings:
10. Was an autopsy performed? ☐ Yes ☐ No	If yes, by whom and what were the findings:

11. Have you treated or advised the deceased during the last 5 years, prior to last illness?
☐ Yes ☐ No If yes, please provide the following information:

Nature of illness or injury	Hospital or institution	Address	Date (YYYY-MM-DD)

12. Did the deceased, to your knowledge, receive treatment during the last 5 years of his life from any other physician, or in any hospital or institution?
☐ Yes ☐ No If yes, please provide the following information:

Nature of illness or injury	Physician, hospital or institution	Address	Date (YYYY-MM-DD)

13. Did the deceased ever use tobacco under any form?
☐ Yes ☐ No If yes, for how many years:

C. Physician's identification

Last name, first name	10-digit telephone No.
License No.	10-digit fax No.

☐ General practitioner
☐ Specialist Specify: _____

X _____ _____
Signature Date (YYYY-MM-DD)

Print **Reset**