canada life™

GROUP LIFE BENEFITS
ATTENDING PHYSICIAN'S CERTIFICATE OF DEATH

M63 BIL

I hereby certify that _____

of _____ employed by _____

died on the _____ day of _____, 20 _____, from

(Chief or Primary cause) _____

(Contributing or secondary cause) _____

When was the illness diagnosed? _____

When in your opinion did the last illness become severe enough to prevent them from working? (Give details).

_____

_____

What was the manner of death? ☐ Natural ☐ Accidental ☐ Suicide ☐ Homicide ☐ Undetermined

Did the deceased smoke? ☐ Yes ☐ No If yes, for how long? _____

Dated at _____ this _____ day of _____ 20 _____

This form should be completed in full by the Attending Physician. Dr. _____
(Doctor's signature)

_____
(Doctor's name - please print)

_____
(Address)

_____
(Telephone)

Clear