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PHYSICIAN'S STATEMENT
Proof of Death

Policyholder: Province of New Brunswick

1. a) Full name of the deceased: _____
   b) Residence at time of death: _____
2. Date of Birth (M/D/Y): _____
3. a) Date of Death (M/D/Y): _____
   b) Cause of Death: _____
   c) Place of Death: _____
4. Cause of Death (Enter only one cause for each a, b. and c.)

   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 or complication which caused the death.
   Due to (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. Interval between onset and death: _____
6. Was an inquest held? ☐ Yes ☐ No
7. Was an autopsy performed? If so by whom and with what findings? _____
   _____
8. Have you treated or advised the deceased during the last 5 years, prior to last illness? ☐ Yes ☐ No
9. 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 provide us with the name of physician, dates and reasons:
   _____
   _____

Are you related to or in a business relationship with this patient? ☐ Yes ☐ No

These statements are true and complete to the best of my knowledge and belief.

Name of Attending Physician: _____
Address: _____
Signature of Attending Physician: _____ Date (M/D/Y): _____
Phone Number: _____ Fax Number: _____

The furnishing of forms shall not be an admission of liability by the Company.