CUMIS®

PROOF OF DEATH
PHYSICIAN STATEMENT

MAILING ADDRESS

Mail: CUMIS, A Division of Co-operators Life Insurance Company
P.O.Box 5065, 151 North Service Road
Burlington, ON L7R 4C2

Phone: 1-800-263-9120 Fax: 1-800-897-7065

Email: claims.centre@cumis.com

Website: www.cumis.com

INSTRUCTIONS

Form to be completed by the Last Attending Physician and/or Coroner if applicable.

Please print clearly and be sure all sections are complete to avoid delays in processing the claim.

The Next of Kin is responsible for the cost of completing this form.

The completed form must be faxed directly from the Physician's office or the original can be mailed to the address provided.

1. DECEASED INFORMATION

Name of Deceased _____ (First Name) _____ (Initial) _____ (Last Name) Date of Birth _____ (MMM/DD/YYYY)

Date of Death _____ (MMM/DD/YYYY) Place of Death (if hospital or institution, provide name) _____

CAUSE OF DEATH	DATE OF DIAGNOSIS
Immediate cause of death:	
Underlying causes of death:	
Other significant conditions:	

Was the deceased's death due to Cancer? ☐ Yes ☐ No If yes, please provide diagnosis date of primary Cancer _____ (MMM/DD/YYYY)

If the deceased's death was not the sole result of an illness or disease, please describe the circumstances of death (e.g., an accident, homicide or suicide)

_____

_____

Was an inquest held? ☐ Yes ☐ No Was an autopsy performed? ☐ Yes ☐ No If yes, by whom _____

How long have you treated the deceased? _____

Did the deceased receive treatment during the last 3 years from any other physician, or any hospital or institution? ☐ Yes ☐ No

If yes, provide the following:

Name	Address	Nature of illness or injury	Dates (MMM/DD/YYYY)

Was the deceased advised of the nature of his/her illness? ☐ Yes ☐ No If yes, when _____ (MMM/DD/YYYY)

Did the deceased ever use any form of tobacco, marijuana, nicotine products or substitutes (including nicotine patch and gum)? ☐ Yes ☐ No ☐ Unknown

Did the deceased ever stop smoking? ☐ Yes ☐ No ☐ Unknown If Yes, when and for how long? _____

2. PHYSICIAN ACKNOWLEDGEMENT

I hereby declare that the answers to the above questions are accurate and complete.

Physician's Stamp

Attending Physician (Please Print) _____

Certified Speciality _____ Family Physician ☐ Yes ☐ No

Address _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)

Phone Number (_____)_____ Fax Number (_____) _____

Physician Signature _____ Date _____ (MMM/DD/YYYY)

3. PRIVACY STATEMENT

Your Privacy Matters to us

Co-operators Life Insurance Company recognizes and respects the importance of privacy. When you enrol for insurance coverage, we establish a confidential file and collect, use and disclose your personal information for the purposes of issuing, administering and servicing your insurance. You may access and correct, if needed, the personal information in your file by sending us a request in writing.

We limit access to your personal information to our staff and other persons we have authorized who have a need to know it to perform their duties. We may store or process your personal information in Canada, the United States or other countries and, under applicable law, governments, courts, law enforcement or regulatory agencies, may, by lawful order, obtain disclosure of your personal information.

We may also share your personal information with the Group Policyholder and its affiliates, affiliates of Co-operators Life Insurance Company or with entities with whom the Group Policyholder or Co-operators Life Insurance Company have made arrangements to advise you of products and services that may be of interest to you. You may choose not to have your personal information shared or used for these additional purposes by contacting us.

For more information about our privacy practices please visit www.cooperators.ca. If you have questions about your privacy you may call us, toll-free, at 1-800-667-8164, send an email to us at privacy@cooperators.ca, or write to us at Co-operators Life Insurance Company, 1900 Albert Street, Regina, SK S4P 4K8, Attention: Privacy Officer.

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