the co-operators®
A Better Place For You®

GROUP BENEFITS PROOF OF DEATH PHYSICIAN STATEMENT

MAILING ADDRESS

Mail: Co-operators Life Insurance Company
Group Life Claims Department
1920 College Avenue
Regina SK S4P 1C4

Fax: 1-866-889-9925

INSTRUCTIONS

The claimant is responsible for the cost of completing this form.

1. DECEASED INFORMATION

Group _____ Account _____ Certificate _____

Name _____ _____ _____
First Name Initial Last Name

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

Date of Birth _____
MMM/DD/YYYY

CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause of death:	
Underlying causes of death:	
Other significant conditions:	

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 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

2. PHYSICIAN ACKNOWLEDGEMENT AND AUTHORIZATION

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

If you would like The Co-operators to communicate with you by email about this claim, please provide your email _____

Co-operators Life Insurance Company uses reasonable safeguards to protect all information it collects, uses, retains and discloses in the course of conducting business. However, the internet is not a secure medium and we do not use email encryption. As such, we cannot guarantee complete privacy and confidentiality of any email transmissions. This includes the email text and any attachments. By authorizing communication by email, you are acknowledging that you have read and understood this notice and disclaimer and are consenting to the transmission of your personal information using email knowing the email and any attachments may be subject to unauthorized access, use or disclosure by third parties. You agree that Co-operators Life Insurance Company is not responsible or liable for any damages or losses you or any other person may suffer as a result of any breach of privacy, confidentiality or security by transmission of your personal information using email communication. If you no longer wish to communicate with Co-operators Life Insurance Company by email, please send notification to Group_life_claims@cooperators.ca.

2. PHYSICIAN ACKNOWLEDGEMENT AND AUTHORIZATION (CONTINUED)

Attending Physician (Please Print) _____

Certified Speciality _____ Family Physician ☐ Yes ☐ No

Address _____ _____ _____ _____
Street City Province Postal Code

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

Physician's Stamp

Physician Signature _____ Date _____
MMM/DD/YYYY

Co-operators Life Insurance Company Privacy Statement

Co-operators Life Insurance Company is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.