



**PHYSICIAN STATEMENT
Accidental Death**

*In this Physician Statement, "you" and "your" mean the Physician who completes it; "we", "us" and "our" mean AIG Insurance Company of Canada, the insurer providing **Accidental Death** coverage.*

THE CLAIMANT IS RESPONSIBLE FOR ANY CHARGE INCURRED FOR COMPLETION OF THIS FORM.

1. a) Full name of the deceased:
b) Residence at time of death:
2. Date of birth (MM/DD/YY):
3. a) Date of accident (MM/DD/YY):
b) Date of death (MM/DD/YY):
c) Place of death:
4. Manner of death: ☐ Accident ☐ Suicide ☐ Homicide ☐ Natural ☐ Undetermined ☐ Pending
5. Cause of death:

Cause of death [enter one cause for each (a), (b) and (c)]	Interval between onset and death
Disease and condition directly leading to death (a disease, injury or complication, which caused the death):	
(a)	
Antecedent causes (morbid conditions if any, giving rise to the above cause (a) stating underlying cause last):	
(b)	
(c)	
Other significant conditions contributing to the death but not related to the disease or condition causing death):	

6. a) Was an inquest held? ☐ Yes ☐ No
b) Was an autopsy performed? ☐ Yes ☐ No
If so, by whom and with what findings?

7. a) Have you treated or advised the deceased during the last 5 years, prior to last illness? ☐ Yes ☐ No
b) 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 question, please furnish us with the name of the physician, dates and reasons:

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

By signing below, you confirm that you understand and agree that the information you provide on this form becomes part of the deceased's Accidental Death file and that we may share that information with affiliates of AIG Insurance Company of Canada, the beneficiary or beneficiaries, the deceased's estate, applicable reinsurers, authorized third parties, including without limitation, third party service providers, and, where authorized by law, government entities, including financial services regulatory bodies and with other insurance companies to allow them to administer insurance with respect to the deceased. Disclosures of information on this form will occur in accordance with AIG Canada's Privacy Principles available at www.aig.ca

Name of Attending Physician:

Address:

Signature of Attending Physician:

Date (MM/DD/YY):

Phone number:

Fax number:

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