PROVIDENT AMERICAN
INSURANCE

PROOF OF DEATH PHYSICIAN'S STATEMENT

Failure to complete this form in its entirety may result in a delay in processing this claim.

INSURED/DECEASED NAME:_____ **POLICY NUMBER:**_____

Residence at time of death:_____
Date of Death:_____ Place of Death:_____
What was the immediate cause of death?_____
How long did the deceased suffer from this condition?_____
Was the death due to suicide, homicide or an accident? ☐ YES ☐ NO
If death was due to an accident, please describe the acident:_____

What were the contributory causes of death?

Disease	Duration

How long did you know the deceased?_____ Date of last visit _____
Give particulars of each condition for which you treated or advised the deceased:

Nature of Condition	Date	Duration	Results

To your knowledge, was the insured hospitalized during the last year of life? ☐ YES ☐ NO

If yes: Hospital's Name and Address	Reason	Dates

Please list the names and addresses of other physicians who attended the deceased during the past five years:

Name	Address	Condition

PHYSICIAN'S SIGNATURE | PRINT PHYSICIAN'S NAME | DATE | TAX ID NUMBER

PHYSICIAN'S ADDRESS | PHYSICIAN'S TELEPHONE NUMBER | PHYSICIAN'S FAX NUMBER

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is subject to criminal and civil penalties.

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