ACE INA Insurance
ACE INA Life Insurance
1400 – 25 York Street
Toronto, Ontario M5J 2V5
Telephone: 416-594-2627 1-877-772-7797

PROOF OF ACCIDENTAL DEATH
ATTENDING PHYSICIAN'S STATEMENT

PLEASE COMPLETE ALL DATES IN MONTH/DAY/YEAR FORMAT

THE CLAIMANT IS RESPONSIBLE FOR ANY FEE CHARGED FOR THIS INFORMATION

Full Name of Deceased		
Date of Birth		Sex
Residence: Street		
City	Province	Postal Code
Date of Death		
Place of Death (If Hospital or Institution, give name)		

CAUSE OF DEATH

1. State the Disease, Injury or Complication which caused Death, not mode of dying, such as Heart Failure, etc.
2. Antecedent Causes: Morbid Conditions, if any, giving rise to the above cause stating the underlying cause last.
3. Other Morbid Conditions contributing to Death, not related to the condition causing Death.
4. To what extent did any antecedent causes contribute to Death?
5. If Death was due to accident, Suicide or homicide, specify which. Describe briefly and include dates
6. Was an Inquest held ☐Yes ☐No
Was an Autopsy performed ☐Yes ☐No
If so, by whom and with what findings?
How was this death said to have been caused?

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7. When and where did you first attend the Deceased for this matter?
8. Was the injury described above, directly and independently of all other causes, sufficient to produce Death?
9. Have you treated or advised the Deceased during the last 3 years? ☐ Yes ☐ No
Did the Deceased, to your knowledge, receive treatment during the last 3 years from any other Physician, or in any Hospital or Institution? ☐ Yes ☐ No
If "Yes" to either question, please furnish the following:
Name
Address
Nature of Illness or Injury
Date
Name
Address
Nature of Illness or Injury
Date

The answers I have made to the above questions are true and complete to the best of my knowledge and belief.

Name of Physician completing this form _____
Please Print

Signature of Physician completing this form _____ Date _____

Office Address	
Phone # ( )	Fax# ( )