CAYMAN FIRST
FIRST IN INSURANCE. TODAY. TOMORROW.

GROUP DEATH CLAIM - PROOF OF DEATH

Form No. GIS25 Sep 1 2011

PLEASE COMPLETE IN BLOCK LETTERS – ALL QUESTIONS MUST BE ANSWERED

PHYSICIAN'S STATEMENT

The Medical certification follows the recommendations of the World Health Assembly made in Geneva on July 24, 1948.
In the interest of accurate vital statistics, please conform to the International List of the Causes of Death.

Full name of deceased	Date of Death (DD/MM/YYYY)
Residence at death	Place of death
Age at death or date of birth (DD/MM/YYYY)	If institution or hospital, give name

Cause of death (enter only one cause for each of a, b and c.)

Disease or condition directly leading to death: *(This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury or complication which caused death).*

(a) ______________________________

Antecedent causes. (Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last).

Due to (b) ______________________________

Due to (c) ______________________________

Other significant conditions: *(contributing to the death but not related to the disease or condition causing death).*

Interval between onset and death

(a) ______________

(b) ______________

(c) ______________

Date of first attendance in last illness (DD/MM/YYYY)	Date of last attendance in last illness (DD/MM/YYYY)

If death was due to accident, suicide or homicide, specify which.
Describe briefly:

Was inquest held? ☐ Yes ☐ No

Was autopsy performed? ☐ Yes ☐ No

If so, by whom and with what findings?

Have you treated or advised the deceased during the last five years, prior to the last illness? ☐ Yes ☐ No

Did the deceased, to your knowledge, receive treatment during the last five 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 of Injury	Approximate Dates (DD/MM/YYYY)

(Print or Stamp)

Physician's Name: ______________________________

Address: ______________________________

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Signature   Date (DD/MM/YYYY)

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