PHYSICIAN'S STATEMENT

PROOFS OF DEATH
Submitted To

☐ American-Amicable Life Insurance Company of Texas
☐ IA American Life Insurance Company
☐ Industrial Alliance Insurance and Financial Services Inc.
☐ Occidental Life Insurance Company of North Carolina
☐ Pioneer American Insurance Company
☐ Pioneer Security Life Insurance Company

P.O. Box 2549 • Waco, TX 76702-2549

This statement is to be furnished without expense to the Company

1. (a) Deceased's name in full _____ Date of Birth _____ Age at Death _____
   (b) Residence at death _____ Occupation _____

2. Sex _____ How long have you know the deceased? _____

3. (a) Date of death _____ Place of death _____
   (b) If death occurred in hospital please give name and address _____
   _____
   (c) When were you first consulted for the condition which directly or indirectly caused death? _____

4. (a) What was the immediate cause of death? _____ Does this agree with Death Certificate? _____
   (b) How long in your opinion did this disease or impairment exist? _____
   (c) What was the date of onset of the first symptom or sign according to the clinical history? _____

5. (a) Contributory cause of death _____
   _____ Duration _____
   (b) Other chronic diseases or impairments _____
   _____ Duration _____

6. (a) If death was due to suicide, homicide or accident, state which _____
   Please describe briefly _____
   _____
   (b) Was an official inquiry held? _____ Was a post-mortem examination made? _____
   If so, please give particulars _____

7. Please give particulars of each condition for which you treated or advised deceased prior to last illness.

Disease or Condition	Date	Duration	Result

8. Please give names and addresses of all other physicians or other practitioners who attended deceased within the five years preceding death.

Name	Address	Disease or Impairment

I hereby certify that the above facts are true and complete to the best of my knowledge.

_____
Physician's printed name

Signature _____ , M.D.

Address _____
Street and Number

Date _____ 20 _____

_____
City State

C-2(8/12)