canopy *health* insurance

# GROUP LIFE CLAIM FORM

## EMPLOYER'S STATEMENT

Employer/Policyholder

Policy Number

Address of Policyholder

Full Name of Deceased

D D M M M Y Y
Deceased's Date of Birth

D D M M M Y Y
Date of Death

Cause of Death

Was death as a result of an Accident? Yes No

Group Life Coverage Amount

D D M M M Y Y
Last full day worked

Stamp

Name of Employer Representative

Signature

Title or Position

Date

**Please enclose the following required documents:**

- Physician's Statement/Proof of Death OR
- Certified copy of the RGD Death Certificate
- Confirmation of coverage and Beneficiary designation
- Completed Banking Information Form
- Police Report (applicable only for Accidental Death)

Canopy reserves the right to request additional information, should this be deemed necessary.

## ATTENDING PHYSICIAN'S STATEMENT

Name of Deceased

Place of Death

D D M M M Y Y

Date of Death

Age at Death

Cause of Death (Disease, injury or complication which caused death)

Interval between onset and death

Antecedent Causes

Specify if death was due to Accident ☐ Suicide ☐ Homicide ☐

Was the cause of death verified by Post Mortem? Yes ☐ No ☐

Were you the deceased's Medical Doctor Yes ☐ No ☐

Did you advise or treat the deceased during the last 3 years, prior to the last illness? Yes ☐ No ☐

Did the deceased receive treatment from any other physician, hospital or institution during the last 3 years? Yes ☐ No ☐

If yes, please provide name, address, nature of illness/injury, and approximate dates.

I hereby certify that the answers to the foregoing questions are accurate and complete to the best of my knowledge and belief.

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Physician's Name

Physician's signature

Date

Address