Manulife Financial

Group Benefits
Attending Physician's Report

If there is a charge for the completion of this form, payment is the responsibility of the claimant. Please print clearly.

Completed reports should be returned to:

Plan contract number(s)	Division number	Union local	Plan member certificate number

Plan administrator's name (last, first, middle initial)

Plan administrator's mailing address (number, street)	City	Province	Postal code

The Medical Certification follows the recommendation of the World Health Assembly made in Geneva on July 24, 1948. It has been accepted in Canada and the United States. In the interest of accurate vital statistics, please conform to the International List of Causes of Death. When complete, please return this form to the plan administrator at the address shown above.

Physician's report

Deceased's name (last, first, middle initial)	Place of death	Date of death (dd/mmm/yyyy)

If death occurred in an institution or hospital, please give name	Age at death

Residence address at death (number, street)	City	Province	Postal code

Cause of death
Enter only one cause for each of a, b and c.

Disease and 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 the death).

(a)	**Interval between onset and death** (a)

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

Due to (b)	**Interval between onset and death** (b)
Due to (c)	(c)

To your knowledge, did the deceased ever smoke? ◯ Yes ◯ No ◯ I don't know

If "Yes", how many years? Number of years

Date of first attendance in last illness (dd/mmm/yyyy)

Date of last attendance in last illness (dd/mmm/yyyy)

If death was due to accident, suicide or homicide, specify which and describe briefly.

Was an inquest held? ◯ Yes ◯ No

Was an autopsy performed? ◯ Yes ◯ No

If "Yes," to either of the above, by whom and what findings?

Have you treated or advised the deceased during the last five years, prior to 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 of the above, please provide the following information.

Name	Address	Nature of illness/injury	Approximate dates
			(dd/mmm/yyyy)
			(dd/mmm/yyyy)

Please complete page 8 of this form.

Attending physician's personal information

Attending physician's full name		Degree or qualification	
Address (number, street)	City	Province	Postal code
Area code and phone number			

Attending physician's signature

Attending physician's signature	Date signed (dd/mmm/yyyy)
x	

The information in this statement will be kept in a group life, health, or disability benefits file with Manulife Financial and might be accessible by third parties to whom access has been granted or those authorized by law. By providing the information you consent to such unedited release of any information contained herein.