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FINANCIÈRE SISIP FINANCIAL
A division of CFMWS
Une division des SBMFC

Attending Physician's Statement (APS) Regarding Death

Group Policy Number 901102

Manulife

(Manulife use only)
Claim Number: _____

1. DECEASED'S INFORMATION

Surname	*First Name*	*Date of Birth (dd-mm-yyyy)*

Place of Death (If hospital or institution, give name):	*Date of Death (dd-mm-yyyy)*

For dependant life claims, Mother's first and last name:	*For dependant life claims, Father's first and last name:*

2. CAUSE OF DEATH

a) DISEASE OR MEDICAL CONDITION

Question	Please provide details	Relevant Dates
i. Disease or condition directly leading to death:		Date of first symptoms of disease or condition: *dd* *mm* *yyyy* Date of diagnosis of disease or condition: *dd* *mm* *yyyy* Interval between onset and death, in months: _____
ii. Antecedent cause:		Date of first symptoms of disease or condition: *dd* *mm* *yyyy* Date of diagnosis of disease or condition: *dd* *mm* *yyyy* Interval between onset and death, in months: _____
iii. Significant condition: (Contributing to the death but not relating to (i) or (ii) above)		Date of first symptoms of disease or condition: *dd* *mm* *yyyy* Date of diagnosis of disease or condition: *dd* *mm* *yyyy* Interval between onset and death, in months: _____

b) ACCIDENT, SUICIDE, OR HOMICIDE

Specify if death was due to an: ☐ accident ☐ suicide ☐ homicide Briefly explain:

Was an inquest held? ☐ Yes ☐ No Briefly explain:

Was an autopsy performed? ☐ Yes* ☐ No
***If Yes,** by whom and with what findings?*
***If Yes,** please provide a copy of the autopsy report.*
Briefly explain:

c) INTRAUTERINE DEATH

When did you first assess and/or treat the pregnant woman?
dd *mm* *yyyy*

Please indicate the:
Fetal weight _____ (grams) &
Gestational age at time of death: by dates _____ ; by ultrasound _____ .

Was a termination of pregnancy procedure (abortion) performed? ☐ Yes* ☐ No ***If Yes,** specify the reason for the termination:*

3. ATTENDING PHYSICIAN

Have you treated or advised the deceased during the last 3 years, prior to last illness? ☐ 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 provide the physician or hospital's name and nature of illness or injury:*

Name Printed:
Please print and/or attach a business card.

Signature: *dd* *mm* *yyyy*

Address:

Telephone:

Physician's Stamp: