

## GROUP LIFE BENEFITS ATTENDING PHYSICIAN'S CERTIFICATE OF DEATH

M63 BIL

I hereby certify that				
	employed by			
died on the	day of		, 20	, from
(Chief or Primary cause)				
When was the illness diagnosed? _				
When in your opinion did the last illn	ess become severe enough to preve	nt them from working	g? (Give details).	
What was the manner of death?	☐ Natural ☐ Accidental ☐	Suicide  Hom	nicide  Undetermined	
Did the deceased smoke?	☐ Yes ☐ No If yes, for	how long?		
Dated at	this	day of	2	0
This form should be completed in	full by the Attending Physician.	Dr.		
			(Doctor's signature)	
			(Doctor's name - please print)	
			(Address)	
			(Telephone)	

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