

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

**M63 BIL**

I hereby certify that \_\_\_\_\_

of \_\_\_\_\_ employed by \_\_\_\_\_

died on the \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_, from

(Chief or Primary cause) \_\_\_\_\_

(Contributing or secondary cause) \_\_\_\_\_

The illness began on the \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_.

Was death caused by accident?     Yes     No    If "Yes", briefly describe \_\_\_\_\_

Was death due to suicide?     Yes     No

Was death due to homicide?     Yes     No

Was an inquest held?     Yes     No    If so, by whom and with what findings? \_\_\_\_\_

Did the deceased smoke?     Yes     No    If yes, for how long? \_\_\_\_\_

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

**This form should be completed in full by the Attending Physician.**    Dr. \_\_\_\_\_

(Doctor's signature)

\_\_\_\_\_  
(Doctor's phone number)

\_\_\_\_\_  
(Doctor's name - please print)