NO. 2 Physician's Statement **Submitted to**

(Before Completing Question 6, Please Read Instructions on Reverse Side)

BRITISH AMERICAN

PROOFS OF DEATH

1. a. Deceased's name in full	a. .....
b. Residence at death (Street, City & Country)	b. .....
c. Occupation at death.	c. .....

2. a. Age of deceased at death?..... b. Sex? ..... c. Colour? .....

d. Height? ..... e. Approximate Weight in Health? ..... f. Colour of Hair? ..... g. Colour of Eyes? .....

h. Were there any identification marks on body?.....

3. Give particulars of each condition for which you treated or advised deceased prior to last illness.

Nature of condition	Dates	Duration	Result

4. How long have you known deceased?

5. a. Date of death?	a. .....
b. Place of death.	b. .....
c. If in a hospital, or institution, give name.	c. .....
6. a. What was immediate cause of death?	a. .....
b. How long in your opinion, did deceased suffer from this disease or impairment?	b. .....
c. What were the contributory causes of death? Give as nearly as you can by dates the duration of each.	c. .....
d. Was death due to suicide, homicide or accident?	d. .....
7. a. When were you first consulted by deceased or by any relative or friend, for the condition which either directly or indirectly caused death?	a. Date..... By Whom?.....
b. Date of last visit?	b. .....
8. Was there an official inquiry as to cause of death or a post mortem examination on the body of the deceased? If so, which, by whom, and with what result?	....

9. Give names and addresses of all other physicians and other practitioners who to your knowledge attended deceased during past three years.

Names	Addresses	Disease or Impairment	Dates

10. From what other disease or impairment has deceased suffered and when?	....

The undersigned hereby certifies that he/she was the attending physician of the above deceased and that these statements are true and complete to the best of his/her knowledge and belief.

Dated at _____ this _____ day of _____ 20 ____

Signature _____

Office Address _____ Qualifications _____

City _____ Country _____

Form No. 87 No. 2
British-American Insurance Company Limited

To Be Completed Only if Policy in Force Less Than Two Years or Death is by Other Than Natural Causes

MEDICAL HISTORY AUTHORIZATION

Dated at ..... 20 .....

To Whom It May Concern:

I hereby request and authorize you to furnish the British-American Insurance Company Ltd., or its representative any and all information you may have concerning

.....Deceased.....PolicyNo.....

with respect to any illness or injury he/she have suffered, medical history consultation, prescriptions or treatments including X-Ray plates and copies of all hospital or medical records pertaining to the above-named insured deceased that the same may be included as part of the proofs of claim submitted by me to the company. A photostat copy of this authorization shall be considered as effective and valid as the original.

Witness..... Signed.....

Signature of Claimant

INSTRUCTIONS

In the interest of accurate vital statistics, please conform to the International List of Causes of Death when answering Question 6. External causes (poisoning, violence, etc.). If an injury, describe the accident. If suicide or homicide, state the means employed. In surgical cases state the nature of operations and the disease or condition requiring such procedure. In Females puerperal states are to be indicated. In Neoplasms give type and part first involved. Avoid indefinite terms. Describe any unusual features.

Where spaces provided for the answers are too small, such details as seem desirable should be given below.