CUNA CARIBBEAN INSURANCE

THE FAMILY INDEMNITY PLAN

PROOF OF DEATH FORM
(To be completed by the attending physician)

NOTICE TO PHYSICIAN: To be completed by attending or family physician having knowledge of conditions causing and contributing to death and returned to the Organization below.

NAME OF DECEASED: _____

ADDRESS: _____

_____

DATE OF BIRTH: _____/_____/_____ **DATE OF DEATH:** _____/_____/_____
DD / MM / YYYY DD / MM / YYYY

CAUSE OF DEATH:

_____
Principal Cause Date of Onset

_____
Contributing Cause Date of Onset

_____
Contributing Cause Date of Onset

WAS DEATH DUE TO: ☐ACCIDENT ☐SUICIDE ☐HOMICIDE? Please give explanation:

_____

_____

_____

I certify that I attended to the deceased from _____ to _____ and death occurred from the causes listed above.

Physician's Name: _____ Telephone _____

Physician's Address: _____

Physician's Signature and Stamp/Seal_____ Date: _____

CERTIFICATE OF ORGANIZATION

I hereby certify that the above named deceased was insured under the Family Indemnity Plan with this Organization.

Organization Name: _____ Telephone _____

Address _____

Signature of Authorized Organization Officer_____ Date: _____