The Family Indemnity Plan

PROOF OF DEATH
(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 Credit Union below.

NAME: _____

ADDRESS: _____

_____

DATE OF BIRTH: _____ DATE OF DEATH: _____

CAUSE OF DEATH:

_____
Principal Cause — Date of Onset

_____
Contributing Cause — Date of Onset

_____
Contributing Cause — Date of Onset

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

_____

_____

_____

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

Physician: _____ Date: _____

Physician's Telephone No: _____

_____, M.D. _____
M.D.'s Signature — Address — City — Country

CERTIFICATE OF CREDIT UNION

I hereby certify the above named deceased had The Family Indemnity Plan Member's Certificate No. with this Credit Union.

_____
Full Name of Credit Union — Policy Number

_____
Mailing Address — Number and Street — City — Country

_____ _____ _____
Telephone Number — Credit Union Hours — Signature — Title

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