

INFORMATION

Transit No.

TRANSIT1

Loan, policy or card number

Loan, policy or card number

Personal Loan

NO_PB

NO_PB2

Mortgage loan

NO_PH

NO_PH2

Line of credit

NO_MCP

NO_MCP2

Commercial loan

NO_CAE

NO_CAE2

DESC_PRET

NO_PRET_AUTRE

NO_PRET_AUTRE2

Life insurance without medical exam

NO_AV

NO_AV2

Individual Insurance

NO_T5

NO_T52

Master Card credit card

NO_AP

NO_AP2

IDENTIFICATION OF THE DECEASED

Surname (maiden name if applicable)

NOM1

Given name

PRENOM1

Sex

M

F

PHYSICIAN'S STATEMENT (Family physician? v yes v no)

Date of birth

Y	M	D

Date of death

Y	M	D

How long have you been treating this patient? _____

1. Place of death (If death occurred in a hospital or other institution, provide the name) _____

2. Cause of death

Illness or condition that caused the death (not the way death occurred, such as a heart attack, asthenia, etc., but the illness, injury or complication that was the cause of death)

Interval between the onset of illness and death

a) _____

b) _____

Previous causes (disabling state, if any, that was the origin of the immediate cause of death)

c) _____

4. Was death caused by: suicide? yes no homicide? yes no accident? yes no

Was there: coroner's inquest? yes no an autopsy? yes no

What were the results? _____

5. Please provide details of the patient's use of tobacco, including the quantity consumed daily, as well as the date when he stopped using tobacco. _____

6. In the past five (5) years has the patient consulted a health care professional, had a medical examination or follow-up, suffered or been diagnosed with or treated for any of the following problems: heart disease or circulatory disorders, blood disorders including cholesterol, blood pressure disorders, tumors or cancer, muscular dystrophy, multiple sclerosis, AIDS, Human Immunodeficiency Virus or any other disease or disorder of the immune system, chest pains or angina, lung disease or respiratory problems, digestive problems, liver disorders, intestinal disorders, kidney disease, urinary tract disorders, genital disorders, nervous system disorders, diabetes, or psychiatric or psychological disorders ?

Don't know

No

Yes

If yes, please mention the name of the disease, the dates of consultations, the treatments received, the hospitalization periods, if applicable, and the date when the patient was informed about the disease :

SIGNATURE OF THE PHYSICIAN

Physician's surname and given name _____

Address (no., street, apt., city, province, postal code) _____

Phone number _____

Signature of physician _____ Date _____

N.B. The deceased's estate is responsible for the fees charged for the completion of this form.