BF&M

Death Claim – Attending Physician’s Statement

This form must be completed in full. Please print.

1. Insured information

Name (first/middle/last):

Policy name:

Policy number: | Certificate number:

Residential address:

DOB (dd-mmm-yyyy): | Age: | Gender: ☐ Male ☐ Female | Height:

2. Physician statement

Date you first saw the deceased (dd-mmm-yyyy): | Date you last saw the deceased (dd-mmm-yyyy):

Was death due to: ☐ Suicide ☐ Homicide ☐ Accident Medical condition Other:

Primary cause of death:

Date of death (dd-mmm-yyyy): | Country of death:

Were there any occupational hazards or personal history connected (remote or proximate) to to the date of death? ☐ Yes ☐ No
If “yes”, provide details:

If in a hospital or institution, provide the name and address:

Details of all medical condition(s) for the past 5 years directly or indirectly contributing to cause of death:

Conditions/Factors	Date of onset of symptoms (dd-mmm-yyyy)	Duration	Treatment/Results

Additional information:

2. Physician statement (cont'd)

Was an autopsy performed? ☐ Yes ☐ No
If "yes", please complete the table below:

Date of autopsy (dd-mmm-yyyy)	Name of doctor or examiner	Autopsy results

At the time of the accident/death, was the deceased under the influence of any of the following:

Prescription medication: ☐ Yes ☐ No Illicit drugs: ☐ Yes ☐ No Alcohol: ☐ Yes ☐ No

Provide names and addresses of all other physicians and practitioners who, to your knowledge, attended the deceased during the past 3 years:

Name of doctor or examiner	Address	Disease or impairment

3. Physician information

Name (first/middle/last):

Name of medical practice:

Address:

Phone: Email:

License number: Country of license:

Declaration

Physician declaration and signature

By signing this form, I confirm/understand that:

- *The furnishing of forms by BF&M does not constitute an admission that there is any assurance in force.*
- *The information provided above is true and complete and I confirm that I have examined the insured identified in section 1.*
- *A photocopy of this authorisation is as valid as the original.*

Declaration (cont'd)

Data protection declaration

By signing this form, I confirm/understand that:

- *I have obtained the claimant's consent to enable the lawful transfer of the insured's personal data to BF&M for the processing purposes described in BF&M's Privacy Policy (www.bfm.bm/privacy).*

I submit this application and fully understand that by checking the "ACCEPT TERMS" box below, I confirm that I (in my capacity as attending physician) understand and agree with the declaration set out above and on the previous page.

☐ **ACCEPT TERMS**

Name:	
Sign:	Date (dd-mmm-yyyy):

For BF&M official use only

Reports submitted: ☐ Accident Report ☐ Employer's Accident Report ☐ Police Report (required)

Date processed: ____/____/____ Admin: ____________ Comments: ____________