

Important: Fill out in block letters and answer each section as accurately as possible.

Section A – Collection of Personal Information

This form allows UV Insurance to collect personal information from the attending physician regarding the death of the insured person, specifically identifying the cause of death.

This personal information is used to:

- ▶ Identify the deceased person
- ▶ Initiate or continue a claims process
- ▶ Comply with legal and regulatory requirements, in particular to prevent, detect or prosecute offences, cyber threats and fraud

The information disclosed on this form will be forwarded to the UV Insurance staff responsible for processing the claim, as well as to any other person authorized by law.

Section B – Information About the Deceased Person

1. First name _____ Last name _____
2. Date of birth

Y					
M					
D					

 3. Date of death

Y					
M					
D					
4. Residence at the time of death _____
5. Did the deceased smoke?
☐ Yes Since when did they smoke? _____
Did they ever quit smoking? ☐ Yes ☐ No If **Yes**, during what period? _____
☐ No Did they ever smoke? ☐ Yes ☐ No If **Yes**, during what period? _____
6. If they died in a hospital or institution, provide the name: _____

Section C – Cause of Death

1. Illness, injury or condition that directly caused the death ☐ Yes ☐ No If **Yes**, please specify: _____ Date of onset of the illness

Y					
M					
D					
2. Preceding causes (medical conditions that may have led to the aforementioned condition) ☐ Yes ☐ No If **Yes**, please specify: _____ Date of onset of the illness

Y					
M					
D					
3. Illness or morbid condition caused by or resulting from ☐ Yes ☐ No If **Yes**, please specify: _____ Date of onset of the illness

Y					
M					
D					
4. Date of first treatment for the last illness

Y					
M					
D					
5. Date of last treatment for the last illness

Y					
M					
D					
6. Was the death due to: ☐ An accident ☐ Suicide ☐ Homicide
If **Yes**, please provide details: _____
7. Was there a coroner's inquest? ☐ Yes ☐ No 8. Was an autopsy performed? ☐ Yes ☐ No
If **Yes**, indicate by whom and provide the findings:

Section C – Cause of Death (cont.)

9. Did you treat the deceased or did they consult you during the five years prior to their last illness? ☐ Yes ☐ No

If **Yes**, please indicate the dates:

Date of onset of the illness	Diagnoses made at that time
Y M D	
Y M D	
Y M D	

10. To your knowledge, was the deceased treated by other physicians or in a hospital or other institution during the past five years?

☐ Yes ☐ No If **Yes**, please provide the following information:

Name of physician	Name of hospital or institution
Date	Diagnosis
Y M D	
Name of physician	Name of hospital or institution
Date	Diagnosis
Y M D	

Section D – Consent and Signature

If any of the personal information is inaccurate, incomplete or unclear, the insured person may have it corrected by submitting a request to UV Insurance.

For more details, please see our [Privacy Policy](#).

As the attending physician, I declare that I am acting in accordance with privacy laws and regulations.

By signing at the bottom of this form, I confirm that the information provided is accurate.

Signature

I declare that the above information is complete and accurate and that it will form part of my insurance application with UV Insurance.

Signed in _____ Date

Y M D

X _____
Signature of the attending physician

Name of the attending physician in block letters

Name of the attending physician's hospital or institution

