



**Attending Physician's
Statement As To Insured's Death**

For All the Commitments You Make*

Please Print—Use A Separate Sheet of Paper Where Space Does Not Permit.

In relation to death of _____	Date of Birth _____	Policy Number _____
Address _____	City _____	State _____ Zip Code _____
On what date did you first attend deceased? _____	Where _____	
Describe the deceased condition at that time _____		
What if any symptoms or signs of disease did you find? _____		
If death was due to trauma, state date of accident _____	How did it occur? _____	
What was the exact nature and extent of the injury? _____		
Between what dates did you treat deceased? _____	From _____	To _____
If confined to hospital, indicate name and address _____	From _____	To _____
If surgery performed, please describe _____	When? _____	
Primary cause of death _____	Date of death _____	
What was the secondary or contributory cause of death? _____		
For what have you previously treated deceased? _____	When? _____	
To your knowledge, was the deceased ever affected with or suffering from any constitutional or local disease, either Hereditary or acquired? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, what? _____	
Did any disease or cause, other than the injury referred to, Operate as a complication, or contribute to produce death? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, what? _____	
Was the deceased under the influence of alcohol and/or drugs at the time of your first examination? Please identify type and quantity, if known. <input type="checkbox"/> Yes <input type="checkbox"/> No		
To what other companies or associations are you reporting this injury? _____		
Your Name (print) _____		
Your Street Address _____	City/Town _____	State/Province _____ Zip Code _____
Physician's Degree(s) _____	Your Telephone Number _____ ()	Taxpayer's Identification Number _____
I authorize the release to CNA of any and all medical records pertaining to the above patient.		
Signed _____	Degree _____	Date _____

Return to: **GARDNER & WHITE
INSURED CLAIMS DEPT.
P.O. BOX 40948
INDPLS, IN 46240-0948**