COLINA

Colina Insurance Limited
P.O. Box N 4728
Nassau, The Bahamas

CLAIMANT'S STATEMENT
(PROOF OF DEATH)

PHYSICIAN'S CERTIFICATE

Note: To be furnished without expense to the Company.
Please sign and stamp for certification

Life Insured's Full Name

First Name	Middle Initial	Last Name

Employer

Age at Death

Date of Death (DD / MM / YYYY)

Residence at death

No. / Street	City	State / Province / Island	P.O. Box / Postal Code

Cause of Death (enter only one cause for each of a, b, c)	Interval between onset and death
Disease or condition directly leading to death (This does not mean the mode of dying such as heart failure, asthenia etc. It means the disease, injury or complication which caused death).	
Antecedent causes (morbid conditions, if any, giving rise to the above condition due to or as a consequence of (a) (b) (c)	
Other significant conditions (contributing to the death but not related to the disease or condition causing death).	

Was death related to acquired immune deficiency syndrome?
◯ Yes ◯ No

Date of first attendance in last illness (DD / MM / YYYY)

Date of last attendance in last illness (DD / MM / YYYY)

Did the Life Insured ever use tobacco under any form? ◯ Yes ◯ No

When did the Life Insured **start** smoking? (DD / MM / YYYY)

When did the Life Insured **stop** smoking? (DD / MM / YYYY)

Did the Life Insured receive treatment during the last 5 years from any other physician? ◯ Yes ◯ No

If 'Yes', please furnish the following:

Name of Physician	Address	Date of Diagnosis (DD / MM / YYYY)

When was the Life Insured informed the first time about this illness? (DD / MM / YYYY)

Name of Physician

Signature of Physician

Date (DD / MM / YYYY)

Medical / File No.

Physician's Stamp