SENIOR LIFE
INSURANCE COMPANY

P.O. Box 2447
Thomasville, GA 31799-2447
877-777-8808
www.SeniorLifeInsuranceCompany.com

PHYSICIAN'S STATEMENT

This information will be used to determine eligibility for insurance and/or administer coverage for benefits under a Senior Life Insurance Company Policy. It is to be completed by the family physician or physician in attendance during the last illness.

PHYSICIAN'S INFORMATION

Doctor's Name: Phone:

Address: City: State: Zip:

POLICY INFORMATION

Deceased's Name: Date of Birth: Date of Death:

INFORMATION REGARDING DEATH OF INSURED

Death was Due to: ❑ Illness ❑ Accident ❑ Homicide ❑ Suicide ❑ Undetermined

Cause of Death (List diagnosis): Was an autopsy performed? ❑ Yes ❑ No

How long did the deceased suffer from the disease, condition, or injury that caused their death?

What other diseases or conditions contributed to the Insured's death?

What date did you first diagnose the conditions contributing to the death? Was the Insured aware of your diagnosis? ❑ Yes ❑ No

Place and Address of Death:

PATIENT HISTORY

Date you first treated the Insured? Who referred the Insured to you?

Name and Address of Insured's Primary Care Physician:

Name of Physician or Hospital that treated the Insured from {00/00/0000 through 00/00/0000}:

List diagnoses of any other impairment, disorder, disease, transplant, or chronic illness the Insured was treated for from {00/000000 through 00/00/0000}:

Did the Insured use tobacco in any form? ❑ Yes ❑ No If yes, what type and for how long?

SIGNATURE

Physician's Signature Date