The Family Indemnity Plan

PROOF OF DEATH
(To be completed by the attending physician)

NOTICE TO PHYSICIAN: To be completed by attending or family physician having knowledge of conditions causing and contributing to death and returned to Organization below.

NAME:

____

ADDRESS:

____

____

DATE OF BIRTH: ______________________________ DATE OF DEATH: ___________________________

CAUSE OF DEATH:

____
Principal Cause Date of Onset

____
Contributing Cause Date of Onset

____
Contributing Cause Date of Onset

WAS DEATH DUE TO: ☐ ACCIDENT ☐ SUICIDE, or ☐ HOMICIDE? Please give explanation:

____

____

____

I certify I attended the deceased from ____________________ to ____________________ and death occurred from the causes listed.

Physician: ___________________________________ Date: ___________________________________

Physician's Telephone No: __________, M.D. ____
M.D.'s Signature Address City Country

CERTIFICATE OF ORGANIZATION

____
I hereby certify the above named deceased had The Family Indemnity Plan Member's Certificate No. with this Organization.

____
Full Name of Organization Policy Number

____
Mailing Address Number and Street City Country

_________________ _________________ ___________________________________
Telephone Number Organization Hours Signature
Title

1254-2137(1/2014)

CUNA MUTUAL GROUP
CMFG Life Insurance Company