Guardian Group
Guardian Life of The Caribbean Limited

COUNTRY:	
POLICY NAME:	
POLICY NUMBER:	

GROUP CERTIFICATE OF DEATH

QUESTIONS TO BE ANSWERED BY THE MEDICAL PRACTITIONER WHO ATTENDED THE LATE

First Name:		Middle Name/s:	
Surname:		Date of Birth: (dd/mm,yyyy)	
Who Died At:		Date of Death: (dd/mm/yyyy)	

	ANSWERS
1. (a) Were you the usual Medical Attendant? **(b)** How Long have you been so? **(c)** If not, state name of previous Medical Attendant	**(a)** **(b)** **(c)**
2. (a) Did you attend him during the whole of his last illness? **(b)** From what disease did he suffer?	**(a)** **(b)**
3. (a) What was the cause of Death? **(b)** Was it verified by Post Mortem?	**(a)** **(b)**
4. When did the disease first manifest itself?	**(dd/mm/yyyy)**
5. (a) Was the last illness which ended in death connected with or secondary to any previous disease? **(b)** If so, what was its nature and duration? **(c)** Was the death caused by suicide?	**(a)** **(b)** **(c)**

I, _____ of _____

Please print name — Please print Facility

do hereby declare that my answers to the above questions are true and correct to the best of my knowledge and belief.

Dated this _____ day of _____ in the year of _____.

Doctor's Signature: *(include Official Stamp)*		
Medical Qualification:	Tel: *(Office)*	Tel: *(Cellular)*
Post Office Address:		