**S.USA Life Insurance Company, Inc.**
P.O. Box 2549
Waco, Texas 76702

1-800-746-1670
Visit us at www.susa-waco.com
E-mail: claims@susa-waco.com

*Policy administration services provided by American Amicable Life Insurance Company of Texas.*

# PHYSICIAN'S STATEMENT

This statement is part of an application for benefits under an S.USA Life Insurance Company, Inc., policy or certificate. It is to be completed by the family physician or physician in attendance during the last illness. The beneficiary is responsible for the completion of this form without expense to the Company.

To: ______________________________________________________________________________________
(Print Doctor's Name)

| 1. Name of Deceased Patient: | 2. Date of Death: | 3. Date of Birth: |
|---|---|---|
| 4. Cause of Death: (State diagnosis)<br>Due to: ☐ Illness ☐ Accident ☐ Homicide ☐ Suicide ☐ Undetermined<br>Was an autopsy performed? ☐ Yes ☐ No | | 5. Place of Death: (Address or Name of Hospital) |

6. How long did patient suffer from the disease, condition, or injury which caused death?

7. What other diseases or conditions contributed to the cause of death?

8. Date you first diagnosed the conditions contributing to death: Month ______ Day ______ Year _______
Was the patient aware of your diagnosis? ☐ Yes ☐ No If yes, date informed: Mo. Day Yr.

PATIENT HISTORY

9. Date you first treated the patient: Month ______ Day ______ Year _______

10. Who referred this patient to you? (State name and address: ) ☐ Doctor ☐ Hospital ☐ Clinic ☐ Family ☐ Other:

11. Name of each hospital where the patient was confined or treated in the last 5 years: (State dates admitted and discharged, with diagnosis, if known)

12. Name and address of patient's regular personal physician:

13. Name and address of other physicians in attendance during the last illness?

14. State diagnoses of any other conditions or diseases the patient was treated for within the last 5 years:

15. If any surgery was performed in the last 5 years, state date and type of surgery:

16. Did the patient use tobacco in any form? ☐ Yes ☐ No If yes, what type and for how long?

*Telephone Number*

Date _____________ Signature of Physician _____________________________________________(_________)______________________

Address ____________________________________________________________________________________________________
(Number and Street) (City) (State) (Zip Code)