GTL | GUARANTEE TRUST LIFE

Mail claims to:
P.O. Box 1144
Glenview, Illinois 60025
Or Fax to (847) 699-1048
Or email to: Claims@gtlic.com
For Customer Service, please call: (800) 338-7452

C ATTENDING PHYSICIAN'S STATEMENT

Deceased's Full Name _____ Age _____

Alternate Name _____

Place of Death *(If in hospital or institution, give name & Address)* _____

Cause of Death Info: Primary Cause of Death: _____

Contributing Causes: _____

Other Conditions Treated: _____

Length of time the Primary or contributing conditions were present prior to death

Condition _____ Years *(Approximately)* _____ Months _____ Days _____

Condition _____ Years *(Approximately)* _____ Months _____ Days _____

Date of first attendance for this last illness _____/_____/_____

Date of last attendance for this last illness _____/_____/_____

Specify if applicable: *Death was due to:* ☐ Accident ☐ Suicide ☐ Homicide

Please describe briefly: _____

Was an autopsy performed? ☐ Yes ☐ No

If so, with what findings: _____

Was an inquest held: ☐ Yes ☐ No

If so, with what findings: _____

Please list any treatments or medical advice given over the last 5 years:

Date *Condition*

Please list any other physicians who, to your knowledge, gave treatment to the deceased over the last 5 years:

Name *Address* *Details*

Date: _____/_____/_____ Attending Physician's Signature: _____

Name _____

Address (Street) (City) (State) (Zip Code)