TRANS GLOBAL
INSURANCE

PAYMENT PROTECTION PLAN CLAIM FORM
CRITICAL ILLNESS BENEFITS – CANCER (Life Threatening)

To allow us to make an assessment of your claim it is imperative that you answer **ALL** of the questions in **FULL.**

INSTRUCTIONS

1. Part 1 is to be completed by claimant.
2. Part 2 to be completed by physician.
3. **Any charge for completion of this form is the claimant's responsibility**

When all required sections are complete, return this claim form to:

TRANS GLOBAL INSURANCE GROUP
Suite 275, 16930-114 Avenue
Edmonton, Alberta T5M 3S2
Tel: 1-844-930-6022 Fax: 1-844-6021

Critical Illness (if You or Your Spouse are diagnosed for the first time in his or her life and survive that First Diagnosis for at least 30 days) is defined as:

Cancer (Life Threatening)

Meaning any malignant tumour characterized by the uncontrolled growth and spread of malignant cells and invasion of tissue. The diagnosis must be made in writing by a physician and be confirmed by histological examination of the involved tissue. Under this Plan Cancer includes leukaemia and Hodgkin's disease but **does not include**:

- All tumours which are histologically described as pre-malignant, as non-evasive or as cancer in situ;
- Stage A prostate cancer, Duke's Stage A colon cancer, or any pre-malignant lesions, benign tumours or polyps;
- Kaposi's sarcoma or cancerous tumours in the presence of Human Immunodeficiency Virus;
- Any skin cancer that is not malignant invasive melanoma and that has not exceeded .75 millimetres in depth.

Part 1: Claimant's Authorization (Please Print)

Account or Card Number:

Name of Primary Cardholder (First name on Credit Card Billing Statement) | Date of birth (M/D/Y)

Male Female |

Address (*number, street, city, province, postal code)* | Telephone no. (*including area code*)

( ) -

DECLARATION & AUTHORIZATION: I certify that the information given here is true and correct. I AUTHORIZE my employer, physician, hospital, insurer, law enforcement agency, fire department or other organization, or person having any records, data or information concerning this claim to furnish such records, data or information to the TRANS GLOBAL INSURANCE GROUP or its authorized representative (collectively "TGI") as requested. I also authorize TGI to share the information on this form with whatever parties it deems necessary to process my claim. TGI to share I understand that in executing this authorization, I waive the right for such information to be privileged. A reproduction of this authorization shall be as valid as the original.

Claimant's signature X | Date (M/D/Y)

Part 2: Attending Physician's Statement (Please Print)

1. a) On what date did your patient first have symptoms? Date (M/D/Y): _____
What were they?

_____

_____

b) When did your patient first consult you for this condition? Date (M/D/Y): _____

Continued on reverse

c) Is this the first occurrence of **Cancer** in the patient's lifetime? **Yes** **No**

d) How long has the insured been your patient? _____

2. a) Please provide the date this cancer was diagnosed. Date (M/D/Y): _____

b) On what date (M/D/Y) was the patient advised of the diagnosis _____ By whom? _____

3. Please provide a copy of the pathology report giving the following details:

- Type of Tumour
- Site of Tumour
- Histology and Staging

4. Please provide the names and addresses of other physicians consulted or hospitals attended by your patient for this caner:

Name	**Address** (number, street, city, province, postal code)	**Date from** (M/D/Y)	**Date to** (M/D/Y)

5. a) Has your patient previously suffered from cancer or any predisposing disorders? If so, please provide dates and details.

_____

_____

b) Has your patient ever been tested for the Human Immunodeficiency Virus?

Date (M/D/Y)	Result:
Date (M/D/Y)	Result:

6. Please provide any other information that would be helpful in the assessment of your patient's claim.

_____

_____

_____

_____

I hereby certify that the above information is based on reasonable medical probability, and is true and correct to the best of my knowledge and belief

Name of attending physician (*please print*) | Specialty | Telephone no. (*including area code)* ( ) -

_____

Address (number, street, city, province, postal code)

_____

Signature | Date (M/D/Y)

_____