TRANS GLOBAL
INSURANCE

PAYMENT PROTECTION PLAN CLAIM FORM
CRITICAL ILLNESS BENEFITS – HEART ATTACK

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
Email: tgi@transglobalinsurance.ca

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:

Heart Attack

Meaning the death of a portion of the heart muscle as a result of inadequate blood supply that has resulted in all of the following evidence of acute myocardial infarction:

- Typical chest pain
- New characteristic electrocardiographic (ECG) changes; and
- The characteristic rise of cardiac enzymes, troponins or other biochemical markers.
- Other acute coronary syndromes, including but not limited to angina, are not covered under this definition.

Part 1: Claimant's Authorization (Please Print)

Account or Card Number:

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

☐ Male ☐ Female |

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

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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. 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 the patient first consult you for this condition (M/D/Y)? _____

   b) Was a diagnosis of myocardial infarction made (please circle)? Yes No

   c) Is this the first occurrence of Heart Attack in the patient's lifetime (please circle)? Yes No

   d) On what date was the diagnosis made (M/D/Y)?: _____

   e) By whom was the diagnosis made? _____

Please provide the names and addresses of other physicians consulted or hospitals attended by your patient for this heart attack.

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

CONTINUED ON REVERSE

2. Please provide the following details pertaining to the insured's myocardial infarction:

   a) Description and date of onset chest pain:

      Date (M/D/Y): _____

      _____

      _____

   b) **ECG changes** in detail at time of event or provide copies or tracings, if available: _____

      _____

   c) **Cardiac enzyme levels**, including CPK – MB fraction and percentage of total CPK at time of diagnosis: _____

      _____

3. What other investigations have been performed? Please provide dates and details, or reports.

   _____

   _____

   _____

   _____

4. When did your patient first suffer symptoms or episodes of cardiovascular disease? Please provide details and dates.

   _____

   _____

   _____

   _____

   _____

5. Please describe including dates, any predisposing conditions or risk factors which your patient has had for cardiovascular disease.

   _____

   _____

   _____

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)*

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_____

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

_____

Signature | Date (M/D/Y)

_____ _____