TRANS GLOBAL
INSURANCE

PAYMENT PROTECTION PLAN CLAIM FORM
CRITICAL ILLNESS BENEFITS – STROKE/CVA

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: 1-844-930-6021
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:

Stroke
Meaning any cerebrovascular incident, excluding transient ischemic attack (mini stroke), producing death of a portion of the brain as a result of thrombosis, intracranial or subarachnoid hemorrhage or embrolization from an extracranial source and with objective evidence of a new permanent neurological deficit persisting for more than 30 days.

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*)

( ) -

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 consulted you for this condition (M/D/Y)?_____
   b) How long has the insured been your patient? _____
   c) Is this the first occurrence of Stroke/CVA in the patient's lifetime (please circle)? Yes No
2. a) Was a diagnosis of Cerebrovascular Accident made (please circle)? Yes No
   b) On what date did the CVA occur (M/D/Y)?_____
   c) Please describe the **cause** of the CVA. _____
   _____
   d) Please describe the residual neurological deficits. _____
   _____
   e) How long have the neurological deficits persisted? _____
   _____
   f) By whom was the diagnosis made? _____

Please provide a copy of the CT scan or MRI if available.

CONTINUED ON REVERSE

3. a) On what date was the patient advised of the diagnosis (M/D/Y)? _____

   b) By whom?_____

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

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

   b) What other investigations have been performed? Please provide details.

_____

_____

_____

_____

_____

5. On what date did your patient first have symptoms or episodes or cerebrovascular disease? What were they?

Date (day, month, year)	Result
_____	_____
	_____
	_____

6. Please describe including dates, any predisposing disorders or risk factors your patient had for cerebrovascular disease.

_____

_____

_____

7. 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)

_____ | _____