TRANS GLOBAL
INSURANCE

PAYMENT PROTECTION PLAN CLAIM FORM- DISABILITY BENEFITS

(After 30 Consecutive Days of Disability)

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

When all required sections are complete, return this claim form in the enclosed envelope 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

Part 1: Claimant's Authorization (Please Print)

Account or Card Number:

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

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: Employer's Statement – to be completed by last employer (Please Print)

Employee's Full Name: _____ Employee's Job Title: _____

State reason for involuntary unemployment by checking one of the boxes listed.

□ Disability □ Military Discharge □ Layoff □ Lockout □ Voluntary Resignation
□ Seasonal Layoff □ Retirement □ General Strike □ Employer Termination* □ Other _____

Type of Employment:
□ Full-time □ Part-time □ Seasonal □ Temporary How many hours per week? _____

First Date of Employment (M/D/Y) _____ / _____ / _____ Last Day Worked (M/D/Y) _____ / _____ / _____

Return to work? □ Yes □ No If "Yes", on what date? (M/D/Y) _____ / _____ / _____

Authorized Signature of Employer: _____ Title: _____

Address of Employer: _____ City/Province: _____ Postal Code: _____

Telephone Number: (_____) _____ Date (M/D/Y): **_____ / _____ / _____**

Part 3: Attending Physician's Statement (Please Print)

1 HISTORY

a) Date symptoms first appeared (M/D/Y) _____

b) Date patient ceased to work because of incapacity (M/D/Y) _____

c) Has patient ever had the same or similar condition (please circle)? Yes No Unknown

If yes, state when and describe: _____

_____

CONTINUED ON REVERSE

d) If diagnosis is pregnancy, give E.D.C. Date (M/D/Y) _____

e) Names and specialties of other treating physicians:

_____

_____

2 DIAGNOSIS (Including any complications).

a) Primary _____

_____

b) Additional conditions or complications _____

_____

3 TREATMENT DATES

a) Date of first visit for current condition (M/D/Y) _____

b) Date of latest visit (M/D/Y) _____

c) Frequency of visits (please circle) Weekly Monthly Other (*specify*) _____

d) Date of hospital inpatient admission (*day, month, year*) _____ Date of discharge (*day, month, year*) _____

4 PROGRESS

Has patient (please circle): Recovered Improved Not improved Retrogressed

a) Is patient following recommended treatment program (please circle)? Yes No (please elaborate)

_____

_____

5 MENTAL / NERVOUS INPAIRMENT (If applicable)

a) History

Precipitating Chronological Events _____

Work Issue Related to this Illness? _____

Pre-morbid Personality? _____

Axis II Diagnosis _____

Relevant Current Dynamics _____

Changes in ADL habits _____

Familial Risk Factors _____

Progress with Treatment Plan _____

b) Are patient's symptoms due to drug or alcohol abuse (please circle)? Yes No

c) If yes, is patient enrolled in a substance abuse program (please circle)? Yes No If yes, state facility _____

d) Has your patient ever been enrolled in a substance abuse program (please circle)? Yes No If yes, state when _____

6 PROGNOSIS

a) Prognosis for medical recovery _____

b) Expected date of return to work (M/D/Y) _____

c) Other factors affecting recovery _____

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)

_____

DISABILITY – GENERAL