TRANS GLOBAL
INSURANCE

PAYMENT PROTECTION PLAN CLAIM FORM
UNEMPLOYMENT

(After 30 Consecutive Days of Unemployment)

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 local union office **only** if you belong to a union.
4. **ATTACH A COPY OF YOUR RECORD OF EMPLOYMENT**

When all required sections are complete, return this claim 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 Primary Cardholder (Name Listed 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*)
( ) -

Employer's Name: _____

Employer's Address: _____

_____

Your Occupation or Job Title: _____

Date of Involuntary Unemployment (M/D/Y): From _____ / _____ / _____ To _____ / _____ / _____

Reason for Involuntary Unemployment: _____

Do you qualify for unemployment benefits for this period of unemployment? □ Yes □ No

If "No", why not? _____

WARNING: Any persons who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may constitute a crime and may also be subject to civil penalties

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

Date (M/D/Y)

X

CONTINUED ON REVERSE

INVOLUNTARY UNEMPLOYMENT

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 □ Wildcat strike/walkout □ Individual or mass layoff
□ Voluntary Resignation □ Normal, Routine or Seasonal Layoff □ Union Labour Dispute □ Retirement
□ General Strike □ Lockout □ Employer Termination* □ Other _____

***Reason for Interruption of Employment:**_____

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

Has he/she qualified for unemployment benefits for this period of unemployment? □ Yes □ No

If "No", why? _____

Has he/she returned 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: Local Union Office Statement (Please Print)

TO BE COMPLETED ONLY BY A UNION REPRESENTATIVE IF YOU ARE PART OF A UNION

Union Member Name: _____

Name of Union _____ Address _____

Telephone # (_____) _____

Is the above named individual a member of your Union? □ Yes □ No

On what date did stoppage begin? _____ / _____ / _____

What is the reason for work stoppage? _____

Has the individual returned to work? □ Yes □ No If so, on what date? _____ / _____ / _____

Completed By: _____ Position with Union: _____

Authorized Signature: _____ Date (M/D/Y): _____ / _____ / _____