



INSURANCE PLAN CLAIM FORM CRITICAL ILLNESS BENEFITS

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: forms@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:

1. **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.
2. **Heart Attack**
 Meaning the death of a portion of the heart muscle as a result of inadequate blood supply that has resulted in evidence of acute myocardial infarction.
3. **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 Account Holder (Name Listed First on Agreement)		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 | Date (M/D/Y)

X

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

1. Please describe the nature and extent of the Critical Illness

On what date was the condition diagnosed or surgery performed? Date (day, month, year) _____

2. Is this the first occurrence of Critical Illness (Life-Threatening Cancer, Heart Attack, Stroke) in the patient's lifetime?
Yes No

3. On what date did patient first consult a medical practitioner in connection with illness? Date (day, month, year)

4. Has the patient undergone any tests or investigations related to the diagnosis? If yes, please provide details and dates.

5. Have you previously suffered from, or received treatment for, a similar or related condition? Yes No
If yes, please give details including dates. _____

6. Is condition due to pregnancy? Yes No
If yes, describe complications: _____

Estimated date of delivery (day, month, year) _____

7. Prognosis/Comments (Please provide further details which you feel could be helpful): _____

8. Please provide details of any other doctors or specialists who have been consulted in connection with your patient's Illness:

Name	Address (number, street, city, province, postal code)	Telephone No. (including area code)	Dates Seen (day, month, year)
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		() -	

9. If patient has been treated at a hospital or similar institution, please supply the following information:

Name of Hospital	City or Town	Date of Admission (day, month, year)	Date of Discharge (day, month, year)

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)
code) | () -

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

Signature | Date (D/M/Y)