



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: forms@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.

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)

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

Signature _____

Date (M/D/Y) _____