TRANS GLOBAL
INSURANCE

INVOLUNTARY UNEMPLOYMENT CLAIM FORM

In order to begin the evaluation of your claim, all applicable sections must be completed and a copy of your Record of Employment (ROE) must be submitted. Please note that you will only be eligible to submit this claim form after you have been unemployed for 30 consecutive days.

INSTRUCTIONS - If completing the claim form by hand, please print clearly

1. Part 1 - To be completed by claimant
2. Part 2 - To be completed by last employer
3. Part 3 - To be completed by a union representative (only if applicable and you belong to a union)

When all the sections have been complete and the claim form has been signed, please return along with your ROE 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: Your Authorization (to be completed by claimant)

Account/Policy/ Loan or Card Number:

Primary Account/Policy/Loan or Cardholder (Name Listed First) | 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: _____

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", please describe 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.

Signature | Date (M/D/Y)

X

Part 2: Employer's Statement (to be completed by last employer)

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

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

Select 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 _____

Was the Employee terminated with or without cause?_____

If without cause, please describe the reason for Termination of Employment: _____

Does the employee qualified for unemployment benefits for this period of unemployment? □ Yes □ No

If "No", please describe why not? _____

Has the Employee returned to work? □ Yes □ No If "Yes", on what date (M/D/Y)? _____/_____/ _____

Signature of Employer:_____ Date (M/D/Y):_____**/**_____**/** _____

Title (Authorized Individual): _____

Employer Address:_____City/Province:_____Postal Code:_____

Telephone Number: (_____) _____

Part 3: Local Union Office Statement (to be completed by union representative)

Employee/Union Member's Name:_____

Name of Union & Local Number:_____

Union Address_____Telephone # (____) _____

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

On what date did stoppage begin (M/D/Y)?_____/_____/ _____

What is the reason for work stoppage or termination?_____

Has the individual returned to work? □ Yes □ No If so, on what date (M/D/Y)?_____/_____/ _____

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

Completed By:_____ **Position with Union:** _____