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
16902 137 Avenue NW
Edmonton, Alberta T5V 0C8
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) Male Female

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

Date (M/D/Y)

X

Continued on reverse

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

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

____

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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)
		( ) -	
		( ) -	

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

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Name of attending physician (*please print*)	Specialty	Telephone no. (*including area code)*
		( ) -

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

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Signature	Date (D/M/Y)