



## 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:  
 16902-137 Avenue NW  
 Edmonton, Alberta T5V 0C8  
 Tel: 1-844-930-6022 Fax: 1-844-930-6021  
 Email: [forms@transglobalinsurance.ca](mailto: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: \_\_\_\_\_