TRANS GLOBAL
INSURANCE

PAYMENT PROTECTION PLAN CLAIM FORM
LIFE BENEFIT

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 is to be completed by the attending physician.
3. **Attach a Certified Death Certificate**

INCOMPLETE OR UNSIGNED CLAIM FORMS MAY BE RETURNED WITHOUT PROCESSING

When all required sections are complete, return this claim form in the enclosed envelope 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

Part 1: Claimant's Authorization (Please Print)

Account or Card Number:

Name of Claimant/Primary Cardholder (Name Listed 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*) ( ) -

Name of Spouse | Date of birth (M/D/Y)

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

Name of Deceased | Date of Death (M/D/Y)

Cause of Death:

□ Accident □ Illness □ Other

Please specify: _____

_____

_____

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 of Insured Cardholder/Claimant | Print Name

X

If not primary cardholder, relationship | Today's Date (M/D/Y)

LIFE

Part 2: Physician's Statement – Cause of Death (Please Print)

1. Full Name of Deceased _____

2. Place of Death (Home, Hospital, etc)_____ Age at Death _____

3. Date of Death _____

4. Dates of attendance of last illness First Visit_____ Last Visit _____

5. IMMEDIATE CAUSE – State the disease or Complication which caused death

   Cause_____Date of Onset_____

6. MORBID CONDITIONS – If any, giving rise to immediate Cause

   Cause_____Date of Onset_____

7. a) Was an inquest held? _____YES _____NO

   b) Was an autopsy performed? _____YES _____NO

   c) Is death due to Accident, suicide or Homicide, state which and describe. _____

   _____

8. a) Have you ever treated or advised the deceased during the last 3 years, prior to last illness? ___YES ___NO

   b) Did the deceased, to your knowledge, receive treatment during the last three years from any other physician, or in any hospital or institution?

   ___YES ___NO

   c) If Yes to either question, please furnish us with the name of physician, dates and reasons.

   _____

   _____

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)*
		( ) -

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

Signature	Date (M/D/Y)
