Manulife

Group Benefits
Request for Approval of Brand-Name Drug

The prescribed drug you are applying for as an exception is covered up to the lowest cost interchangeable price. If this exception is approved you will receive reimbursement up to the reasonable and customary price for the product dispensed.

The cost of the prescribed drug will only be considered under this plan provided the prescribing physician indicates that the lowest cost interchangeable drug cannot be tolerated or is ineffective for the patient.

To apply for an exception, please complete Sections 1 and 3 and have your physician complete Section 2.

1 General information

You can obtain your plan number and your certificate number from your ID card.

Plan contract number _____ Plan member certificate number _____

Plan sponsor _____

Plan member name (first, middle initial, last) _____

Date of birth (dd/mmm/yyyy) _____ Daytime phone number ( ) _____

Address (number, street, apartment) _____

City _____ Province _____ Postal code _____

Patient's name (first, middle initial, last) _____

Date of birth (dd/mmm/yyyy) _____ Relationship to insured _____

DIN (Drug Identification Number) _____

2 Physician's statement

To be completed by physician

Please note: Any charges for the completion of this form are the plan member's responsibility.

Drug prescribed (chemical name, dosage form, strength) _____

In order for the cost of the prescribed drug to be considered under this policy, you must select the applicable medical reason below indicating why the lowest cost interchangeable drug cannot be tolerated or is ineffective for this patient.

◯ Adverse reaction ◯ Therapeutic failure

Physician's name (first, middle initial, last) _____

Physician's telephone number ( ) _____

Physician's address (number, street, suite) _____

City _____ Province _____ Postal code _____

Physician's signature _____ Date signed (dd/mmm/yyyy) _____

3 Authorization and consent

I certify that I, my spouse and/or my dependants of minor or major age ("Dependants"), have received all goods or services claimed and that the information provided for this claim is true and complete. **I authorize** Manulife to collect, use, maintain and disclose personal information relevant to this claim ("Information") for the purposes of Group Benefits plan administration, audit and the assessment, investigation and management of this claim ("Purposes"). **I am authorized** by my Dependants to disclose and receive their Information, for the Purposes. **I authorize** any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with Manulife, its reinsurers and/or its service providers, for the Purposes. **I authorize** the use of my Social Insurance Number ("SIN") for the purposes of identification and administration, if my SIN is used as my plan member certificate number. **I agree** a photocopy or electronic version of this authorization is valid. **I understand** that Manulife's Privacy Policy and Privacy Information Package are available at www.manulife.ca/planmember, or from my Plan Sponsor.

PLEASE SIGN AND DATE HERE

Signature of plan member _____ Date signed (dd/mmm/yyyy) _____

4 Mailing instructions

Please send the completed form to the appropriate address.

If you live outside Quebec:
Manulife Group Benefits
Health and Dental Claims, 500 G-B
500 KING ST N
WATERLOO ON N2J 4C6
Fax submissions: (519) 883-5712

If you live in Quebec:
Manulife Group Benefits
Health and Dental Claims
2000 MANSFIELD ST
MONTREAL QC H3A 2Y9
Fax submissions: (514) 286-6737