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 confirm:

That the information in this form, and any further verbal or written statement provided by me to Manulife in the future is true, accurate and complete to the best of my knowledge.

I understand:

- That my claims and my coverage may be denied or terminated because I provided false, incomplete, or misleading information.
- That if Manulife determines a claim submission:
  - is incorrect, the claim will be corrected, and any overpayment will be recovered by Manulife;
  - is false or misrepresented, the claim will be reported, together with any related information/documentation to my plan sponsor, and any false claims may be referred to law enforcement authorities for possible prosecution.
- I am required to refund any money that I may owe to Manulife or my Plan Sponsor in accordance with the provisions of my Group Benefits plan and I authorize monies to be deducted from my future claims.

Privacy

I authorize:

- Manulife and/or its service providers, its reinsurers and their service providers to collect, use, maintain, and disclose my personal information relevant to this claim ("Personal Information") for the purposes of Group Benefits plan administration, audit, the assessment, investigation, and management of this claim, and/or other purposes identified in the Personal Information Statement for employers' Group Benefits plans (collectively, the "Purposes").
- Any person or organization who has Personal Information about me, including any medical and health care professionals, institution, pharmacy or any other medical or health care related facility, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any other administrators of other benefits programs to collect, use, maintain, disclose and exchange this information with each other and with Manulife, its reinsurers and/or its service providers, for the Purposes.
- The use of my Social Insurance Number ("SIN") for identification and administrative purposes, if my SIN is used as my plan member certificate number.

Continued on the next page.

3. Authorization and consent (continued)

I understand:

- That except where there are contractual restrictions, Manulife employees, authorized organizations, service providers and reinsurers are located both within Canada and outside of Canada. Therefore, my Personal Information may be subject to interprovincial or cross-border transfers for the Purposes and may be subject to the laws of those jurisdictions.
- A decision about my claim may be taken exclusively on the basis of an automated decision using my Personal Information.
- I may withdraw my consent for certain uses of my Personal Information, subject to legal and contractual restrictions. I may not withdraw my consent for Manulife to collect, use, or disclose Personal Information needed for my claim. If I do so, Manulife may treat my withdrawal of consent as a request to dismiss, rescind or terminate my claim.
- I have the right to access and verify my Personal Information maintained in Manulife's files and to request any factually inaccurate Personal Information be corrected, if appropriate.

Requests can be sent to: **Privacy Officer Manulife, P.O. Box 1602, Del Station 500-4-A, Waterloo, Ontario N2J 4C6** or **Canada_Privacy@manulife.ca**

For more information, I can review the **Personal Information Statement for employers' Group Benefits plans** and the **Canadian Privacy Policy.**

I authorize Manulife to use the email address I provided as an additional means of communication about my file. I acknowledge correspondence by email may contain Personal Information including but not limited to sensitive information such as medical, employment and financial information. I understand that email communication is not yet a secure means of communication. I understand that I am responsible for updating the email address maintained by Manulife. I understand I can revoke the use of email address at any time by removing my email address online or contacting Manulife.

If applicable, I authorize Manulife to deposit all payments due to me from the above referenced Group Benefits policy ("Payments") into the bank account ("Account") that I have identified on this form. I confirm that this direct bank deposit authorization applies to the financial institution herein named by me and any other financial institution I choose to name in the future and shall remain valid until revoked in writing by me or my duly authorized representative.

I understand and agree that upon the deposit of any Payment(s) into the Account, Manulife is fully discharged from any further liability with respect to such Payment(s). I also understand and agree that Manulife may, at any time and without prior notice, discontinue the direct deposit of Payment(s), as requested herein, and require my personal written endorsement relating to future Payment(s). I also hereby acknowledge and agree that any Payment(s) made by Manulife into the Account, to which I am not entitled, either by contract or by law, shall not form part of my property, and shall be immediately refunded to Manulife, either by me or by representatives of my estate.

I understand that expenses reimbursed under the Health Care Spending Account may not be claimed for personal income tax purposes. I understand that should any tax consequences arise for reimbursement of these expenses,
I am responsible for the payment of such taxes.

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 Street N
Waterloo, Ontario N2J 4C6
Fax submissions: (519) 883-5712

If you live in Quebec:
Manulife Group Benefits
Health and Dental Claims
2000 Mansfield Street
Montreal, Quebec H3A 2Y9
Fax submissions: (514) 286-6737

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