Manulife Financial

For your future™

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 name	
Plan member name (first, middle initial, last)			Date of birth (dd/mmm/yyy)
Address (number, street, apartment)	City	Province	Postal code
Patient's name (first, middle initial, last)			Date of birth (dd/mmm/yyy)
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

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 Financial ("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.

Manulife Financial Group Benefits
Health Claims
PO BOX 1653
WATERLOO ON N2J 4W1

Manulife Financial Group Benefits
Health Claims
PO BOX 2580 STN B
MONTREAL QC H3B 5C6