RESET

Manulife

Affinity Markets
Prescription Drug Special Reimbursement Request

1 Patient information

Plan member's name (first, middle initial, last)	Plan number	Identification number

Patient's name (first, middle initial, last)	Date of birth (dd/mmm/yyyy)

Address	City

Province/State	Postal code/Zip code	Country	Telephone number
			( )

2 Physician information

Physician's name	Signature of physician	Date (dd/mmm/yyyy)

Address	City	Province	Postal code

Telephone number Ext.	Fax number
( )	( )

3 Drug requested for special reimbursement

To be completed by physician / Please print

Product name, dosage and quantity (requested for reimbursement)

Specific clinical and diagnostic evidence supporting the use of this medication and onset date of the condition

Identify reason why this drug product is now prescribed: e.g., patient's history, risk factors, concurrent use of other drugs (list drugs) failure to respond to or experienced adverse reactions to other drugs.

Identify other drugs prescribed currently or previously for claimants condition (as identified above)

Expected duration of therapy

Date of onset symptoms	Date of diagnosis	Date of initial consultation for this condition

Additional information

PRINT

Save As

Please complete page 2.

4 Special reimbursement procedure

In some cases, additional diagnostic or clinical information may be required. The information provided on this form is considered confidential.

This special reimbursement request form must be completed by your attending physician. The cost, if any, of obtaining this information is at the expense of the patient/plan member. Forward the completed form to:

Manulife Financial Affinity Markets
Health Claims
PO BOX 4214, STATION A
TORONTO ON M5W 5M4

Manulife Financial will not assume responsibility for any fees associated with the completion of this form.

5 Patient authorization

I certify that the information in this form is true and complete, to the best of my knowledge, and does not contain a claim for any expenses previously paid for by any plan.
I authorize any person or organization who has information pertaining to this claim, including any health care provider, insurance company, any type of workers' compensation board and investigative agencies, to release and exchange such information requested by Manulife Financial and/or its claims service providers for the purpose of plan administration including processing and investigating this claim.
I authorize Manulife Financial and its claims service providers to collect, to use and to exchange with the persons or organizations listed above any information needed for the purpose of plan administration including processing and investigating this claim.
If this claim is made on behalf of my spouse and/or dependents, I am authorized to disclose information about them, for the purpose of plan administration including processing and investigating this claim.
If my social insurance number is used as my certificate number, I authorize its use for the identification and administration of my benefits.
I agree that a photocopy or electronic version of this authorization shall be as valid as the original.

Signatures

If patient is under 16 years of age, the signature of the plan member is required.

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

At Manulife, we know that confidentiality of personal information is important. Any information you provide to us will be kept in an Affinity Markets Life and Health Benefits file. Access to your information will be limited to:

- our employees and service representatives in the performance of their jobs;
- persons to whom you have granted access; and
- persons authorized by law.

You have the right to request access to the personal information in your file and, if necessary, correct any inaccurate information. You may request to review the personal information it contains and make corrections by writing to: Chief Privacy Officer, Manulife, PO Box 1602, Del Stn 500-4-A, Waterloo, Ontario N2J 4C6.
A copy of our privacy principles and practices is available for view at **manulife.ca**.

6 Statement of confidentiality

The specific and detailed information requested on the Prescription Drug Special Reimbursement Request is required to process the insured person's claim request. To protect the confidentiality of this information, The Manufacturers Life Insurance Company (Manulife Financial) will establish a "financial services file" from which this information will be used to process the application, offer and administer services and process claims. Access to this file will be restricted to those Manulife Financial employees, mandataries, and administrators who are responsible for the assessment of risk (underwriting), marketing and administration of services and the investigation of claims, and to any other person you authorize or as authorized by law. These people, organizations and service providers may be in jurisdictions outside Canada, and subject to the laws of those foreign jurisdictions. Your consent to the use of personal information to offer you products and services is optional and if you wish to discontinue such use, you may write to Manulife Financial at the address shown below. Your file is secured in our offices or those of our administrator or agent. You may request to review the personal information it contains and make corrections by writing to: Chief Privacy Officer, Manulife, P.O Box 1602, Del. Stn 500-4-A, Waterloo, Ontario N2J 4C6.
A copy of our privacy principles and practices is available for view at manulife.ca.

7 Questions?

We're here to help!
Should you have any questions on this form, please feel free to contact us:

Phone:
Toll Free 1-800-268-3763
(Monday - Friday, 8am - 8pm ET)

Email:
more_info@manulife.com