Manulife Financial

Affinity Markets
Prescription Drug Special Reimbursement Request

1 Patient information

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

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

Address	City	Province	Postal code

Telephone number
( )

2 Physician information

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

Address	City	Province	Postal code

Telephone number	Fax number
( )	( )

3 Drug requested for special reimbursement

Please print.

Product name, dosage and quantity (requested for reimbursement)

Specific clinical and diagnostic evidence supporting the use of this medication

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

Additional information

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

Telephone: 1-800-COVER ME® (1-800-268-3763)

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 Financial, 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.