Manulife Financial

ManuScript™ Pay-Direct Drug Plan

Group Benefits
e-Request for Drug Exception

Complete this form when requesting coverage for a prescription drug(s) standardly not covered by your Group Insurance Plan. Request is for an individual Plan Member and/or his or her dependants and must be requested by the Plan Sponsor and approved by underwriting. The form is to be sent to: Manulife Financial, Attention: Underwriting Department, 380 Weber Street North, PO BOX 1650, WATERLOO ON N2J 4V7.

1 General information

Plan sponsor name	Plan contract number	Division number
Millwrights' Health & Welfare Trust Fund For Alberta	119848	010

Plan member name (first, middle initial, last)	Plan member certificate number

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

2 Request for drug exception

DIN number	Effective date (dd/mmm/yyyy)	Drug name

Reason for request

Please give details of the MEDICAL reason why you cannot tolerate the drug(s) covered by your plan.

If the above drug(s) is (are) required on an ongoing basis (i.e more than this prescription), this form must be signed by the prescribing doctor.

Physician's name	Physician's telephone number

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

3 Authorization

Print

I certify that the information provided for this claim is true and complete. **I authorize** my employer to make deductions from my pay, if necessary, for the additional Group Benefits that I am applying for. **I understand** that any personal information provided to or collected by Manulife Financial in accordance with this authorization, will be kept in a Group Benefits health file. **I understand** that access to my personal information will be limited to: Manulife Financial employees, representatives, reinsurers, and service providers in the performance of their jobs; persons to whom I have granted access; and persons authorized by law. I understand that I have the right to request access to the personal information in my file, and, where appropriate, to have any inaccurate information corrected. **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/groupbenefits, or from my Plan Sponsor.

Plan member signature	Date (dd/mmm/yyyy)

Plan administrator signature	Date (dd/mmm/yyyy)

4 For Manulife Financial office use only

Underwriter authorized signature	Date (dd/mmm/yyyy)

La version française du document se trouve à l'adresse www.manuvie.com/assurancecollective.