Drug exception application form

Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies, is committed to keeping information concerning this application confidential.

1 Important – please read carefully

Sometimes it may be medically necessary for your physician to prescribe a drug that is not covered, not fully covered or that requires more frequent dispensing than is currently eligible under your plan. If this is your situation, you can request that Sun Life Assurance Company of Canada make an exception.

Exceptions will only be made for drugs which legally require a prescription.

To be eligible for coverage, trials with two alternative drugs covered on your plan may be required.

If you have already purchased the medication for which you are requesting an exception, please attach all original receipts along with a regular extended health care claim form.

Your exception request will be reviewed and a decision will be communicated to you in writing and will include the period for which this decision applies.

Please note that the completion of this form is not a guarantee of approval. It must be completed in full, otherwise it will be returned to you. Any expense for medical evidence to support this request is your responsibility.

2 To be completed by Plan Member

Please have your physician complete the reverse side of this form.

Plan Member information

Contract number	Member ID number	Your plan sponsor/employer		
Your last name		First name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)
Your address (street number and name)				Apartment or suite
City			Province	Postal code
Preferred language of correspondence ☐ English ☐ French		Daytime phone number		

Claimant information

The claimant is the person for whom you are making the claim.

Last name	First name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)
Relationship to you ☐ Self ☐ Spouse ☐ Child		Full-time student ☐ Yes ☐ No	Disabled ☐ Yes ☐ No

Reason for request (choose one)

- ☐ Request for the full cost of the drug to be eligible under my plan: claimant is unable to take the lower priced equivalent drug.
- ☐ Request for the highest coinsurance available under my plan: claimant is unable to take an alternate drug available under a higher coinsurance.
- ☐ Request to be covered for a drug not covered under my plan.
- ☐ Request for additional dispensing fee to be covered under my plan.

If the request is for your child who is a full-time student, please provide the name and address of the educational institution your child is attending, and a copy of the record from the educational institution confirming your child's enrolment.

Name of the educational institution		
Address (street number and name)		Apartment or suite
City	Province	Postal code
Start of enrolment (dd-mm-yyyy)	End of enrolment (dd-mm-yyyy)	Number of hours enrolled per week

2 To be completed by Plan Member (continued)

Coordination of Benefits

Complete this section if you or your spouse are covered under another benefit plan. Send your request to the claimant's primary plan first. If the claimant is your dependent/child, send your request first to the plan of the parent whose birthday falls earlier in the year.

When you receive your acceptance or declination statement from the primary plan, send a copy plus copies of your receipts to the claimant's secondary plan to claim any unpaid amount.

Is the claimant covered under another benefit plan? ☐ Yes ☐ No

If yes, please provide details below of the person whose benefit plan covers the claimant.

Last name		First name	
Date of birth (dd-mm-yyyy)	Relationship		Type of coverage ☐ Single ☐ Family
Name of insurance company		Contract number	Member ID number

Is this drug covered under the primary plan? ☐ Yes ☐ No

If your other benefit plan is with Sun Life Financial, do you want us to process this form through both benefit plans? ☐ Yes ☐ No

Signature of covered family member X	Date (dd-mm-yyyy)

Financial assistance and provincial plan programs

Provinces may offer drug coverage to their residents, please verify your eligibility under your provincial drug plan before submitting your request.

Are you receiving or have applied for any financial assistance from another source (e.g. provincial or patient assistance program)?

☐ Yes ☐ No

If yes, under which program?

Please provide documentation of acceptance or declination.

Authorization and signature

I authorize Sun Life Assurance Company of Canada, its agents and service providers to collect, use and disclose information needed for underwriting, administration and adjudicating claims under this Plan with any person or organization who has relevant information pertaining to this application including health professionals, institutions, investigative agencies, insurers and reinsurers.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original.

Plan Member's signature X	Date (dd-mm-yyyy)

3 To be completed by prescribing physician

Condition and treatment

Diagnosis
Describe relevant medical condition

3 To be completed by prescribing physician (continued)

Drug exceptions requested

Drug name

DIN

Is this drug exception a ☐ new request? or a ☐ renewal request?

Treatment effective date (yyyy-mm-dd)

Anticipated duration of therapy

Dosage

Medical reason for requesting drug exception: ☐ Contraindication ☐ Severe adverse reaction ☐ Therapeutic failure ☐ Drug interaction

☐ Other (please specify) ____________________

Describe the nature, extent and severity of the above reason

How is the drug being monitored for effectiveness and safe use?

Are you aware if other physicians or practitioners are treating this patient and prescribing medication for the same condition?

List other drugs patient has used/is using for this medical condition.

1. Drug name — DIN

2. Drug name — DIN

Comments

Physician’s last name

First name

Telehone number

Physician’s address (street number and name)

Apartment or suite

City

Province

Postal code

Physician’s signature

X

Date (yyyy-mm-dd)

Dispensing fee frequency exceptions requested

Drug name

DIN

Is this drug exception a ☐ new request? or a ☐ renewal request?

Treatment effective date (yyyy-mm-dd)

Medical reason for requesting dispensing fee frequency exception: ☐ Patient safety ☐ Treatment monitoring

☐ Other (please specify) ____________________

Physician’s last name

First name

Telehone number

Physician’s address (street number and name)

Apartment or suite

City

Province

Postal code

Physician’s signature

X

Date (yyyy-mm-dd)

4 Respecting your privacy

Please keep copies of all correspondence and forms.

Respecting your privacy is a priority for the Sun Life Financial group of companies. We keep in confidence personal information about you and the products and services you have with us to provide you with investment, retirement and insurance products and services to help you meet your lifetime financial objectives. To meet these objectives, we collect, use and disclose your personal information for purposes that include: underwriting; administration; claims adjudication; protecting against fraud, errors or misrepresentations; meeting legal, regulatory or contractual requirements; and we may tell you about other related products and services that we believe meet your changing needs. The only people who have access to your personal information are our employees, distribution partners such as advisors, and third-party service providers, along with our reinsurers. We will also provide access to anyone else you authorize. Sometimes, unless we are otherwise prohibited, these people may be in countries outside Canada, so your personal information may be subject to the laws of those countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit *www.sunlife.ca/privacy*.

Questions? Please visit *www.sunlife.ca* or call toll-free 1-800-361-6212 Monday - Friday, 8 a.m. - 8 p.m. ET

Mailing instructions – keep a copy of your records

Mail or fax your completed form to the claims office nearest you.
Fax number: 1-855-342-9915

Sun Life Assurance Company
of Canada
PO Box 11658 Stn CV
Montreal QC H3C 6C1

Sun Life Assurance Company
of Canada
PO Box 2010 Stn Waterloo
Waterloo ON N2J 0A6

If your plan and member access allow it, you can submit your completed form through the 'Send documents' feature of the my Sun Life Mobile app. Simply enter ''drug exception'' as the reference number.