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A Better Place For You®

GROUP BENEFITS
REQUEST FOR BRAND NAME DRUG COVERAGE

MAILING ADDRESS

Mail: Co-operators Life Insurance Company
Extended Health Care Claims
1900 Albert Street
Regina, SK S4P 4K8

Fax: (306) 761-7101

INSTRUCTIONS

To be eligible for coverage for the brand name drug requested, there must be medical evidence indicating that a true adverse reaction has occurred. Please refer to Health Canada's Canada Vigilance Adverse Reaction Reporting form for Health Canada's definition of a true adverse reaction.

Any costs incurred for the completion of this request are the responsibility of the patient.

PART 1 - PATIENT INFORMATION

Group _____ Account _____ Certificate _____

Plan Member _____ _____ _____
First Name Initial Last Name

Patient _____ _____ _____
First Name Initial Last Name

Address _____ _____ _____ _____
Street City Province Postal Code

Date of Birth _____ Relationship to Plan Member _____
MMM/DD/YYYY

PART 2 - PHYSICIAN INFORMATION

Physician _____ _____ _____ Specialty _____
First Name Initial Last Name

Address _____ _____ _____ _____
Street City Province Postal Code

Telephone Number (_____) _____ Fax Number (_____)_____

Drug Name _____

Coverage for a brand name drug will be eligible only if the patient has experienced a substantive adverse reaction to a generic equivalent.

The adverse reaction must be reported to Health Canada and a copy of the completed Health Canada Vigilance Adverse Reaction Reporting Form must be submitted to our office.

Have you completed and sent the Health Canada Vigilance Adverse Reaction Reporting Form to Health Canada; and are you including a copy of the completed form with this request? ☐ Yes ☐ No

I hereby certify that the information provided in this request is true, complete and accurate.

Physician Signature _____ Date _____
MMM/DD/YYYY

PART 3 - PATIENT/GUARDIAN AUTHORIZATION

Co-operators Life Insurance Company Privacy Statement

At The Co-operators, we recognize and respect the importance of privacy. When you apply for insurance or open an account with us, we will ask for your consent to collect, use, keep and share your personal information. We will explain what information we need, what we will use it for and who we will share it with. We will open a confidential file to collect, use, keep and share your personal information for the purposes of confirming your identity, reviewing your insurance needs and determining suitability of our products and services for you, assessing your application for insurance, issuing and administering your policy, including assessing and processing claims, administering your investments, meeting our contractual and regulatory obligations, detecting and preventing fraud, and performing business and statistical analysis. We will not share your personal information for other purposes, except with your consent or as required or permitted by law.

We may tell you about products and services that may be of interest to you. You can tell us what information you want to receive from us and you can withdraw your consent at any time. You may access and correct, if needed, the personal information in your file by sending us a request in writing.

We limit access to your personal information to our staff and other people we have authorized who need to use it to perform their duties. This may include our third-party service providers who may use your personal information for processing, storage, analysis and disaster recovery purposes outside of Canada. They could be required by law to give your personal information to courts, governments or regulators outside of Canada. To protect your personal information, we ensure that privacy and security requirements are included in all third-party service provider contracts.

You can find more details about The Co-operators privacy policy at www.cooperators.ca. If you have any questions regarding our privacy policies or about how we collect, use, keep and share your personal information, please contact our Privacy Officer at The Co-operators at 1-888-887-7773, or by e-mail: privacy@cooperators.ca

I authorize Co-operators Life Insurance Company (a) to use the personal information disclosed on this form, and any other personal information known to Co-operators Life Insurance Company regarding the above-named patient, for the purpose of assessing this prior authorization request and any related claim and administering the benefit plan under which any such claim is made, and (b) to contact, and to obtain any such personal information from and to disclose any such personal information to, any physician, pharmacist or other health care professional having knowledge of such patient's health relevant to this request and any related claim.

I hereby certify that the information provided in this request is true, complete and accurate.

Patient/Legal Guardian Name _____ Telephone Number (_____) _____

Signature of Patient/Legal Guardian _____ Date _____
MMM/DD/YYYY