Medical Cannabis

The purpose of this form is to obtain information required to assess your drug claim.

IMPORTANT: Please answer all questions. Your claim assessment will be delayed if this form is incomplete or contains errors.

Any costs incurred for the completion of this form are the responsibility of the policyholder/patient.

Canada Life recognizes and respects the importance of privacy. Personal information collected is used for the purposes of assessing eligibility for this drug and for administering the benefits policy. For a copy of our Privacy Guidelines, or if you have questions about Canada Life's personal information policies and practices (including with respect to service providers), refer to canadalife.com or write to Canada Life's Chief Compliance Officer.

I authorize Canada Life, any healthcare provider, any insurance or reinsurance company, administrators of government benefits or patient assistance programs or other benefits programs, other organizations, or service providers working with Canada Life or any of the above, located inside or outside Canada, to exchange personal information when relevant and necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

I acknowledge that the personal information is needed to assess eligibility for this drug and to administer the benefits policy. I acknowledge that providing consent will help Canada Life to assess my claim and that refusing to consent may result in delay or denial of my claim. Canada Life reserves the right to audit the information provided on this form at any time and this consent extends to any audit of my claim. This consent may be revoked by me at any time by sending written instruction to that effect.

I also consent to the use of my personal information for Canada Life and its affiliates' internal data management and analytics purposes.

If the patient is a person other than myself, I confirm that the patient has given their consent to provide their personal information and for Canada Life to use and disclose it as set out above.

I certify that the information given below is true, correct, and complete to the best of my knowledge. Failure to provide true, correct and complete information on this form could result in revocation of any approval decision, a requirement to repay paid claims or other appropriate action.

Policyholder's signature: _____ Date: _____

Form Completion Instructions:

1. **Complete "Patient Information" sections.**
2. **Have the prescribing physician complete the "Physician Information" sections.**
3. **Send all pages of the completed form to us by mail, fax or email as noted below.**

Note: As email is not a secure medium, any person with concerns about their form/medical information being intercepted by an unauthorized party is encouraged to submit their form by other means.

Mail to: **The Canada Life Assurance Company**
Drug Claims Management
PO Box 6000
Winnipeg MB R3C 3A5

Fax to: **The Canada Life Assurance Company**
Fax 1-204-946-7664
Attention: Drug Claims Management

Email to: **cldrug.services@canadalife.com**
Attention: Drug Claims Management

For additional information contact Group Customer Contact Services at 1-800-957-9777.

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canada life™

Medical Cannabis

Policyholder Information – Complete all sections of this page (please print)

Policyholder:	Patient Name:	
Policy Name:	Policy Number:	Policyholder ID Number:
Patient Date of Birth (DD/MM/YYYY):	Address (number, street, city, province, postal code):	

Please indicate preferred contact number and if there are any times when telephone contact with you about your claim would be most convenient.

May we contact you by email? (Note that some correspondence may still need to be sent by regular mail).

☐ Yes ☐ No If yes, please provide email address: _____

Do you have coverage of medical cannabis with another carrier? ☐ Yes ☐ No

If Yes, a) indicate start date (DD/MM/YYYY): _____

b) coverage provided by: _____

Physician's Information (please print)

Name of prescribing physician:

Specialty:

Address (number, street, city, province, postal code):

Telephone Number (including area code):	Fax Number (including area code):

1. Product Name: Medical Cannabis
2. Is your patient authorized to possess cannabis for medical purposes under current legislation? ☐ Yes ☐ No
3. Prescribed dosage form and regimen: _____
4. Diagnosis / Indication for use (include date of initial diagnosis) (MM/YYYY): _____
   - ☐ Spasticity or neuropathic pain associated with multiple sclerosis
   - ☐ Chemotherapy-induced nausea and vomiting or neuropathic pain associated with cancer
   - ☐ Anorexia or neuropathic pain associated with HIV/AIDS
   - ☐ Symptoms associated with palliative care
5. What is the anticipated duration of treatment with medical cannabis? _____

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Medical Cannabis

I certify that the information provided is true, correct, and complete.

Physician's Signature: _____ Date: _____

License Number: _____

It is important to provide the requested information in detail to help avoid delay in assessing claims for medical cannabis. The completed form can be returned to Canada Life by mail, fax, or email.

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