Prior Approval Form
For Medical Cannabis

Sun Life Financial

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

1 Important – please read carefully

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. Given the confidential nature of your information, we will issue our response to you in writing.

To purchase Medical Cannabis eligible under this plan, you must follow the current Health Canada regulations outlined on the Government of Canada website. You are required to register with a Health Canada authorized licensed producer, who will also dispense the cannabis for medical purposes. If you meet the clinical criteria and are approved for coverage via this form, your expenses can be reimbursed.

2 To be completed by plan member

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 telephone number		Fax 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

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	

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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 Medical Cannabis covered under the primary plan? ☐ Yes ☐ No

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

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

***This section must be signed and dated by the Plan member for this form to be processed.**

Authorization and signature

I certify that the information I provided above is true and complete. 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 prior approval 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	*Date (dd-mm-yyyy)
X	

3 To be completed by prescribing physician

Prescribing physician's last name (please print)	First name (please print)	
License number		
Specialty		Telephone number
Address (street number and name)		Apartment or suite
City	Province	Postal code

Date of diagnosis (dd-mm-yyyy)	Quantity of Medical Cannabis per day	Duration of use

3 To be completed by prescribing physician (continued)

Patient's last name	Patient's first name	Date of birth (dd-mm-yyyy)

Medical Cannabis will be eligible for reimbursement only if the patient satisfies the criteria listed below. If the patient does not satisfy the criteria, then the Medical Cannabis will not be eligible for reimbursement (please confirm by checking off the last box below). When assessing requests for coverage and claims, we consider guidance by Health Canada, physicians' licensing authorities, and national medical professional organizations. The eligible expense under this plan is that portion of the expense that is not payable or available under another extended health care benefit plan.

If approved, eligibility for reimbursement for Medical Cannabis is effective for 12 months and may be reassessed at any time by Sun Life Assurance Company of Canada's discretion.

Please indicate if the patient's diagnosis and symptoms satisfy one or more of the following criteria, for the treatment of:

☐ Cancer:
- ☐ with severe or refractory pain
- ☐ Nausea and/or vomiting associated with cancer treatments

OR

☐ Multiple Sclerosis:
- ☐ with Neuropathic pain
- ☐ with Spasticity. Is there functional impairment?
  - ☐ Yes ☐ No

  If yes, please specify.

OR

☐ Spinal cord injury:
- ☐ Refractory spasticity in spinal cord injury

OR

☐ Epilepsy:
- ☐ Refractory paediatric onset epilepsy

OR

☐ Rheumatoid Arthritis:
- ☐ with pain which failed to respond to standard therapy

OR

☐ HIV or AIDS:
- ☐ with Anorexia
- ☐ with Neuropathic pain

OR

☐ in Palliative care

OR

☐ Patient does not meet the criteria above.

OR

☐ Other diagnosis (please provide details of diagnosis and symptoms, for individual consideration):

3 To be completed by prescribing physician (continued)

Declaration

I declare that:

- This patient has a medical condition requiring treatment, and
- The patient reports that cannabis relieves the symptoms caused by this medical condition, and
- To my knowledge, the patient is not suffering from, and is not at high risk for, harms related to cannabis, and
- The patient has been informed of the potential risks of medical cannabis, and
- The patient has been informed of alternative therapies for the patient's medical condition.

Physician's signature	Date (dd-mm-yyyy)
X	

Respecting your privacy

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 our toll-free number 1-800-361-6212 Monday - Friday, 8 a.m. - 8 p.m. ET.

Send us your form

All pages of this form must be submitted together. Keep a copy for your records.

You can submit **all** pages of this form through the mobile app. Please use 'medical cannabis' as the reference number.

OR,

Mail or fax all completed pages of the form to the claims office nearest you.

Fax number: 1-855-342-9915

Sun Life Assurance Company of Canada
Attention: Claims Dept.
PO Box 11658 Stn CV
Montreal QC H3C 6C1

Sun Life Assurance Company of Canada
Attention: Claims Dept.
PO Box 2010 Stn Waterloo
Waterloo ON N2J 0A6