

According to your province of residence, please submit form to:

Quebec
Group Health and Dental Claims
PO Box 800, Station Maison de la Poste
Montreal, Quebec H3B 3K5
Fax: 1-855-884-9811

All Other Provinces
Group Health and Dental Claims
PO Box 4643, Station A
Toronto, Ontario M5W 5E3
Fax: 1-877-780-7247

1. IMPORTANT – PLEASE READ CAREFULLY

Your request for the biologic reference drug exception will be reviewed and you will be informed, whether or not it has been approved. You should not submit your claim before you receive your approval. All medical information received from you and your physician will be kept confidential.

2. MEMBER/PATIENT INFORMATION

Member's first name _____ Last name _____
Policy no. _____ Certificate no. _____
Address _____ Postal code | | | | | | | |
Telephone _____ Email _____
Patient's first name (if different) _____ Last name _____
Relationship to member: spouse dependent child Date of birth | | | | | | | | Y M D

3. ATTENDING PHYSICIAN'S STATEMENT

Requested biologic reference drug _____ DIN _____ Dosage and frequency _____
Anticipated duration of drug therapy _____
Reason for the request: Pregnant patient – Due date: _____
 Pediatric patient: _____
 Patient for whom treatment with at least two other biologic drugs has failed for the same medical condition.
Please indicate the biologic drugs tried: _____
 Other documented medical reason: _____
Physician's first name _____ Last name _____
Address _____ Postal code | | | | | | | |
Telephone _____ Fax _____ License number _____
Attending physician's signature _____ Date | | | | | | | | Y M D

4. MEMBER CONFIRMATION/AUTHORIZATION

I confirm that the information contained in this form is true and complete to the best of my knowledge. On behalf of myself, or my dependent, if applicable, I authorize my physician or, if applicable, my dependent's physician, to exchange information with Industrial Alliance Insurance and Financial Services Inc., its employees, agents and service providers for the purpose of assessing my request for a brand name drug exception. If the request for a brand name drug exception is in respect to my dependent, I confirm that I am authorized to disclose information about him/her with respect to the request. If my Social Insurance Number is used for my certificate number, I authorize its use for the administration of my group insurance plan. I agree that a photocopy of this Confirmation/Authorization is as valid as the original.

Member's signature _____ Date | | | | | | | | Y M D