Manulife Financial

ManuScript™ Pay-Direct Drug Plan

Group Benefits
Authorization for Extended Prescription

Complete this form when you require a supply of medication that exceeds the prescription's maximum days' supply standard allowed by your contract. For consideration, please send completed form to the address provided below or by fax to 519-883-5712. For processing please allow 10 working days when mailing via Canada Post or 3 business days when sending via fax.
Manulife Financial, Attention: ManuScript Pay-Direct Drug Claim Service, PO Box 485, WATERLOO ON N2J 4A9

1 Plan member information

Plan sponsor name	Plan number	Account/Division number

Plan member name (first, middle initial, last)	Certificate number	Date of birth (dd/mmm/yyyy)

Patient name (first, middle initial, last)

Relationship to plan member	Patient's date of birth (dd/mmm/yyyy)

Drug/Medication name

Prescription DIN number	Supply required ◯ Days ◯ Months

Reason required

Pharmacy name

Pharmacy address	City	Province	Postal code

Pharmacy contact name	Pharmacy telephone number
	( )

2 Authorization

I certify that the information in this form is true and complete, to the best of my knowledge, and does not contain a claim for any expenses previously paid for by any plan.
I authorize any person or organization who has information pertaining to this claim, including any health care provider, insurance company, any type of workers' compensation board, investigative agencies and my plan sponsor, to release and exchange such information requested by Manulife Financial and/or its claims service providers for the purpose of plan administration including processing and investigating this claim.
I authorize Manulife Financial and its claims service providers to collect, to use and to exchange with the persons or organizations listed above any information needed for the purpose of plan administration including processing and investigating this claim.
If this claim is made on behalf of my spouse and/or dependants, I am authorized to disclose information about them, for the purpose of plan administration including processing and investigating this claim.
If my social insurance number is used as my certificate number, I authorize its use for the identification and administration of my group benefits.
I agree that a photocopy or electronic version of this authorization shall be as valid as the original.

At Manulife Financial, we know that confidentiality of personal information is important. Any information you provide to us will be kept in a Group Life and Health Benefits file. Access to your information will be limited to:
- our employees and service representatives in the performance of their jobs;
- persons to whom you have granted access; and
- persons authorized by law.

You have the right to request access to the personal information in your file and, if necessary, correct any inaccurate information.

Plan member signature	Date signed (dd/mmm/yyyy)

3 Manulife office use only

Approved?	Manulife Financial representative signature	Date signed (dd/mmm/yyyy)
◯ Yes ◯ No		