

Important: Fill out in block letters and answer each section as accurately as possible.

Section A—Collection of Your Personal Information

By signing this form, you authorize UV Insurance to collect, use and disclose your personal information to assess this request.

This personal information is used to:

- ▶ Confirm your identity;
- ▶ Obtain additional information required to complete the review of your request;
- ▶ Contact the relevant healthcare professionals (including your pharmacists, treating physicians, nurses, pharmacy technical assistants and dietitians), healthcare facilities, insurance companies, government authorities, government programs and patient support programs;
- ▶ Comply with legal and regulatory requirements, in particular to prevent, detect or prosecute offences, cyber threats and fraud.

The information disclosed on this form will be forwarded to the UV Insurance staff responsible for processing the claim, as well as to any other person authorized by law.

Section B—Member Identification (contractholder)

1. Certificate # _____ Group # _____
2. First name _____ Last name _____
3. Date of birth

		Y			M			D	

Section C—Patient Identification

1. First name _____ Last name _____
2. Date of birth

		Y			M			D	
3. Address _____ App. # _____
City _____ Province _____ Postal code _____
4. Telephone

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5. Work

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 Ext. _____
6. Email _____
7. Relationship to member (contract holder) ☐ Member ☐ Spouse ☐ Dependent child
8. Name of drug _____
9. Name of physician _____

Section D—Other Insurance Medication Coverage

Provincial Plan

Are you covered by a provincial plan (e.g., RAMQ)? ☐ Yes ☐ No

- ▶ If **Yes**: Please send us a copy of the form submitted to the other insurer, along with a copy of the approval or denial.

Private Plan

Do you have prescription drug coverage with another private insurer (other than UV Insurance)? ☐ Yes ☐ No

- ▶ If **Yes**: Please send us a copy of the form submitted to the other insurer, along with a copy of the approval or denial.

Name of the private insurer _____

Relationship between the member and the holder of the other insurance policy ☐ Member ☐ Spouse ☐ Dependent child

If the member is a dependent, please provide the date of birth of the contractholder under the other insurer's plan.

Date

		Y			M			D	

Section E—Consent and Signature

I consent to the third parties listed above in Section A providing UV Insurance with the information required to review my request, including my medication profile, medical conditions, blood test results, imaging reports, medical scores, pharmacy contact information, prescription drug coverage from my previous insurers and information from my Québec Health Record (QHR). I also authorize UV Insurance to disclose such information to the third parties listed above. UV Insurance will collect and disclose only the personal information strictly necessary to review this request.

I understand that this consent also applies to my dependents if they are covered by this request, and I certify that I have obtained their permission.

Please note that you may withdraw your consent to the disclosure or use of your personal information at any time. However, withdrawing your consent may result in legal or contractual consequences related to the administration of your insurance policy. UV Insurance will explain any such consequences to you, if applicable. To request a correction to your personal information (including information that is inaccurate, incomplete or outdated), to access your file or to withdraw your consent, you must submit a written request to the UV Insurance Privacy Officer at the following address: 1990 Jean-Berchmans-Michaud Street, Drummondville, QC J2C 7G7.

For more information, please visit our website to view our [Privacy Policy](#).

Signature

By signing below, the undersigned confirms that they have read and accepted the information contained in this form.

X _____ Date

Y	M	D
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Insured's signature Signatory's name in block letters

