Assumption Life

# NO SUBSTITUTION REQUEST

**Fax form to 506-853-5434**
**or mail to Group Insurance, Assumption Life, P.O. Box 160/770 Main Street, Moncton NB E1C 8L1**
**or scan and email to group@assumption.ca**

**TO BE COMPLETED BY MEMBER (PLEASE PRINT CLEARLY)**

| Member Name | Group Number | Certificate Number (10 digits) |
|---|---|---|
| | | |

| Patient Name | Relationship to Member |
|---|---|
| | ☐ Member ☐ Spouse ☐ Child ☐ Other |

| Address | | | | |
|---|---|---|---|---|
| | | | | |
| **City** | **Province** | **Postal Code** | **Telephone Number** | **Patient Date of Birth (YYYYMMDD)** |
| | | | ( ) | |

I hereby authorize any physician, hospital, insurance company, other healthcare professional and Assumption Life to exchange information in connection with this claim for the purpose of No Substitution Request exception evaluation, adjudication of claims, and administration of my health benefits program. I assume responsibility for any cost associated with the completion of this form. A photocopy of this form shall be as valid as the original.

| Signature | Date (YYYY/MM/DD) |
|---|---|
| X | |

**TO BE COMPLETED BY HEALTHCARE PROFESSIONAL (PLEASE PRINT CLEARLY)**

| Name of Healthcare Professional | Healthcare Professional Designation and Qualification | Date (YYYY/MM/DD) |
|---|---|---|
| | | |

| Address | | | Healthcare Professional Signature | |
|---|---|---|---|---|
| | | | X | |
| **City** | **Province** | **Postal Code** | **Telephone Number** | **Fax Number** |
| | | | ( ) | ( ) |

**INCOMPLETE FORMS WILL DELAY PROCESSING**

**IMPORTANT:**

☐ Make sure to submit a completed *Health Canada Adverse Drug Reaction (ADR) form* along with this *No Substitution Request*. To obtain the ADR form, click on the following link:

http://www.hc-sc.gc.ca/dhp-mps/alt_formats/pdf/medeff/report-declaration/ar-ei_form-eng.pdf