Dosecann
Cannabis Program

For Client

Dosecann Cannabis Program
1-833-565-2278
clientcare@dosecann.com
55 Bruce Crescent
Ottawa, Ontario K7C 3T3
Monday – Friday
9:00 AM to 5:00 PM EST

CONSENT FORM B – TO ALLOW ACCESS TO CLIENT INSURANCE COVERAGE INFORMATION

I, the undersigned, hereby authorize the insurance company listed below (my **"Insurer"**) to communicate with Dosecann Cannabis Program and its respective representatives (collectively, the **"Program"**) for the purposes of determining the extent to which my insurance coverage will cover the cost of medical cannabis. This information may include, but is not limited to, whether my insurance coverage covers the cost of medical cannabis, the amount of such coverage, the deductible applicable to such coverage, and the terms and conditions of such coverage. To do so, I understand that the Program may need to disclose to my Insurer details regarding: (i) my medical document; and (ii) the nature of my health condition(s).

I understand that: (i) this authorization is voluntary; (ii) I may withdraw my authorization at any time by advising the Program in writing; and (iii) I may ask the Program's privacy officer any questions that I may have regarding the collection, use and disclosure of my personal information by the Program (by emailing clientcare@dosecann.com). For further details about our privacy practices and procedures, the Program's privacy policy can be accessed at: dosecann.com/privacy

First Name _____ Last Name _____
Street Address _____
City _____ Postal Code _____
Primary Phone _____ Email Address _____
Insurer Name _____ Policy Number _____
Certificate Number _____

Name (please print) _____
Signature _____
Date _____