Animas® CANADA a division of LifeScan Canada Ltd.

Authorization to Release Information

Client Name _____
(Last Name, First Name)

_____ (_____)_____
Physician Name Physician Phone Number

Insurance Company Name – Primary Health Insurance Coverage: _____

Insurance Company Name – Secondary Health Insurance Coverage: _____

ANIMAS CANADA AUTHORIZATION

I acknowledge that in order to receive insurance coverage for my purchase of an Animas® insulin pump or Dexcom G4® PLATINUM CGM system and/or related supplies, the insurance provider(s) will require evidence that the device is medically necessary.

I acknowledge and agree that the use of Animas Canada's services in connection with facilitating the processing of insurance claim(s) for coverage of my purchase of the device and related supplies is optional and that I am not required to use these services or provide the consent below in order to purchase the products.

I authorize Animas Canada to (i) contact the above physician(s) and to collect from them the information referred to in the Certificate of Medical Necessity for an Animas® insulin pump or Dexcom G4® PLATINUM CGM system and/or such other information related to my relevant medical condition as may be required by the insurance provider(s) in order to process the insurance claim(s), (ii) disclose such information and the information in my Insurance Information form to the above insurance provider(s) at the address of such insurance provider(s) set out in my Insurance Information Form, and (iii) communicate with such insurance provider(s) on my behalf regarding the coverage of an Animas® insulin pump or Dexcom G4® PLATINUM CGM system and/or related supplies under the policies referred to in my Insurance Information Form, in each case in order to facilitate the processing of my insurance claim(s) by the insurance provider(s). I acknowledge that the insurance provider(s) above may be located or have offices outside of my home province, and consent to the transfer of my personal information outside of my province for the purpose of the disclosures to such insurance provider(s) as described above.

I understand that Animas Canada may retain my personal information for so long as necessary to fulfill the purposes described above and to meet legal, regulatory and reasonable record retention policy requirements.

I agree to notify Animas Canada immediately of any changes to my insurance coverage or if there are changes to the information provided in my Insurance Information Form.

PHYSICIAN AUTHORIZATION

I authorize the physician referred to above to disclose to Animas Canada, for the purpose of the collection, use and disclosure by Animas Canada as described above, the information referred to in the attached Certificate of Medical Necessity for an Animas® insulin pump or Dexcom G4® PLATINUM CGM system and/or related supplies and/or such other information related to my relevant medical condition as may be required by the insurance providers(s) in order to process my insurance claim(s).

I understand that for further information about Animas Canada's personal information practices and how I may access, or withdraw my consent to the collection, use and disclosure of, my personal information, I may visit www.Animas.ca for a copy of your privacy policy.

Name of Client/Parent of Guardian: _____ **Relationship to Client** (if Parent of Guardian)**:** _____

Client/Parent or Guardian Signature: _____ **Date** (mm/dd/yyyy)**:** _____/_____/_____

INSURANCE AUTHORIZATION

I authorize Animas Canada to contact, on my behalf, the Primary Health Insurance Coverage provider referred to above, to obtain information about and claim coverage for an Animas® insulin pump or Dexcom G4® PLATINUM CGM system and/or related supplies for the client referred to above under the policies referred to in the Insurance Information Form signed by me.

Name of Primary Policy Holder: _____ **Relationship to Client** (if Parent of Guardian)**:** _____

Primary Policy Holder Signature: _____ **Date** (mm/dd/yyyy)**:** _____/_____/_____

I authorize Animas Canada to contact, on my behalf, the Secondary Health Insurance Coverage provider referred to above, to obtain information about and claim coverage for an Animas® insulin pump or Dexcom G4® PLATINUM CGM system and/or related supplies for the client referred to above under the policies referred to in the Insurance Information Form signed by me.

Name of Secondary Policy Holder: _____ **Relationship to Client** (if Parent of Guardian)**:** _____

Secondary Policy Holder Signature: _____ **Date** (mm/dd/yyyy)**:** _____/_____/_____

Email, fax or mail this completed form to Animas Canada:

Animas Canada, 200 Whitehall Drive, Markham, ON L3R 0T5
Tel: 1.866.406.4844 Fax: 1.866.406.4033 Email: CustomerCare@Animas.ca

Your privacy is very important to us. For more information about our Privacy Policy, please visit www.Animas.ca