HEXO CORP

Registration 1 de 2

☐ This application is to amend or renew an existing HEXO registration

Applicant Information

To be filled out by the applicant or person responsible for the applicant who has a permanent address in Canada. If the applicant does not reside in a private residence and has no permanent address, the Assisted Living Form will also need to be completed and included with this application.

Applicant Gender: ☐ M ☐ F ☐ Other: _____

Applicant Name: _____ SURNAME, GIVEN NAME

Applicant Date of Birth: _____ YYYY/MM/DD

☐ I agree to receive HEXO's newsletter containing news, updates and promotions regarding HEXO's products. You can withdraw your consent at any time.

Applicant Phone Number: _____ OPTIONAL ☐

Alternate Phone Number: _____ OPTIONAL ☐

☐ Voicemail messages may be left at this number

Applicant Email: _____ REQUIRED FOR ONLINE ORDERS

Client Identification Number (CID): _____ COMPLETE ONLY IF THE APPLICANT IS OR HAS BEEN REGISTERED WITH THE HEXO

Note: the residential and shipping addresses cannot be a PO Box

Residential Address in Canada (where the applicant ordinarily resides)

Can be left blank if submitting the Assisted Living form

Address: _____ Apt./Suite Number: _____

City: _____ Province: _____ Postal Code: _____

Mailing Address (where correspondence will be sent)

****** LEAVE BLANK IF SAME AS RESIDENTIAL ADDRESS ******

Address: _____ Apt./Suite Number: _____

City: _____ Province: _____ Postal Code: _____

Shipping Address* (where the product will be shipped)

****** LEAVE BLANK IF SAME AS RESIDENTIAL ADDRESS ******

Address: _____ Apt./Suite Number: _____

City: _____ Province: _____ Postal Code: _____

** Medical marijuana may be shipped to **one** of the following:*

- *the applicant's place of residence (residential address)*
- *the applicant's mailing address*
- *the institution providing services to the applicant (if completed Assisted Living form accompanies this application)*
- *the applicant's health care practitioner (if consent was provided on the signed Medical Document accompanying this application)*

Direct Billing For Canadian Forces Veterans

* Direct billing is subject to approval by Veterans Affairs Canada.

In order for HEXO to bill Veterans Affairs Canada directly*, we require you to:

1. Ensure your health care practitioner indicates your medical condition on your Medical Document.
2. Provide us with your Veterans Affairs Canada client number: _____
3. Fill out the HEXO's Consent to Disclose Personal Health Information to Veterans Affairs Canada form.

I hereby confirm the information set out in the application is correct and complete and that HEXO is relying on this information.

I hereby state:
(a) the applicant ordinarily resides in Canada;
(b) the information in the application and the medical document is correct and complete;
(c) the medical document is not being used to seek or obtain fresh or dried marihuana or cannabis oil from another source;
(d) the original of the medical document is provided in support of the application; and
(e) the applicant will use fresh or dried marihuana or cannabis oil only for their own medical purposes.
(f) the applicant consents to the health care practitioner named in the Medical document disclosing required personal health information to the HEXO for the purpose of registering the applicant in compliance with the requirements of the *Access to Cannabis for Medical Purposes Regulations.*
(g) the applicant is aware that the benefits and risks associated with the use of marihuana are not fully understood and that the use of marihuana may involve risks that have not been identified; and the applicant accepts those risks.
(h) by signing this registration form, applicant or caregiver (if applicable) allow HEXO to send registration information to the mailing and email addresses provided therein.

See the HEXO's Personal Information and Privacy Policy and Risk Statement at:
www.thehydropothecary.com/privacy

You hereby acknowledge that this Application requires you to provide certain Personal Information to HEXO. Such information is being collected and will be used by HEXO for the purposes of completing your registration, which includes, without limitation, determining your eligibility to purchase products from HEXO, for determining your qualification for financial assistance, if available to you, from certain third parties (i.e. Veteran's Affairs Canada, Quebec's Commission de la santé et de la sécurité du travail or private insurance companies) (collectively, "Authorized Third Parties"), for research and study purposes and for providing ongoing support to you.

You hereby agree that your Personal Information may be disclosed by HEXO to: (a) Authorized Third Parties, (b) any parties, including but not limited medical or academic researchers, involved in conducting research or study services but only provided such parties are under strict obligations to maintain the confidentiality of the Applicant's Personal Information and (c) HEXO's client support team. ***By signing this Application, you consent to the foregoing collection, use and disclosure of your Personal Information.***

Note: If the person responsible for the applicant signs this form, the About Your Caregiver form will need to be completed and submitted with this application.

☐ Applicant or ☐ Individual Responsible for Applicant's Signature
(Please select who is signing)

	YYYY/MM/DD
Print Name	*Date*

Signature
