COMPASSIONATE PRICING APPLICATION FORM

First Name: _____

Last Name: _____

Phone Number: _____

Confirmation of need for finance assistance:

- By completing this form, you confirm that you would like to participate in Tilray Medical's compassionate pricing program, and your Personal Gross Income is under $32,500 per year.
- Tilray Medical may make changes to its Compassionate Pricing or terminate its Compassionate Pricing Program at any time.
- Tilray Medical may terminate your participation in the Compassionate Pricing Program should any information provided by you be false or misleading.
- You agree to provide Tilray Medical with verification of income, should it be requested and failure to do so, will result in you no longer being eligible to participate in the compassionate pricing program

I acknowledge that Tilray Medical is a medical marketplace brand of Aphria Inc, which is a federally authorized 'Sale for Medical Purposes' licence holder. As such, I acknowledge that Aphria Inc is responsible for completing all registrations and transactions through Tilray Medical and with whom I will be registered.

By signing this application form, I acknowledge that I have read and understand the information below and consent to the collection, use and disclosure of my personal information (including personal health information and financial information) by Aphria Inc, and its authorized agents and service providers as explained. I understand that my personal information will be collected, used and disclosed for purposes relating to the assessment of my eligibility to participate in the Compassionate Pricing Program (the "Program") and for the management and administration of the Program, including the provision of the Program services to me, should I be judged eligible to participate, and provision of information about the Program to me. I understand that in order to verify my annual gross income, I may be required to provide a copy of the initial Notice of Assessment received from the Canada Revenue Agency for the most recent year for myself.

I understand that Aphria Inc has a legal obligation to report adverse events relating to its products and to monitor product complaints. Personal information provided to the Program may be (i) monitored by Aphria Inc or its service providers for safety-related data and product complaints in order to ensure compliance with these legal reporting requirements, and (ii) reported to local or international health authorities. Aphria inc may contact you or your physician for additional information to fulfill its reporting obligations. Your personal information may be combined with the information of others who participate in the Program in order to generate aggregated data that does not contain identifying information ("Aggregated Data"). Aggregated Data may be used by Aphria Inc and its service providers to improve and/or refine the Program to design and implement other patient programs and for research purposes including the identification of trends such as product utilization, adherence or outcomes.

Please note that Aphria Inc and its service providers may store or process your personal information in Canada. In addition, your personal information may be used or disclosed to third parties when permitted or required by applicable laws, court orders or government regulations (collectively, "Applicable Laws").

Your personal information will be retained only for as long as is needed to fulfill the purposes for which it was collected and in order to comply with Applicable Laws. Industry standard safeguards will be used to protect the security of the personal information that is collected. You may contact Aphria Inc at any time to update or access your personal information, modify or withdraw your consent (in part or in full), express a privacy-related concern, or inquire about the privacy practices of the Program (including those related to foreign information processing). You can reach us at patientbenefits@tilraymedical.com. Please note that if you modify or withdraw your consent, your ability to receive the Program services may be limited.

Patient Signature: _____

Date: _____

Once completed, please submit this form to *patientbenefits@tilraymedical.com* or mail it to us at:

PO Box 20009 269 Erie St South, Leamington, ON N8H 3C4