
**(1986-1990) HEPATITIS C
SETTLEMENT AGREEMENTS**

BETWEEN:

PERSON REQUESTING THE REVIEW 21377

(THE "CLAIMANT")

AND:

HEPATITIS C CLAIMS CENTRE

(THE "FUND")

DECISION ON REQUEST FOR REVIEW NO. 21377

Arbitrator/Referee : M^e Serge Brault, NAA, IMAQ

Appearance for the Claimant : Himself

Appearance for the Fund :
M^e Catherine Martin,
McCarthy Tétrault

Place : Montreal

Date of decision : March 19, 2026

I

INTRODUCTION

[1] This appeal comes before me as a court-appointed arbitrator/referee pursuant to a judgment of the Superior Court of Quebec rendered on October 12, 2023.

[2] The Claimant identified by the number shown above appeals on August 4, 2025, a decision by the Fund Administrator established under the *Hepatitis C Settlement Agreement*.

[3] The Fund's decision denies the Claimant's request brought under Protocol No. 15 on May 1, 2025, for loss of services payments to totally and permanently disabled Approved Dependents of a HCV Infected Person.

[4] In addition to Protocol No. 15, Protocol No. 10 entitled *Loss of the Services of the HCV Infected Person in the Home (Amended Version 2024)* is also relevant to this appeal.

[5] These protocols relate to the implementation of the *Hepatitis C Settlement Agreement (1986-90)* approved on June 15, 1999, as well as to various subsequent implementation and extension documents.

[6] Since neither party requested a hearing, in accordance with the procedure governing this review, I invited both the Claimant and the Fund Counsel to submit their arguments in writing in support of their respective positions; both complied.

[7] The Claimant also took advantage of the opportunity to submit additional documentation. Subsequently, I received in mid-November 2025 a letter dated November 12, 2025, from a doctor in Toronto described by the Claimant as his treating physician. I made sure that this document was brought to the attention of the Fund Counsel, who, however, did not comment on it.

II

THE CLAIM DENIED BY THE FUND

[8] A proper understanding of the dispute requires some historical background.

[9] In March 2015, the Claimant was approved by the Fund as a “Family Member” of a HCV Infected Person, namely his mother (hereinafter Madam), who passed away in January of that year as a result of her HCV infection.

[10] Under the rules in effect at the time, Madam was eligible to receive payments from the Fund during her lifetime, either as compensation for loss of income or as compensation for loss of services in the home. She chose and received periodic compensation for the loss of services in the home.

[11] Born in [REDACTED], the Claimant was over 21 years old at the time of his mother’s death. He lived with his parents, however, as he himself is in fragile health, and suffers, according to the file, from multisystem inflammatory syndrome, which he describes in the letter he sent to the Administrator on July 18, 2024.

[12] As stated above, the claim denied by the Fund had been submitted to it by the Claimant under Protocol No. 15 entitled:

a Special distribution benefit [...] for the extended payment of compensation for loss of services in the home in the case of living dependents with total and permanent disability. (Modified version 2024)

[13] Upon review of the file, there appears to be some ambiguity surrounding what precisely constitutes the Fund's denial and when that denial occurs.

[14] According to the Fund Counsel, the denial is stated in the following two-paragraph email, which the Fund sent to the Claimant on May 29, 2025, and which I reproduce here:
[Screenshot redacted]

[15] This is followed by extensive correspondence between the Claimant and the Fund, to which the Claimant responds with the following long email in reply to the email received on May 29:

[Screenshot redacted]

[Screenshot redacted]

[16] This email chain concludes when, on July 17, 2025, the Claimant receives the following letter, in which it is worth noting the poor quality of the language, an email that I reproduce as is:

[Translation]

“ [...]

Date: July 17, 2025

Reference Number: 21377

To begin, we would like to clarify the benefits mentioned in your last email. You stated that your claim is for Loss of Support and not Loss of Services in the Home. *In Schedule A, Article 4.03, an Approved HCV Infected Person cannot claim compensation for loss of income and compensation for the loss of Services in the Home for the same period.* In the case of [REDACTED]

, compensation for the Loss of Services in the Home was chosen. She has never received compensation for Loss of Income.

Article 6.01 states that if a HCV Infected Person dies and the death was caused by his or her infection with HCV, the Approved Dependants of such HCV Infected Person will be entitled to be compensated for their Loss of Support. The Loss of Support is an amount each calendar year equal to 70% of the deceased HCV Infected Person's Annual Loss of Net Income for such year until he or she would have attained the age of 65 years determined in accordance with article 4.02. In other words, the Loss of Support applies when the infected person has received compensation for Loss of Income. Since [REDACTED] was receiving the Loss of Services in the Home, the Approved Dependents will receive the Loss of Services in the Home. To receive the Loss of Support benefit, you must provide documents proving the infected person's three best consecutive years of income. Since [REDACTED] claimed the Loss of Services in the Home, it is because this amount was higher than the Loss of Income. This assessment is made at the time the infected person first submits a claim for Loss of Services or Loss of Income.

Article 6.03 - Dependants and other Family Members of a HCV Infected Person will only be entitled to make Claims pursuant to Sections 6.01 and 6.02 (or, in lieu thereof, under Section 5.01(2)) and they will not be entitled to make any other Claims or to any additional or other compensation. Therefore, the compensation for the Loss of Services in the Home to dependents must be divided among them. In this case, the amount would be divided among all dependents of [REDACTED], including the spouse of [REDACTED]

Appendix 10 - **COURT APPROVED PROTOCOL LOSS OF THE SERVICES OF THE HCV INFECTED PERSON IN THE HOME** states at point 19 that *when the Approved Dependent is a Child, the loss of services in the home will be presumed to continue until his or her 25th birthday, unless the Child provides evidence satisfactory to the Administrator that some other period of loss is appropriate.* This is where Appendix 15

- **SPECIAL DISTRIBUTION BENEFIT ELECTION FOR ALIVE PERMANENTLY DISABLED DEPENDANTS** comes into play. *This protocol applies to totally and permanently disabled Approved Dependants and Approved Late Claim Dependants who are alive and who receive or have received compensation for loss of the deceased HCV Infected Person's services in the home who request the Special Distribution Benefit extending loss of services payments beyond the actuarially calculated notional life expectancy of the deceased HCV Infected Person upon whom they were dependent.* The form for applying for this benefit was sent to you in February 2025 because you stated that you are a dependent with a disability.

In your May 30, 2025, email you wrote, [translation] "the medical documents, past and current disability certificates, the attestations from my insurer at that time also support this and demonstrate that I was dependent on my mother, suffered from a severe disability, had no income, was unable to provide for my needs, and lived under the same roof as my mother." On review of the medical documents, it appears that several healthcare professionals were unable to provide a diagnosis supporting significant disability. This is reiterated by the statement from your insurer for your long-term disability application that there is no documentation explaining that you cannot perform sedentary work and that your disability application was approved only for the duration of the parasite treatment, a period of about six weeks. Furthermore, for a claimant to receive payments for Loss of Services in the Home as a Dependent over 25 years old, the abovementioned protocol states that total and permanent disability is required. The documents you sent us do not establish total and permanent disability beyond a reasonable doubt. Additionally, when you applied for the plan in 2015, you stated that you were a Family Member and not a Dependent. So, even if you provided evidence that you were a Dependent, you did not provide evidence of a total and permanent disability.

Sincerely,

The Hepatitis C Claims Centre (1986-1990)”

[Reproduced as is – bold in the original]

[17] In her written submission, the Fund Counsel (para. 13) describes this long document as a “*formal letter of denial [...which] also addresses the points raised in the email*” from the Claimant in response to the one received from the Fund on May 29.

[18] For his part, on August 5 the Claimant submitted this request for review of the Fund’s decision, a decision that he clearly identifies as the lengthy letter dated July 17 and reproduced above.

III

THE SUBJECT OF THE REVIEW

[19] Appendix A of the *Hepatitis C Settlement Agreement (1986-90)* sets out at article 10 the legal provisions applicable to the resolution of disputes.

[20] I consider it appropriate to recall certain general points, including the following applicable in this case:

“10.02 [...] Each Referee and Arbitrator, may exercise all of the jurisdiction and powers granted to him or her hereunder.

10.04 Conduct of Reference and Arbitration

(1) A reference will be conducted in accordance with the provisions of Appendix C hereto.”

[21] Appendix C sets out certain rules relating to the authority of the arbitrator seized of a reference, including the following:

“1. Powers of Referee

[...]

a) to establish the procedure to be followed during the reference;

[...]

e) to accept oral or written evidence as the Referee in his or her discretion considers proper, whether admissible in a court of law or not;

[...]

g) to determine the subject matter of the reference and, in the exercise of his or her discretion, to award costs, in accordance with a tariff to be established by the Courts.

[22] The relative ambiguity mentioned above regarding what would constitute the denial of the initial claim submitted to the Fund prompts me to consider it appropriate to clarify the subject of this review, that is, the main issue in dispute.

[23] In fact, according to the very extensive file entrusted to me (about 400 pages), the issue in dispute, if not the issues, is likely to vary depending on which of the two parties names it/them: Is it the email of May 29 or the letter dated July 17?

[24] Paragraph (g) of article 1 of Appendix C, reproduced above, explicitly authorizes me to “*determine the subject matter of the reference*”.

[25] Although simple in appearance, it is important to clearly define the question to be decided in order to avoid getting sidetracked and, as a result, to ensure it is answered.

[26] Specifically, is the subject of the review the validity, compliance with the Agreement and its protocols, the reasons for denial stated on May 29, as the Fund argues; or rather the numerous reasons listed in the letter dated July 17 to which the Claimant has endeavored to respond in his written submission?

[27] On consideration, I share the opinion of the Fund Counsel, who places this denial on May 29 when the Fund wrote to the Claimant that his claim “*must be denied*.”

[28] With respect, I am of the view that the letter dated July 17 that the Fund sent to the Claimant is more like an argument, a submission, an explanation, than a proper decision; the latter being, in simple terms, a denial on the grounds of not being entitled to it.

[29] Ultimately, the resolution of the dispute depends on the answer to the following question: Yes or no, is the Claimant entitled to the requested compensation and is the denial he received on May 29 or July 17 justified?

[30] That said, I will clarify my point right away to avoid any drift towards what would be a false debate over a question of lateness.

[31] Article 10.01 of Appendix A of the Plan in fact provides a 30-day period to file a request for review of a decision by the Fund.

[32] To anyone tempted to argue that this request for review, dated August 5, is therefore late since it was made more than 30 days after the “*denial*” dated May 29; I immediately clarify that my intention in the preceding paragraphs was solely to outline the subject of the dispute and not to determine the date of the denial that gave rise to it. I readily place this date on July 17, since the Fund itself contributed to the extension of these deadlines.

[33] Since the Fund’s position did not became clear for the purposes of a request for review on July 17, this request is therefore not late; which, moreover, no one has claimed.

IV THE ISSUES IN DISPUTE

[34] The claim submitted to the Fund in May 2025 is found in the file at pages 17 to 21.

[35] The form used by the Claimant is for “*a special distribution benefit extending loss of services in the home payments for alive permanently disabled dependents.*”

[36] This document was signed on April 4, 2025, and reached the Fund on May 1.

[37] This form seeks, for the Claimant, to implement Protocol No. 15, whose first article states:

“1. This protocol applies to totally and permanently disabled Approved Dependants and Approved Late Claim Dependants who are alive and who receive or have received compensation for loss of the deceased HCV Infected Person’s services in the home who request the Special Distribution Benefit extending loss of services payments beyond the actuarially calculated notional life expectancy of the deceased HCV Infected Person upon whom they were dependent.”

[38] In its email of May 29, the Fund writes to the Claimant:
[Screenshot redacted]

[39] Upon review, the reasons for denying the claim are threefold. I will examine the validity of each, if necessary, in the following order, understanding that if the review of one of these grounds determines the outcome of the dispute, I will stop there.

[40] The grounds are as follows:

1. The requested benefit is intended only for “*Approved Dependents of the HCV Infected Person [...]*.” In short, a benefit stipulated for a person who was previously an Approved Dependent of a HCV Infected Person.

2. The benefit in question consists of “extending” a loss of services benefit already in place and that the HCV Infected Person was already receiving. In other words, for a living person to be eligible, the deceased HCV Infected Person must have received this benefit during their lifetime.

3. To be eligible for this benefit, the Approved Dependent making the claim must have been under 25 years old at the time of the death of the HCV Infected Person.

[41] Let us see what the evidence on file shows:

1. A benefit accessible only to an Approved Dependent under the Plan

[42] The claim in dispute is subject to the rules of Protocol No. 15, which applies to “*Approved Dependents*” who are totally disabled.

[43] The status of a “*Dependent*” is distinct from that of a “*Family Member*” of an “*Approved HVC Infected Person*” as the Claimant has the status of an “*Approved Family Member*”. These distinctions between qualities of persons are listed in Appendix A of the Agreement.

[44] “*Family Member*” means, according to article 1.01 of Appendix A, in particular, and as is the case here, the Child of an HCV Infected Person.

[45] A person will be approved as a family member of an “*Approved HCV Infected Person*” if he or she meets the definition set out in the same article.

[46] This will be the case when the Fund has “*approved*” the “*claim*” made to it in this regard pursuant to article 3.07 of Appendix A. I remind you that a “*claim*” means the application for approval of this status received by the Fund. The terms of this approval are set out in the Appendix and are not of interest here, as that is not the dispute.

[47] In this case, it happened in 2015 for the Claimant when the Fund approved him for the purposes of the Plan as a “*Family Member*” of his mother who was infected with HCV and died shortly before.

[48] The status of a “*Dependent*” as defined in article 1.01 of Appendix A, comprises two elements. The first is to be an “*Approved Family Member*” of an HCV Infected Person. The second is to be an “*Approved Family Member*” whom the HCV Infected Person was supporting at the time of their death. In other words, to have been an Approved Dependent of the person who died from HCV during their lifetime.

[49] Furthermore, the approval of the status of “*Dependent*” is itself a condition, a status, that could only be obtained through the Fund’s official approval within two years of the death of the HCV Infected Person; or according to other deadlines stipulated in article 3.06 but not relevant in this case.

[50] According to the evidence on file, which is otherwise uncontested, the Claimant, who asserts that he was totally disabled and dependent on his mother, never submitted, nor did anyone else on his behalf, any claim, even a late one, for approval by the Fund as a “*Dependent*” for the purposes of the Plan.

[51] At the time of his mother's death, the Claimant born in [REDACTED] was about [REDACTED] years old. According to a medical note included in the file he submits to the Fund, the Claimant would be

[REDACTED].

[52] The Claimant described extensively in his email exchanges with the Fund a health condition he had at the time of his mother's death, a condition that appears to have made him a person heavily and permanently dependent on her. With respect, the designation of "*Approved Dependent*" is determined solely by the Fund, which grants it only upon request, and the Claimant does not have this status.

[53] Certainly, the medical file of several hundred pages submitted to the Fund attests to a series of health problems of all kinds experienced by the Claimant. However, I do not see approval anywhere by the Fund of the Claimant's status as a "*Dependent*".

[54] The authority of the arbitrator consists in ensuring that the Fund's decisions comply with the various rules governing it. The arbitrator does not have the authority to replace the Fund, nor to ignore or revise its court-approved operating rules.

[55] Since this review concerns exclusively the denial of a claim for benefits under the extension of loss of services in the home payments by an approved "*Dependent*" and the Claimant does not have this status, I must acknowledge that the denial of his claim is in accordance with the Plan.

[56] I would like to briefly mention one aspect of the correspondence that followed the denial on May 29. A genuine debate ensued, particularly regarding the nature of the claim. At one point, the Claimant states (file p. 152) that he was the victim of a misunderstanding about the subject of his claim, as he alleges that he wanted to submit: [translation] "*a claim for loss of support, and not for loss of services in the home [...]*".

[57] With respect, this late-stage argument cannot prevail here. The subject of this review is the Fund's handling of the Claimant's benefits claim (pp. 17 to 21 of the file). This is a request to extend payment of benefits for loss of services. I cannot hear, nor could I comment on, an issue unrelated to the claim that was actually made and denied.

[58] However, since the benefit being sought from the Fund is only available to an Approved Dependent and the Claimant does not have this status, the Fund rightly and in accordance with the provisions of Protocol No. 15 denied the claim.

[59] Since this conclusion alone determines the outcome of this review, it is neither appropriate nor necessary for me to address the other issues raised above, as the outcome of this appeal is already decided.

V
CONCLUSION & DISPOSITION

[60] For all of the reasons stated above, the Fund's decision to deny claim No. 21377 is upheld.

Given in Montreal, this 19th of March, 2026



Serge Brault, Arbitrator Referee