The 1986-1990 Hepatitis C Claims Centre
P.O. Box 2370, Station D
Ottawa Ontario, Canada
K1P 5W5
Tel: 1-877-434-0944

GEN 18

Uninsured Funeral Expense Form

Strictly Private and Confidential

APPROVED HCV PERSONAL REPRESENTATIVE
PLEASE AFFIX
HERE ONE OF THE PRE-PRINTED
LABELS PROVIDED

* If you do not have the labels, call 1-877-434-0944 for instructions.

CORRECTIONS ONLY:
Write any name and address corrections below, if any corrections are necessary:

PLEASE READ THE INSTRUCTIONS CAREFULLY WHEN COMPLETING THIS FORM.

This form is to be completed by the Approved HCV Personal Representative of the Deceased HCV Infected Person. Please complete line 1 about the Deceased HCV Infected Person and line 2 about yourself.

SECTION A – PERSONAL INFORMATION

DECEASED HCV INFECTED PERSON

1.

First Name	Middle Name/Initial	Last Name	
Home Address at the Time of Death	**City**	**Province/Territory**	**Postal Code**
Date of Birth (DD/MM/YYYY)	**Date of Death (DD/MM/YYYY)**	**Social Insurance Number**	
/ /	/ /	- -	

APPROVED HCV PERSONAL REPRESENTATIVE

2.

First Name	Middle Name/Initial	Last Name	
Home Address	**City**	**Province/Territory**	**Postal Code**
Home Phone	**Work Phone**	**Facsimile**	**E-Mail Address**
( ) -	( ) -	( ) -	

SECTION B – OTHER BENEFIT INFORMATION

3. Did you receive any reimbursement on behalf of the HCV Infected Person from the Canada Pension Plan for funeral expenses? ☐ Yes ☐ No

If yes, please indicate the amount received. $_____

4. Was there any funeral insurance to offset the expenses listed in Section C – Funeral Expenses? If yes, complete the following information: ☐ Yes ☐ No

Name of Insurance Carrier	Policy Number	Amount Received	Phone Number
		$ _____	( ) -
Mailing Address	**City**	**Province/Territory**	**Postal Code**

SECTION C – FUNERAL EXPENSES

Please indicate all incurred funeral expenses.

5.	Date DD/MM/YYYY	Amount	Receipt?	Description of Expense
a.	/ /	$	☐ Yes ☐ No	
b.	/ /	$	☐ Yes ☐ No	
c.	/ /	$	☐ Yes ☐ No	
d.	/ /	$	☐ Yes ☐ No	
e.	/ /	$	☐ Yes ☐ No	
f.	/ /	$	☐ Yes ☐ No	
g.	/ /	$	☐ Yes ☐ No	
h.	/ /	$	☐ Yes ☐ No	
i.	/ /	$	☐ Yes ☐ No	
j.	/ /	$	☐ Yes ☐ No	
k.	/ /	$	☐ Yes ☐ No	
l.	/ /	$	☐ Yes ☐ No	
m.	/ /	$	☐ Yes ☐ No	
n.	/ /	$	☐ Yes ☐ No	

PLEASE ATTACH ALL RECEIPTS RELATING TO INCURRED FUNERAL EXPENSES.

If missing receipts, please provide an explanation:

SECTION D – DECLARATION BY THE APPROVED HCV PERSONAL REPRESENTATIVE

I certify that the information provided is true and correct. I am not making any false or exaggerated claims to obtain benefits that I am not entitled to receive.

_____ **Date Signed**

_____ **Approved HCV Personal Representative's Signature**