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

Election of $120,000 lump sum payment where the HCV Infected Person died prior to January 1, 1999

For use where none of the Claimants are a Minor or a Mentally Incompetent Adult

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 FORM INSTRUCTIONS, THE DEFINITIONS INCLUDED WITH THIS FORM AND THE ESTATE CLAIMS-FLOWCHARTS CAREFULLY BEFORE COMPLETING THIS FORM.

A GEN 21 Form is to be completed jointly by the Approved HCV Personal Representative of the deceased HCV Infected Person and by every living Family Member and/or Dependant who is a Spouse, Child, Parent, Sibling, Grandparent or Grandchild of the Deceased HCV Infected Person and every living Dependant who is a former Spouse of the deceased HCV Infected Person to whom the HCV Infected Person was providing support or was under a legal obligation to provide support on the date of the HCV Infected Person's death (the "Claimant").

Do not use Form GEN 21 if any of the Claimants is a Minor or a Mentally Incompetent Adult. Call the Administrator to request the Form GEN21M.

SECTION A – PERSONAL INFORMATION

HCV INFECTED PERSON

1.	First Name	Middle Name/Initial	Last Name	
	Home Address at time of death	City	Province/Territory	Postal Code

APPROVED HCV PERSONAL REPRESENTATIVE

2.	First Name	Middle Name/Initial	Last Name	
	Home Address	City	Province/Territory	Postal Code

SECTION B – ELECTION

The $120,000 election entitles the Claimants to share a $120,000 lump sum payment, allocated as they direct. In order for the election to be effective, the Claimants must agree to make the $120,000 election in Section 5.01(2) of the Transfused HCV Plan or the Hemophiliac HCV Plan and must agree on the allocation to each Claimant. If any Claimant chooses not to make the election, the Estate will instead be entitled to a $50,000 payment, reimbursement for uninsured funeral expenses incurred up to $5,000, Approved Family Members will be entitled to pre-set family member payments and, where applicable, Approved Dependants may claim for Loss of Support or Loss of Services.

If all Claimants wish to elect to share the $120,000 lump sum payment, check the box at **(a)**.

If any Claimant does not wish to elect to share the $120,000 lump sum payment, check the box marked **"no election."**

3.	Choice: (select only one):	
	(a)☐	The election pursuant to Section 5.01(2) of the Transfused HCV Plan or Hemophiliac Plan ($120,000 and uninsured incurred funeral expenses to a maximum of $5,000)
	(b)☐	**No election** ($50,000 Estate payment, uninsured incurred funeral expenses to a maximum of $5,000, pre-set family member payments and, where applicable payments for loss of support or services)
	If you chose 3(b), go directly to Section F – Certification by the Approved HCV Personal Representative	

SECTION C - WAIVER AND CONSENT ($120,000)

4. All persons signing this form (including counterparts as described in the Instructions) agree and consent to the election ($120,000 lump sum) made in paragraph 3 in full satisfaction of all claims pursuant to the applicable Plan **except** for**:**

a) the claim of the Approved HCV Personal Representative for reimbursement of up to $5,000 for uninsured funeral expenses on behalf of the Estate of the deceased HCV Infected Person;

b) any claims a person may have if he/she qualifies as a Secondarily-Infected Person who is a Spouse of a Deceased Primarily-Infected Person or Deceased Primarily-Infected Hemophiliac (or person with Thalassemia Major) in respect of his/her own HCV infection; or

c) any claims a person may have if he/she qualifies as a Secondarily-Infected Person who is a Child of a Deceased HCV Infected Person in respect of this/her own HCV infection.

CONFIRM CONSENT BY MARKING AN "X" IN THE CONSENT & DECLARATION COLUMN
SEE ALLOCATIONS CHART

SECTION D – DECLARATIONS ($120,000)

5. All persons signing this form (including counterparts as described in the Instructions) declare that they do not know of any living Family Member and/or Dependant who is a Spouse, Child, Parent, Sibling, Grandchild or Grandparent of the Deceased HCV Infected Person or of any living Dependant who is a former Spouse of the Deceased HCV Infected Person to whom the HCV Infected Person was providing support or was under a legal obligation to provide support on the date of the HCV Infected Person's death, other than the persons listed in the Chart.

6. All persons signing this form (including counterparts as described in the Instructions) declare that they believe that all Claimants listed in the Chart are of the age of majority and are mentally competent.

7. All persons signing this form (including counterparts as described in the Instructions) further declare that they agree and consent to the allocation and payment of monies to each listed in the Chart on the basis set out therein and direct the Administrator to pay to each Claimant the amount he or she has been allocated in the Chart.

CONFIRM CONSENT BY MARKING AN "X" IN THE CONSENT, & DECLARATION COLUMN
SEE ALLOCATIONS CHART

SECTION E –BREAKDOWN OF ALLOCATIONS CHART ($120,000)

The Approved HCV Personal Representative must include a listing of every living Family Member and/or Dependant who is a Spouse, Child, Parent, Sibling, Grandchild or Grandparent of the Deceased HCV Infected Person and every living Dependant who is a former Spouse of the Deceased HCV Infected Person to whom the HCV Infected Person was providing support or was under a legal obligation to provide support on the date of the HCV Infected Person's death.

- List the required information in the Allocations Chart forming part of Form Gen 21.
- Indicate the dollar amount to be allocated to each Claimant listed in the Allocations Chart including the amount, if any, to be allocated to the Approved HCV Personal Representative on behalf of the Estate.
- Any allocation to the Approved HCV Personal Representative on behalf of the Estate must be made separately from any allocation for the personal claim he or she may also have as a Family Member and/or Dependant.
- If the agreed allocation to any Claimant is nil, please enter nil.
- The total allocation must equal $120,000.
- The Administrator cannot process the election until a completed Form GEN21 and the Allocations Chart agreeing to the election has been duly completed and received outlining an allocation that has been agreed to by all Claimants.

SECTION F – CERTIFICATION BY APPROVED HCV PERSONAL REPRESENTATIVE (NO ELECTON)

Where no election is being made, the Approved HCV Personal Representative must read, date and sign the certification below in the presence of a witness.

I certify that the information I have provided is true and correct. I have discussed the $120,000 election with eligible Claimants and all eligible Claimants did not agree to the $120,000 lump sum payment.

I am not making any false or exaggerated claims to obtain benefits that I am not entitled to receive.

_____ _____/_____/_____
Signature of the Approved HCV Personal Representative of the HCV Infected Person **DD MM YYYY**

_____ _____
Signature of witness **Name of witness (please print)**

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

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

CERTIFICATION-Please read, sign and date this Allocation Chart in the presence of a witness.
Each person signing this Allocations Chart certifies that he/she does not know of any living Family Member and/or Dependant who is a Spouse, Child, Parent, Sibling, Grandchild or Grandparent of the Deceased HCV Infected Person or of any living Dependant who is a former Spouse of the Deceased HCV Infected Person to whom the HCV Infected Person was providing support or was under a legal obligation to provide support on the date of the HCV Infected Person's death, other than the persons named below. The information about himself/herself provided is true and correct. He/she is not making any false or exaggerated claims to obtain benefits that he /she is not entitled to receive.

ALLOCATIONS CHART

Name of Claimant	Home Address	Date of Birth D/M/Y	Social Insurance Number	Relationship to HCV Infected Person	Allocation $	Signature of Claimant	Consent and Declarations	Date DD/MM/YY	Witness
		/ /					☐ **Yes** I have read, understand and agree to sections B, C and D	/ /	Signature of Witness Print Name
		/ /					☐ **Yes** I have read, understand and agree to sections B, C and D	/ /	Signature of Witness Print Name
		/ /					☐ **Yes** I have read, understand and agree to sections B, C and D	/ /	Signature of Witness Print Name
		/ /					☐ **Yes** I have read, understand and agree to sections B, C and D	/ /	Signature of Witness Print Name

CHART – CONTINUED

CERTIFICATION-Please read, sign and date this Allocation Chart in the presence of a witness.
Each person signing this Allocations Chart certifies that he/she does not know of any living Family Member and/or Dependant who is a Spouse, Child, Parent, Sibling, Grandchild or Grandparent of the Deceased HCV Infected Person or of any living Dependant who is a former Spouse of the Deceased HCV Infected Person to whom the HCV Infected Person was providing support or was under a legal obligation to provide support on the date of the HCV Infected Person's death, other than the persons named below. The information about himself/herself provided is true and correct. He/she is not making any false or exaggerated claims to obtain benefits that he /she is not entitled to receive.

Name of Claimant	Home Address	Date of Birth	Social Insurance Number	Relationship to HCV Infected Person	Allocation $	Signature of Claimant	Consent and Declaration	Date DD/MM/ YY	Witness
		/ /					☐ **Yes** I have read, understand and agree to sections B, C and D	/ /	Signature of Witness Print Name
		/ /					☐ **Yes** I have read, understand and agree to sections B, C and D	/ /	Signature of Witness Print Name
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CHART – CONTINUED

CERTIFICATION-Please read, sign and date this Allocation Chart in the presence of a witness.
Each person signing this Allocations Chart certifies that he/she does not know of any living Family Member and/or Dependant who is a Spouse, Child, Parent, Sibling, Grandchild or Grandparent of the Deceased HCV Infected Person or of any living Dependant who is a former Spouse of the Deceased HCV Infected Person to whom the HCV Infected Person was providing support or was under a legal obligation to provide support on the date of the HCV Infected Person's death, other than the persons named below. The information about himself/herself provided is true and correct. He/she is not making any false or exaggerated claims to obtain benefits that he /she is not entitled to receive.

Name of Claimant	Home Address	Date of Birth	Social Insurance Number	Relationship to HCV Infected Person	Allocation $	Signature of Claimant	Consent to Waiver and Declaration	Date DD/MM/YY	Witness
		/ /					☐ **Yes** I have read, understand and agree to sections B, C and D	/ /	Signature of Witness Print Name
		/ /					☐ **Yes** I have read, understand and agree to sections B, C and D	/ /	Signature of Witness Print Name
		/ /					☐ **Yes** I have read, understand and agree to sections B, C and D	/ /	Signature of Witness Print Name
		/ /					☐ **Yes** I have read, understand and agree to sections B, C and D	/ /	Signature of Witness Print Name