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

$72,000 Lump Sum Payment Where the Primarily Infected Hemophiliac (or person with Thalassemia Major), Also Infected With HIV Died Prior to January 1, 1999

For use where none of the Claimants is 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 FLOW CHARTS CAREFULLY BEFORE COMPLETING THIS FORM.

A HEMO 22 Form is to be completed jointly by the Approved HCV Personal Representative of the deceased Primarily Infected Hemophiliac (or person with Thalassemia Major) also infected with HIV and by every living Family Member and/or Dependant who is a Spouse, Child, Parent, Sibling, Grandparent or Grandchild of the deceased and every living Dependant who is a former Spouse of the deceased to whom the deceased Primarily Infected Hemophiliac (or person with Thalassemia Major) was providing support or was under a legal obligation to provide support on the date of the Primarily Infected Hemophiliac's (or person with Thalassemia Major) death (collectively "the Claimants").

Do not use Form HEMO 22 if any of the Claimants is a Minor or a Mentally Incompetent Adult. Call the Administrator to request the Form HEMO 22M.

SECTION A – PERSONAL INFORMATION

HCV INFECTED HEMOPHILIAC (OR PERSON WITH THALASSEMIA MAJOR)

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 – CONSENT TO $72,000 LUMP SUM PAYMENT

The $72,000 lump sum payment must be shared between the Claimants, and will be allocated as they direct. In order for the election to be effective, the Claimants must agree to the allocation to each individual.

The $72,000 fixed payment is the only amount available under the Plan for Claimants, unless they have satisfactory medical proof that the death of the Primarily Infected Hemophiliac (or person with Thalassemia Major), also infected with HIV, was caused by his or her infection with HCV.

3. All persons signing this form (including counterparts as described in the Instructions) agree and consent to share the $72,000 fixed payment available under section 5.01(4) of the Hemophiliac HCV Plan in full satisfaction of all claims pursuant to the Plan **except** for**:**

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

b) any claims a person might have if he/she qualifies as a Secondarily-Infected Person who is a Child of a deceased Primarily Infected hemophiliac (or person with Thalassemia Major) in respect of his/her own HCV infection.

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

SEE ALLOCATIONS CHART

SECTION C – DECLARATIONS	
4.	*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 Primarily-Infected Hemophiliac (or person with Thalassemia Major) or of any living Dependant who is a former Spouse of the deceased Primarily-Infected Hemophiliac (or person with Thalassemia Major) to whom the deceased was providing support or was under a legal obligation to provide support on the date of the death, other than the persons listed in the Allocations Chart.*
5.	*All persons signing this form (including counterparts as described in the Instructions) declare that they believe that all Claimants listed in the Allocations Chart are of the age of majority and are mentally competent.*
6.	*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 Claimant listed in the Allocations 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 Allocations Chart.* **CONFIRM CONSENT BY MARKING AN "X" IN THE CONSENT & DECLARATION COLUMN** **SEE ALLOCATIONS CHART**

SECTION D – BREAKDOWN OF ALLOCATIONS CHART

The Approved HCV Personal Representative must write the name every living Family Member and/or Dependant who is a Spouse, Child, Parent, Sibling, Grandchild or Grandparent of the deceased Primarily Infected Hemophiliac (or person with Thalassemia Major) and every living Dependant who is a former Spouse of the deceased Primarily Infected Hemophiliac (or person with Thalassemia Major) to whom the deceased Primarily-Infected Hemophiliac (or person with Thalassemia Major) was providing support or was under a legal obligation to provide support on the date of the deceased Primarily-Infected Hemophiliac's (or person with Thalassemia Major) death (collectively "the Claimants"), in the Allocations Chart.

- List the required information in the Allocations Chart forming part of Form HEMO 22.
- 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 an eligible Family Member and/or Dependant.
- If the agreed allocation to any Claimant is nil, please enter nil.
- The total allocation must equal $72,000.
- The Administrator cannot process the election until a completed Form HEMO 22 and Allocations Chart agreeing to the election has been duly completed and received outlining an allocation that has been agreed to by all Claimants.

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 the below Allocations 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 Primarily-Infected Hemophiliac (or person with Thalassemia Major) or of any living Dependant who is a former Spouse of the deceased Primarily-Infected Hemophiliac (or person with Thalassemia Major) to whom the deceased Primarily-Infected Hemophiliac (or person with Thalassemia Major) was providing support or was under a legal obligation to provide support on the date of the deceased Primarily-Infected Hemophiliac's (or person with Thalassemia Major) death, other than the persons listed in the Allocations Chart. 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 Hemophiliac	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
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ALLOCATIONS CHART – CONTINUED

CERTIFICATION-Please read, sign and date the below Allocations 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 Primarily-Infected Hemophiliac (or person with Thalassemia Major) or of any living Dependant who is a former Spouse of the deceased Primarily-Infected Hemophiliac (or person with Thalassemia Major) to whom the deceased Primarily-Infected Hemophiliac (or person with Thalassemia Major) was providing support or was under a legal obligation to provide support on the date of the deceased Primarily-Infected Hemophiliac's (or person with Thalassemia Major) death, other than the persons listed in the Allocations Chart. 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 Hemophiliac	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
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ALLCATIONS CHART – CONTINUED

CERTIFICATION-Please read, sign and date the below Allocations 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 Primarily-Infected Hemophiliac (or person with Thalassemia Major) or of any living Dependant who is a former Spouse of the deceased Primarily-Infected Hemophiliac (or person with Thalassemia Major) to whom the deceased Primarily-Infected Hemophiliac (or person with Thalassemia Major) was providing support or was under a legal obligation to provide support on the date of the deceased Primarily-Infected Hemophiliac's (or person with Thalassemia Major) death, other than the persons listed in the Allocations Chart. 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 deceased Infected Hemophiliac	Allocation $	Signature of Claimant	Consent and Declaration	Date DD/MM/YY	Witness
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Name	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
		/ /					☐ **Yes** I have read, understand and agree to sections B, C and D	/ /	Signature of Witness Print Name
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