The 1986-1990 Hepatitis C Claims Centre
PO Box 2370, Station D
Ottawa (Ontario) K1P 5W5
Canada
Tel: 1 877 434-0944
www.hepc8690.ca

GEN 17
P-HCV$F-G17/1

Election for $30,000 Fixed Payment or Loss of Income / Services Payment Form

Strictly Private and Confidential

CLAIMANT PLEASE AFFIX HERE ONE OF THE PREPRINTED LABELS PROVIDED

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

CORRECTIONS ONLY
Write any name, address or telephone number corrections below, if any corrections are necessary.

Only persons who are currently applying at Level 3 must complete this Form. This Form is to be completed by the HCV Infected Person or his or her Approved HCV Personal Representative. If you are the HCV Infected Person, please complete line 1. If you are the Approved HCV Personal Representative of the HCV Infected Person, please complete line 1 about the HCV Infected Person and line 2 about yourself.

SECTION A – PERSONAL INFORMATION

HCV INFECTED PERSON

1.	First Name	Middle Name/Initial	Last Name	
	Mailing Address	City/Municipality	Province/Territory	Postal Code

APPROVED PERSONAL REPRESENTATIVE

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

SECTION B – ELECTION OF BENEFITS

Please read the instructions carefully before making this election. Only make this election if the HCV Infected Person is a Level 3 Claimant. Please indicate which of the three options the HCV Infected Person or his or her Approved HCV Personal Representative elects. If you elect the $30,000 fixed payment option, please go to Section D – Declaration. If you elect Compensation for Loss of Income or Loss of Services in the Home, please go to section C – Waiver.

3. The HCV Infected Person elects to be paid the following:
- ☐ The $30,000 Fixed Payment; **OR**
- ☐ Compensation for Loss of Income; **OR**
- ☐ Compensation for Loss of Services in the Home.

SECTION C – WAIVER OF LUMP SUM PAYMENT

Only sign this waiver if the HCV Infected Person or his or her Approved HCV Personal Representative elects to waive the $30,000 fixed payment and instead receive Compensation for Loss of Income or Loss of Services in the Home. **I waive the fixed payment of $30,000 for Disease Level 3.**

_____ _____

Date Signed | Signature of HCV Infected Person or Approved HCV Personal Representative

SECTION D – DECLARATION	
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	Signature of HCV Infected Person or Approved HCV Personal Representative

Note: Once a payment is made for loss of income or loss of services in the home under this election, the waiver of the $30,000 fixed payment shall become **irrevocable** and the $30,000 fixed payment shall not be made at any time thereafter under any circumstances whatsoever.