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

LOSS OF SUPPORT OR LOSS OF SERVICES COMPENSATION

UNDERTAKING OF ADULT HAVING CARE AND CONTROL OR LEGAL GUARDIAN OF AN APPROVED DEPENDANT WHO IS A MINOR OR A MENTALLY INCOMPETENT ADULT WHO IS ENTITLED TO LOSS OF SUPPORT OR LOSS OF SERVICES

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.

APPROVED DEPENDANT		
First Name	Middle Name/Initial Last Name	
Approved Dependant's relationship to the deceased HCV Infected Person	Approved Dependant's date of birth (DD/MM/YYYY)	Approved Dependant's Age
	/ /	

The Approved Dependant is a (check one box) ☐ MINOR **or** ☐ MENTALLY INCOMPETENT ADULT.

I, _____ am the ADULT HAVING CARE AND CONTROL OVER **or**
(Print Full Name)

I am the LEGAL GUARDIAN of the above-named Approved Dependant.

A Claim for loss of services/support has been made on behalf of the above-named Approved Dependant who is a minor or a mentally incompetent adult. The allocation of **"Common and Exclusive Expenses"** which the above-named **Approved Dependant is currently entitled to** are outlined in the attached "Allocation Chart". The above-named Approved Dependant may opt to make further Claims for loss of services / loss of support. His or her **entitlement to future compensation** for loss of services / loss of support will be assessed, calculated and outlined in a similar "Allocation Chart", as amounts may become due.

UNDERTAKING TERMS AND CONDITIONS

On behalf of the above-named Approved Dependant, **I AGREE AND ACCEPT THAT ALL CURRENT AND FUTURE COMMON AND EXCLUSIVE EXPENSES ARE TO BE CALCULATED IN ACCORDANCE WITH THE COURT APPROVED PROTOCOL** for *Claims Where One or More Family Member and/or Dependant(s) is a Minor or a Mentally Incompetent Adult* (hereinafter called the "Protocol").

Special Note: If you disagree with the allocation formula as outlined in the Protocol, you may file a **Request for Review Form**, which can be obtained from the Administrator. Please note that if a request for review is filed, the Administrator is unable to issue payment for such compensation until the Arbitrator, Referee or Court determines the loss of support / loss of services payment and allocation.

I CERTIFY, as the adult having care and control of above-named **Approved Dependant who is a minor or mentally incompetent adult that he or she resides with me on a full-time basis.**

I UNDERSTAND, AGREE TO AND UNDERTAKE THE FOLLOWING:

A. **ALL CURRENT AND FUTURE COMMON EXPENSES** received by me, the adult Approved Dependant who resides in the same household as Approved Dependants who are minors , will be used for the benefit of all Approved Dependants resident in the household; and

B. **ALL CURRENT AND FUTURE EXCLUSIVE EXPENSES,** for the above-named Approved Dependant, received by me the adult having care and control of the Approved Dependant who is a minor, will be used for his or her direct benefit; and

C. The **Administrator will be notified if there is a material change of circumstances in the household**, such as the departure of an Approved Dependant who is a **minor** from the household.

D. **ALL CURRENT AND FUTURE COMMON AND EXCLUSIVE EXPENSES** for the **Approved Dependant who is a mentally incompetent adult** received by me, the Legal Guardian appointed to manage said Approved Dependant's financial affairs, will be used for the above-named Approved Dependant's direct benefit.

¨ *Important Information* ¨

Regarding Approved Dependants Who Are Minors
*If at any time the Administrator has a concern that this **undertaking is not being complied with** or that the circumstances in the household have changed so that payment to the adult member of the household or the adult with care and control of the minor who provided the undertaking is no longer reasonable, the Administrator shall reassess and recalculate the allocation compensation if necessary and/or adjust payment of the compensation for loss of support.*

*The Administrator retains the **discretion to pay** the common expenses and the exclusive expenses for an Approved Dependant who is a minor **to the person who in the Administrator's opinion is best qualified to administer** the payment on behalf of the **Approved Dependant who is a minor**, including, if appropriate, the Public Guardian and Trustee or the Children's lawyer.*

Regarding Approved Dependants Who Are Mentally Incompetent Adults
*If at any time the Administrator has a concern that the share of the common expenses and/or the exclusive expenses of the **Approved Dependant who is a mentally incompetent adult are not being used for his or her benefit**, the **Administrator shall withhold those payments and notify the appropriate Public Guardian and Trustee** through Fund Counsel. The Administrator shall recommence making payments in the manner and at the time directed by the appropriate Public Guardian and Trustee or by order of the Court.*

CONSENT TO UNDERTAKING

I UNDERSTAND, AGREE TO AND ACCEPT TO ABIDE BY ALL OF THE FOREGOING TERMS AND CONDTIONS OF THIS UNDERTAKING for as long as the above-named Approved Dependant is a minor or a mentally incompetent adult receiving compensation for loss of services / loss of support paid by the 1986-1990 Hepatitis C Administrator.

Signature: _____ Date Signed: _____
Adult Having Care and Control of Above-named Approved Dependant **OR** Legal Guardian.
DD / MM / YYYY

Witness' Signature: _____ Date Signed: _____
DD / MM / YYYY

Print Witness' Name: _____