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

Loss of Income/Support – MASTER 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 corrections below, if any corrections are necessary:

PLEASE READ THE INSTRUCTIONS INCLUDED WITH THIS FORM CAREFULLY BEFORE COMPLETING THIS FORM.

The information collected in this Form will help determine the calculation of loss of income/support compensation.

1) The disabled HCV Infected Person is living: if you are the disabled HCV Infected Person or the Approved HCV Personal Representative of a living disabled HCV Infected Person who is a minor or mentally incompetent adult, complete this Form, Form GEN 11, GEN 19 and have your Treating Physician complete the "Disability Section" of the Treating Physician Form TRAN/HEMO 2 or Form TRAN/HEMO 2D to make a claim for **loss of income**.

OR

2) The disabled HCV Infected Person who died on or after January 1, 1999: the Approved HCV Personal Representative must complete this Form, Form GEN 11, GEN 19 and have the HCV Infected Person's Treating Physician complete the "Disability Section" of the Treating Physician Form TRAN/HEMO 2 or Form TRAN/HEMO 2D to claim **pre-death loss of income on behalf of the Estate** of the disabled HCV Infected Person who has died.

AND/OR

3) The HCV Infected Person who died either before or after January 1, 1999: Dependants complete this Form and Form GEN 19 to claim **post-death loss of support only.**

SECTION A – PERSONAL INFORMATION

HCV INFECTED PERSON

1.	First Name	Middle Name/Initial	Last Name	
	Home Address	City	Province/Territory	Postal Code
	Date of Birth: DD/MM/YYYY			
	/ /			

APPROVED HCV PERSONAL REPRESENTATIVE

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

DEPENDANT

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

CLAIM DESCRIPTION

3.

Indicate Claimant type:

☐ **Living disabled** HCV Infected Person

☐ Approved HCV Personal Representative for the living disabled HCV Infected Person who is a **minor or mentally incompetent adult**

☐ Approved HCV Personal Representative for the disabled HCV Infected Person who is **deceased – pre-death** loss of income

☐ **Dependant** of the deceased HCV Infected Person – **post-death** loss of support

Indicate claim type:

☐ Loss of Income

☐ Loss of Support

To claim compensation for Loss of Services in the Home you must complete Form GEN 12 – MASTER FORM.

Only one type of loss can be claimed for any period of time.

SECTION B - APPLICATION FOR COMPENSATION FOR LOSS OF INCOME/SUPPORT

HCV INFECTED PERSON'S INFECTION INFORMATION

4.

	DD / MM/ YYYY
Date of infection with HCV	/ /
Date of Diagnosis with HCV	/ /

If unknown, leave blank. The date of infection will be assumed to be the earliest transfusion from a confirmed positive donor in the Class Period or, if this is unknown or inapplicable, the date of first receipt of Blood during the Class Period that is not from a donor known to be uninfected.

5.	When did the HCV Infected Person first become disabled due to his/her infection with HCV, which led to a loss of income?	Start Date DD/MM/YYYY / /
6.	If the HCV Infected Person is deceased, please indicate date of death?	Start Date DD/MM/YYYY / /
7.	Was the disabled HCV Infected Person working prior to his or her infection with HCV?	☐ Yes ☐ No
8.	Was the disabled HCV Infected Person infected before his or her eighteenth birthday?	☐ Yes ☐ No
9.	Was the disabled HCV Infected Person infected with HCV while attending (full-time) an accredited educational institution in Canada and before entering the workforce on a permanent and full-time basis?	☐ Yes ☐ No

If yes, provide the following information:

Name of Accredited Educational Institution			Date Last Attended	DD/MM/YYYY
				/ /
Address			Program and Level	
City	Province/Territory	Postal Code	Date of Completion of Studies or Projected Date of Completion	DD/MM/YYYY / /
Is the HCV Infected Person now attending school? ☐ Yes ☐ No				

SECTION C – DISABILITY BENEFITS

10. Is/was the disabled HCV Infected Person receiving disability benefits from the Canada Pension Plan or the Quebec Pension Plan, a workers compensation plan or any other sickness, accident or disability insurance plan? If yes, complete the following information:

Name and Phone # of Benefit Provider	Mailing Address of Benefit Provider	Policy Number	Date Commenced DD/MM/YYYY	Amount per Month
			/ /	$
( ) -				
			/ /	$
( ) -				
			/ /	$
( ) -				

Please attach all documentation regarding the above disability benefit information.

SECTION D – LOSS OF INCOME/ SUPPORT

PRE-CLAIM INCOME INFORMATION

See the *Instructions* provided for the definitions of Pre-Claim Income and Normal, Related or Self-Employment and for the indexation table. Provide the HCV Infected Person's Pre-Claim Income information for 3 consecutive years of your choosing, as requested in the table below unless the HCV Infected Person has no pre-claim employment income history because of the answers given on lines 7 to 9 above.

Year 1: _____(calendar year)	**Normal Employment**	**Related Employment**	**Self-Employment**
Pre-Claim **gross** earned income amount	$	$	$
Year 2: _____(calendar year)	**Normal Employment**	**Related Employment**	**Self-Employment**
Pre-Claim **gross** earned income amount	$	$	$
Year 3: _____(calendar year)	**Normal Employment**	**Related Employment**	**Self-Employment**
Pre-Claim **gross** earned income amount	$	$	$

- **Attach the complete Federal and Quebec, if a resident of Quebec, Income Tax Return and Notice of Assessment for each year chosen above.**
- **If you are unable to provide a copy of the HCV Infected Person's complete Income Tax Return and Notice of Assessment for the years selected above, please obtain a Tax Summary from Canadian Customs and Revenue Agency (and, the ministère du revenu du Quebec if required) for the years, (see Form Instructions for information on how to obtain a Tax Summary) and complete Form GEN 10A. Also complete Form GEN 10B if the HCV Infected Person lives or lived in one of provinces listed on the Form.**
- **If the HCV Infected Person reported Self-Employment Income complete Form GEN 10C.**
- **Failure to provide the income documentation requested will delay the processing of your claim.**

POST-CLAIM INCOME INFORMATION

See the *Instructions* provided for the definition of Post-Claim Income and Normal, Related or Self-Employment. Provide the HCV Infected Person's Post-Claim Income information for every year that a claim is being made for his or her loss of income/support due to a disability caused by the infection with HCV.

If the HCV Infected Person is deceased and a pre-death claim for loss of income is being made, you must complete all boxes relevant to the deceased's Post-Claim Income information up to and including the year of death.

If the HCV Infected Person is deceased and a claim by Dependants for post-death loss of support is being made, only certain boxes need to be completed. Please read the *Instructions* page in this regard carefully.

Attach the complete Federal and Quebec, if a resident of Quebec, Income Tax Return and Notice of Assessment for each Post-Claim Income year. Dependants who are claiming post-death loss of support must attach the T4A(P) (and, if a resident in Quebec, the RL-2) benefit statement for each Post-Claim Income year after the year of death.

If you are unable to provide a copy of the HCV Infected Person's complete Federal and Quebec, if a resident of Quebec, Income Tax Return and Notice of Assessment for the Post-Claim Income years, please obtain a Tax Summary from Canadian Customs and Revenue Agency (and the Ministère du revenu du Quebec, if required) for the years, (see Form Instructions for information on how to obtain a Tax Summary) and complete Form GEN 10A. Also complete Form GEN 10B if the HCV Infected Person lives or lived in one of the provinces listed in the Form.

If the HCV Infected Person reported Self-Employment Income complete Form GEN 10C.

Failure to provide the income documentation requested throughout will delay the processing of your claim.

Year:_____ (calendar year)	**Gross Earned Income**			
Province of Residence on Dec. 31 that year:	Post-Claim Gross Earned Income	**Normal Employment**	**Related Employment**	**Self-Employment**
		$	**$**	**$**
Name & Address Of Employer:	(Un) Employment Insurance: Ei/Ui or CPP/QPP Disability Benefits	**Ei/Ui**	**Ei/Ui**	**Ei/Ui**
		$	**$**	**$**
		CPP/QPP	**CPP/QPP**	**CPP/QPP**
		$	**$**	**$**
Position & Essential Tasks:	Income Continuation or Disability Payments	**Taxable**	**Taxable**	**Non-Taxable**
		$	**$**	**$**
	All other compensation	**Taxable**	**Taxable**	**Non-Taxable**
Number of Regular Hours Per Week:		**$**	**$**	**$**
	Alimony or Maintenance Payments deducted for Tax purposes? (enter amount)			**$**
☐ Full- time ☐ Part-time ☐ Contract	Disability Tax Credit claimed? ☐ Yes ☐ No			

Photocopy this page before completing if you are claiming for more than 4 years

Year:_____ (calendar year)	**Gross Earned Income**			
Province of Residence on Dec. 31 that year:	Post-Claim Gross Earned Income	**Normal Employment**	**Related Employment**	**Self-Employment**
		$	$	$
Name & Address Of Employer:	(Un) Employment Insurance: Ei/Ui or CPP/QPP Disability Benefits	**Ei/Ui**	**Ei/Ui**	**Ei/Ui**
		$	$	$
		CPP/QPP	**CPP/QPP**	**CPP/QPP**
		$	$	$
Position & Essential Tasks:	Income Continuation or Disability Payments	**Taxable**	**Taxable**	**Non-Taxable**
		$	$	$
	All other compensation	**Taxable**	**Taxable**	**Non-Taxable**
Number of Regular Hours Per Week:		$	$	$
	Alimony or Maintenance Payments deducted for Tax purposes? (enter amount)	$		
☐ Full- time ☐ Part-time ☐ Contract	Disability Tax Credit claimed? ☐ Yes ☐ No			

Year:_____ (calendar year)	**Gross Earned Income**			
Province of Residence on Dec. 31 that year:	Post-Claim Gross Earned Income	**Normal Employment**	**Related Employment**	**Self-Employment**
		$	$	$
Name & Address Of Employer:	(Un) Employment Insurance: Ei/Ui or CPP/QPP Disability Benefits	**Ei/Ui**	**Ei/Ui**	**Ei/Ui**
		$	$	$
		CPP/QPP	**CPP/QPP**	**CPP/QPP**
		$	$	$
Position & Essential Tasks:	Income Continuation or Disability Payments	**Taxable**	**Taxable**	**Non-Taxable**
		$	$	$
	All other compensation	**Taxable**	**Taxable**	**Non-Taxable**
Number of Regular Hours Per Week:		$	$	$
	Alimony or Maintenance Payments deducted for Tax purposes? (enter amount)	$		
☐ Full- time ☐ Part-time ☐ Contract	Disability Tax Credit claimed? ☐ Yes ☐ No			

Year:_____ (calendar year)	**Gross Earned Income**			
Province of Residence on Dec. 31 that year:	Post-Claim Gross Earned Income	**Normal Employment**	**Related Employment**	**Self-Employment**
		$	**$**	**$**
Name & Address Of Employer:	(Un) Employment Insurance: Ei/Ui or CPP/QPP Disability Benefits	**Ei/Ui**	**CPP**	**QPP**
		$	**$**	**$**
		CPP/QPP	**CPP/QPP**	**CPP/QPP**
		$	**$**	**$**
Position & Essential Tasks:	Income Continuation or Disability Payments	**Taxable**	**Taxable**	**Non-Taxable**
		$	**$**	**$**
	All other compensation	**Taxable**	**Taxable**	**Non-Taxable**
Number of Regular Hours Per Week:		**$**	**$**	**$**
	Alimony or Maintenance Payments deducted for Tax purposes? (enter amount)			**$**
☐ Full- time ☐ Part-time ☐ Contract	Disability Tax Credit claimed? ☐ Yes ☐ No			

SECTION E – DECLARATION BY CERTAIN CLAIMANTS, IF APPLICABLE

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

_____ _____

Date Signed **Signature of the disabled HCV Infected Person or the Approved HCV Personal Representative**

SECTION F – DEPENDANTS CHART/ POST-DEATH LOSS OF SUPPORT ONLY

The attached Chart is to be **completed by the Dependant** who has undertaken to submit the claim and this Form.

The Dependants Chart must **list every living Dependant to whom the HCV Infected Person was providing support or was under a legal obligation to provide support on the date of death including a former spouse, if applicable**.

- List the required information in the Dependant Chart forming part of Form GEN 10.
- **Each Dependant named in the Chart must sign** the Chart where indicated. If the Dependant is a minor or mentally incompetent adult, the Personal Representative of such person must sign the Chart.
- **Each Dependant must read the Certification** statement above the Chart carefully before signing.

If any Dependant is a mentally incompetent adult, please indicate the name of the person appointed to act as his or her **legal Guardian**, and provide a copy of the court order appointing such Guardian.

If any Dependant is a minor in the province where he or she resides, please indicate the name of the **adult who has care, custody and control of the minor** in the address column. Should the Dependant claim for post-death loss of support be approved, this adult will hear further from the Administrator about receiving payment.

After this Chart is fully completed and signed and supporting documentation is collected, the Dependant must return this Form GEN 10 and supporting documentation to the Administrator.

Counterparts: For convenience, the **Dependant who has undertaken to submit the claim may make one or more machine copies** of the **completed Dependants Chart** on which he/she has named every Dependant, and send such a copy to Dependants who must complete any additional personal information and date and sign the Dependants Chart in front of a witness. Dependants must return their original signed copy to the Dependant who has undertaken to submit the claim. Such copies are called counterparts. The Dependant who has undertaken to submit the claim must file all forms, including signed original counterparts, with the Administrator in a single submission.

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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:

DEPENDANTS CHART

CERTIFICATION-Each Dependant to whom the HCV Infected Person was providing support or was under a legal obligation to provide support must read and sign this Dependants Chart.

By signing this Dependants Chart, I certify that: a) I do not know of any living Dependant, who is a Spouse, Child, Parent, Sibling, Grandchild, Grandparent or former Spouse to whom the HCV Infected Person was providing support or was under a legal obligation to provide support on the date of death other than the Dependants listed in this Chart; b) all of the information provided in this Chart is true and complete to the best of my knowledge, information and belief; and c) I am not making any false or exaggerated claims to obtain benefits.

Name of Dependant	Dependant is a mentally incompetent adult	Dependant is a minor	Home Address and Telephone Number (if the Dependant is a mentally incompetent adult or a minor include name of legal Guardian or adult with care custody and control)	Date of Birth D/M/Y	Social Insurance Number	Relationship to HCV Infected Person	Signature of Dependant or Personal Representative of minor/mentally incompetent adult Dependant
	☐ Yes	☐ Yes		/ /			
	☐ Yes	☐ Yes		/ /			
	☐ Yes	☐ Yes		/ /			
	☐ Yes	☐ Yes		/ /			

DEPENDANTS CHART

CERTIFICATION-Each Dependant to whom the HCV Infected Person was providing support or was under a legal obligation to provide support must read and sign this Dependants Chart.

By signing this Dependants Chart, I certify that: a) I do not know of any living Dependant, who is a Spouse, Child, Parent, Sibling, Grandchild, Grandparent or former Spouse to whom the HCV Infected Person was providing support or was under a legal obligation to provide support on the date of death other than the Dependants listed in this Chart; b) all of the information provided in this Chart is true and complete to the best of my knowledge, information and belief; and c) I am not making any false or exaggerated claims to obtain benefits.

Name of Dependant	Dependant is a mentally incompetent adult	Dependant is a minor	Home Address and Telephone Number (if the Dependant is a mentally incompetent adult or a minor include name of legal Guardian or adult with care custody and control)	Date of Birth D/M/Y	Social Insurance Number	Relationship to HCV Infected Person	Signature of Dependant or Personal Representative of minor/mentally incompetent adult Dependant
	☐ Yes	☐ Yes		/ /			
	☐ Yes	☐ Yes		/ /			
	☐ Yes	☐ Yes		/ /			
	☐ Yes	☐ Yes		/ /			
	☐ Yes	☐ Yes		/ /			