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

GEN 10C

Self-Employment Information 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.

If the **HCV Infected Person is/was self-employed during any or all of the Pre-Claim or Post-Claim Income years**, complete this Form-GEN 10C. Do not complete this Form if the HCV Infected Person was not self-employed in one or more of the relevant years.

- If the **HCV Infected Person is living**, he or she must complete this Form; OR
- If the HCV Infected Person is living but is a **minor or mentally incompetent adult**, his or her Approved HCV Personal Representative must complete this Form; OR
- If the HCV Infected Person is **deceased**, the Approved HCV Personal Representative claiming **pre-death loss of income** on behalf of the Estate must complete this Form; AND/OR
- If there is a **post-death loss of support** claim, the **Dependants** of the deceased must complete this Form.

SECTION A – PERSONAL INFORMATION

HCV INFECTED PERSON WHO IS/WAS SELF-EMPLOYED

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 OR DEPENDANT

2.	First Name	Middle Name/Initial	Last Name	
	Home Address	City	Province/Territory	Postal Code
	Indicate Claimant Type:			

SECTION B – SELF-EMPLOYMENT INFORMATION

3.	If self-employed, indicate the type of business or organization below:			
	☐ Sole Proprietorship	☐ Partnership	☐ Limited Liability Company	☐ Other_____.

Name of Business		Phone Number	Fax Number
		( ) -	( ) -
Street Address	City	Province/Territory	Postal Code

4.	If self-employed in a partnership, or limited company, please indicate the percentage of the business owned by the HCV Infected Person.	%
5.	If self-employed, please indicate the position/office of the HCV Infected Person in the business.	
6.	Briefly explain the duties of the position (i.e. bookkeeping, staff supervision, marketing, sales, other): _____ _____ _____ _____	
7.	What was the disabled HCV Infected Person's income for the year he or she became disabled by his/her infection with HCV? Please confirm the stated income with the Financial Statements for the business.	Amount $ Calendar Year
8.	Did the disabled HCV Infected Person receive any other Form of compensation from the business (i.e. bonuses, commissions, etc)?	☐ Yes ☐ No
9.	If yes, what form did the compensation take? Please provide details below: _____ _____ _____	
10.	How frequently was the HCV Infected Person paid his or her salary?	
11.	While the HCV Infected Person is disabled, can/did the business operate?	☐ Yes ☐ No

Please provide the Financial Statements for the business for each Pre-Claim and Post-Claim Income year. Failure to provide the income documentation requested will delay processing your claim.

SECTION C - BUSINESS ACCOUNTANT INFORMATION

12.	Name of Practice	Phone Number	Fax Number	
		( ) -	( ) -	
	Mailing Address	City	Province/Territory	Postal Code

SECTION B - DECLARATION

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 Claimant**