APP

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

Request for Review by Arbitrator /Referee

Strictly Private and Confidential

CLAIMANT 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:

If you wish to have the Administrator's decision reviewed by an Arbitrator/Referee, you must forward this REQUEST FOR REVIEW to the Administrator within 30 days from the date that you received the Administrator's letter of decision.

SECTION A - HCV INFECTED PERSON

First Name	Middle Name/Initial	Last Name

Home Address	City	Province/Territory	Postal Code

Date of Birth (DD/MM/YYYY)	Provincial/Territorial Health Number	Province/Territory of Health Plan
/ /	- -	

SECTION B: CLAIMANT INFORMATION (*Please check the appropriate box*)

1. Claimant is: ***(Please check the appropriate box)***

☐ Primarily-Infected Person
☐ Secondarily-Infected Person
☐ Approved HCV Personal Representative of HCV Infected Person
☐ Approved Dependant of HCV Infected Person
☐ Approved Family Member of HCV Infected Person

☐ HCV Transfused Plan <u>or</u>
☐ HCV Hemophiliac Plan

2. You are requesting that the Arbitrator / Referee review the Administrator's decision about:

☐ Denial of Claim
☐ Fixed Payments
☐ HCV Drug Therapy
☐ Out-of-Pocket Expenses
☐ Uninsured Treatment and Medication
☐ Costs of Care
☐ Loss of Income
☐ Loss of Services
☐ Loss of Support
☐ Death Benefits Allocation

13_03_01

SECTION B: REVIEW OF ADMINISTRATOR'S DECISION

3. I wish to have the Administrator's decision reviewed by,

Referee ☐ or

Arbitrator ☐

(Choose one of the above by checking one box)

4. I wish to review the Administrator's decision for the following reasons:

____

____

____

____

____

(Continue on separate sheet of paper if needed)

5. The Administrator shall be responsible for preparing the Claimant's file for consideration on this review. As a result, please check one of the following options:

☐ YES — I have provided all necessary documents upon which I rely for my claim to the Administrator and do not intend to file any further documents with the Administrator.

☐ YES — I have the following additional documents which the Arbitrator/ Referee should consider in support of my appeal.

(i) _______________________________________

(ii) _______________________________________

(iii) _______________________________________

(iv) _______________________________________

(Attach additional list, as required)

6. ☐ YES — I wish to have the following person(s) testify in person before the Arbitrator/Referee:

(i) _______________________________________
(Print Name)

____
(Occupation)

____
(Address)

____
(Telephone No.)

SECTION B: REVIEW OF ADMINISTRATOR'S DECISION cont.

6.

☐ YES I wish to have the following person(s) testify in person before the Arbitrator/Referee:

(ii) ____
(Print Name)
____
(Occupation)
____
(Address)
____
(Telephone No.)

(iii) ____
(Print Name)
____
(Occupation)
____
(Address)
____
(Telephone No.)

(iv) ____
(Print Name)
____
(Occupation)
____
(Address)
____
(Telephone No.)

(Attach additional list, as required).

7.

There will be an in-person hearing if you and/or Fund Counsel intend to present oral evidence (testimony). Where no oral evidence is required, it is within the sole discretion of the arbitrator/referee as to whether an in-person hearing is required. If you believe an in-person hearing is required, please state the reason below.

____
____
____
____
____
____
____
____

(Continue on separate sheet of paper if needed)

__________________________ ________________________________

Date Signed **Signature of Claimant**