



## Pre-1986/Post-1990 Hepatitis C Settlement

### REQUEST FOR REVIEW (Appeal)

In the event that a Claim is rejected or a Claim is accepted but the claimant disagrees with some part of the Administrator's decision, a claimant may appeal the Administrator's decision by completing the enclosed Request for Review Form.

#### **TO COMMENCE AN APPEAL**

Claimants must complete and return the Request for Review Form to the Administrator within **30 days** after receipt of the Administrator's letter of decision.

#### **PROCESS FOR APPEALS**

- 1) Appeals will be conducted in writing only (no oral hearing).
- 2) If you decide to act through a representative, you must notify the Administrator, Fund Counsel, the Court Appointed Monitor, and the Appeals Officer in writing. You must also provide a written consent.
- 3) Upon receipt of this form, the Administrator will send to both you and Fund Counsel, the Appeal File (which includes a copy of this form, a complete copy of the application and the Administrator's decision).
- 4) You will have 30 days following the date of mailing of the Appeal File to provide any supplementary evidence and/or submissions to Fund Counsel.
- 5) Fund Counsel will review the materials. If there are deficiencies in the materials, Fund Counsel will contact you and will assist you to rectify such deficiencies.
- 6) Fund Counsel will forward the supplementary evidence and/or submissions to the Administrator which will be added to the Appeal File.
- 7) The Administrator will have 30 days following the date of mailing of the Claimant's supplementary evidence and/or submissions to forward, in writing, the results of its reconsideration and any reply submissions to Fund Counsel and the Claimant.

- 8) If the Administrator reconsiders and accepts the Claim, the Appeal is concluded and you have the following options:
  - a. You can accept the revised decision; **OR**
  - b. You can continue with the appeal.
- 9) If you choose to continue with the appeal:
  - a. You must notify Fund Counsel and the Administrator within 30 days of receipt of the revised decision. If you fail to advise of your election, you will be deemed to have accepted the revised decision and the appeal will be concluded.
  - b. Once you have notified Fund Counsel and the Administrator, you will have twenty days (20) to provide supplementary submissions to Fund Counsel.
  - c. Fund Counsel will forward the submissions to the Appeals Officer and to the Administrator once satisfied that the submissions are sufficiently complete and organized.
  - d. The Administrator will forward the Appeal File to the Appeals Officer.
  - e. Within twenty (20) days of receiving the Appeal File, the Appeals Officer will advise the parties in writing whether further submissions are necessary, or whether he/she will proceed on the basis of the completed Appeal File.

### **APPEAL DECISION**

The Appeals Officer will release his/her Reasons for Decision in writing.

### **FURTHER APPEALS TO THE COURT**

- 1) Except as set out below, the decision of the Appeals Officer is final and binding and there is no further right of appeal.
- 2) The only evidence which may be considered on a further appeal to the Court is the evidence that is contained in the Appeal File.
- 3) If you wish to appeal the decision of an Appeals Officer to the Court having jurisdiction in the Class Action of which you are a Class Member, you must send to Fund Counsel a Request for Appeal to the Court within thirty (30) days of the receipt of the Appeals Officer's Reasons for Decision. Fund Counsel will provide the Request for Appeal to the Court form to the Court Appointed Monitor and the presiding Judge in the jurisdiction in which you are a Class Member.

**Pre-1986/Post-1990 Hepatitis C Settlement**

**REQUEST FOR REVIEW FORM**  
*Strictly Private and Confidential*

If you wish to appeal the Administrator's decision, you must forward this REQUEST FOR REVIEW form to the Administrator within 30 days from the date that you receive the Administrator's decision.

**Section A – HCV INFECTED CLASS MEMBER**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Home Address \_\_\_\_\_  
City \_\_\_\_\_ Province/Territory \_\_\_\_\_ Postal Code \_\_\_\_\_  
Country \_\_\_\_\_ Date of Birth (MM/DD/YYYY) \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**Section B – HCV PERSONAL REPRESENTATIVE**

Complete this Section about yourself if you are an HCV Personal Representative submitting a claim on behalf of an HCV Infected Class Member who is a minor, a mentally incompetent adult, or deceased.

Complete Section A above about the HCV Infected Class Member.

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Home Address \_\_\_\_\_  
City \_\_\_\_\_ Province/Territory \_\_\_\_\_  
Postal Code \_\_\_\_\_ Country \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**Section C – PLACE OF RESIDENCE ON JULY 9, 2007**

Confirm whether the place of residence of the person submitting this Request for Review is the same as the above on July 9, 2007.  Yes (If not, complete the information below.)

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

**Section D – CLAIMANT INFORMATION**

Check the appropriate box.

Claimant is the:

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

**Section E – TYPE OF APPEAL**

Check the appropriate box.

You are appealing the following decision:

- Denial of Claim
- Fixed Payments (Disease Level)
- Past Loss of Services in the Home
- Past Loss of Income
- Loss of Support
- Other \_\_\_\_\_

Specify the reasons for appealing the Administrator’s decision:

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\_\_\_\_\_  
Date Signed (Month Day Year)

\_\_\_\_\_  
File Number

\_\_\_\_\_  
Claimant’s Signature

\_\_\_\_\_  
Print Name