Form 10 - Past Loss of Services in the Home

Strictly Private and Confidential

If you wish to claim for Past Loss of Income instead of Past Loss of Services in the Home, you must complete FORM 9. Only one claim type may be made for any period of time.

To be completed by:

1) The HCV Infected Class Member is living, is approved at disease level 4 or higher and is at least 60% disabled due to his or her infection with HCV and this has caused his or her inability to perform services in the home: the disabled HCV Infected Class Member or the HCV Personal Representative of a living disabled HCV Infected Class Member who is a minor or mentally incompetent adult must complete this form to claim compensation for past loss of services in the home.

You must have the Treating Physician complete the “Disability Section” of the Treating Physician Form (FORM 2).

OR

2) The HCV Infected Class Member who died on or after January 1, 1999, was approved at disease level 4 or higher and was at least 60% disabled due to his or her infection with HCV and this caused his or her inability to perform services in the home: the HCV Personal Representative, on behalf of the Estate, must complete this Form to claim pre-death loss of services in the home.

You must have the Treating Physician complete the “Disability Section” of the Treating Physician Form (FORM 2).

AND/OR

3) The Dependants of an HCV Infected Class Member who died either before or after January 1, 1999. Dependants are eligible only if the HCV Infected Class Member had attained Disease Level 4 or higher prior to death, and HCV materially contributed to the death. The Dependants must have been living with the HCV Infected Class Member at the date of death and suffered a loss of the HCV Infected Class Member’s services in the home after his or her death. The Dependant who has undertaken to submit the claim and complete this form to claim post-death loss of services must complete the attached Dependants Chart and ensure that every Dependant living with the deceased at the time of death signs the Dependants Chart. Complete and return this form to the Administrator.

Section A - HCV Infected Class Member

Last Name ______________________________ First Name ________________________ Middle Initial _____________

Home Address ____

City ___________________________________ Province/Territory _________________ Postal Code _____________

Country ____ Date of Birth ____
(Month Day Year)

Province/Territory of Health Plan ___________________ Health Number ______________________________________

Home Phone (_______) ___________ - __________________ Work Phone (_______) ___________ - __________

Section B - HCV Personal Representative

Last Name ______________________________ First Name ________________________ Middle Initial _____________

Home Address ____

City ____ Province/Territory ____________________________________

Postal Code _____________________________ Country ____

Home Phone (_______) ___________ - __________________ Work Phone (_______) ___________ - __________

Section C - Dependant

Last Name ______________________________ First Name ________________________ Middle Initial _____________

Home Address ____

City ____ Province/Territory _____________________________________

Postal Code ______________________________ Country ____

Home Phone (_______) ___________ - __________________ Work Phone (_______) ___________ - __________

Section D – Declaration (Post-Death Loss Only – Go To Section E)

I certify that if qualified for this type of compensation, I agree to accept compensation for Loss of Services in the Home for any period that it is more financially advantageous in comparison to either Loss of Income or Loss of Support compensation.

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

______________________________ Date Signed (Month Day Year)

______________________________ Signature of HCV Infected Class Member, or HCV Personal Representative

Section E - Dependants Chart- Post-Death Losses Only

The attached Dependants Chart is to be **completed by the Dependant who has undertaken to submit the claim and this form.** After this Chart is fully completed and signed as indicated below and supporting documentation is collected, the Dependant must return this form and supporting documentation to the Administrator.

The Dependants Chart must list every living Dependant who was living with the HCV Infected Class Member at the time of his or her death.

- List the required information in the Dependants Chart included with this Form.
- 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 personal representative in the address column and provide a copy of the court order appointing such personal representative.

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 Dependants claim for post-death loss of services be approved, the Administrator will contact this adult about receiving payment.

Counterparts: For convenience, the Dependant who has undertaken to submit the claim may make one or more photocopies of the completed Dependants Chart on which he/she has named every Dependant, living with the HCV Infected Class Member at the time of his or her death. He or she sends such a copy to Dependants who must complete any additional personal information and date and sign the Dependants Chart. 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 with the Administrator, including signed original counterparts, in a single submission.

Failure to provide the Dependants chart will delay the processing of your claim.

Dependants Chart

Certification

Each Dependant to whom the HCV Infected Class Member was providing support or was under a legal obligation to provide support must read and sign this Dependants Chart. (If the Dependant is a mentally incompetent adult or a minor include the name of the personal representative or adult with care, custody and control).

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 Class Member 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 claim to obtain benefits.

Dependant #1

Dependant Last Name ____________________ Dependant First Name ____________________

Home Address ____

City ____________________ Province/Territory ______________ Postal Code __________

Country ____________________ Date of Birth ____________________
(Month Day Year)

Home Phone (_____) ________ - ____________ Work Phone (_____) ________ - ________

Relationship to HCV Infected Class Member ________________________________

Dependant is a: ❑ A Mentally Incompetent Adult ❑ A Minor

Living with the HCV Infected Person at the time of death: ❑ Yes

____
Date Signed (Month Day Year)

____
Signature of Dependant or personal representative of minor/mentally incompetent adult Dependant

Dependant #2

Dependant Last Name ____________________ Dependant First Name ____________________

Home Address ____

City ____________________ Province/Territory ______________ Postal Code __________

Country ____________________ Date of Birth ____________________
(Month Day Year)

Home Phone (_____) ________ - ____________ Work Phone (_____) ________ - ________

Relationship to HCV Infected Class Member ________________________________

Dependant is a: ❑ A Mentally Incompetent Adult ❑ A Minor

Living with the HCV Infected Person at the time of death: ❑ Yes

____
Date Signed (Month Day Year)

____
Signature of Dependant or personal representative of minor/mentally incompetent adult Dependant

Dependant #3

Dependant Last Name____________________ Dependant First Name ____________________

Home Address ____

City ____________________ Province/Territory ____________ Postal Code __________

Country ____________________ Date of Birth ____________________
(Month Day Year)

Home Phone (____) ______ - ________ Work Phone (____) ______ - ______

Relationship to HCV Infected Class Member ____________________________

Dependant is a: ❑ A Mentally Incompetent Adult ❑ A Minor

Living with the HCV Infected Person at the time of death: ❑ Yes

____
Date Signed (Month Day Year)

____
Signature of Dependant or personal representative of minor/mentally incompetent adult Dependant

Dependant #4

Dependant Last Name____________________ Dependant First Name ____________________

Home Address ____

City ____________________ Province/Territory ____________ Postal Code __________

Country ____________________ Date of Birth ____________________
(Month Day Year)

Home Phone (____) ______ - ________ Work Phone (____) ______ - ______

Relationship to HCV Infected Class Member ____________________________

Dependant is a: ❑ A Mentally Incompetent Adult ❑ A Minor

Living with the HCV Infected Person at the time of death: ❑ Yes

____
Date Signed (Month Day Year)

____
Signature of Dependant or personal representative of minor/mentally incompetent adult Dependant

Dependant #5

Dependant Last Name____________________________ Dependant First Name ________________________________

Home Address ____

City ___________________________________ Province/Territory __________________ Postal Code ______________

Country ____ Date of Birth ____
(Month Day Year)

Home Phone (________) ____________ - ___________________ Work Phone (________) ____________ - ___________

Relationship to HCV Infected Class Member ____

Dependant is a: ❑ A Mentally Incompetent Adult ❑ A Minor

Living with the HCV Infected Person at the time of death: ❑ Yes

____
Date Signed (Month Day Year)

____
Signature of Dependant or personal representative of minor/mentally incompetent adult Dependant

Dependant #6

Dependant Last Name____________________________ Dependant First Name ________________________________

Home Address ____

City ___________________________________ Province/Territory __________________ Postal Code ______________

Country ____ Date of Birth ____
(Month Day Year)

Home Phone (________) ____________ - ___________________ Work Phone (________) ____________ - ___________

Relationship to HCV Infected Class Member ____

Dependant is a: ❑ A Mentally Incompetent Adult ❑ A Minor

Living with the HCV Infected Person at the time of death: ❑ Yes

____
Date Signed (Month Day Year)

____
Signature of Dependant or personal representative of minor/mentally incompetent adult Dependant

Dependant #7

Dependant Last Name____________________________ Dependant First Name ________________________________

Home Address ____

City ___________________________________ Province/Territory __________________ Postal Code ______________

Country ____ Date of Birth ____
(Month Day Year)

Home Phone (________) ____________ - ___________________ Work Phone (________) ____________ - ___________

Relationship to HCV Infected Class Member ____

Dependant is a: ❑ A Mentally Incompetent Adult ❑ A Minor

Living with the HCV Infected Person at the time of death: ❑ Yes

____
Date Signed (Month Day Year)

____
Signature of Dependant or personal representative of minor/mentally incompetent adult Dependant

Dependant #8

Dependant Last Name____________________________ Dependant First Name ________________________________

Home Address ____

City ___________________________________ Province/Territory __________________ Postal Code ______________

Country ____ Date of Birth ____
(Month Day Year)

Home Phone (________) ____________ - ___________________ Work Phone (________) ____________ - ___________

Relationship to HCV Infected Class Member ____

Dependant is a: ❑ A Mentally Incompetent Adult ❑ A Minor

Living with the HCV Infected Person at the time of death: ❑ Yes

____
Date Signed (Month Day Year)

____
Signature of Dependant or personal representative of minor/mentally incompetent adult Dependant