

**Form 9 - Instructions**  
**Past Loss of Income and/or Loss Of Support**

**To be completed by:**

- (a) A living HCV Infected Class Member at Disease Level 4 or higher whose infection with HCV has caused Past Loss of Net Income prior to attaining age 65; **OR**
- (b) The HCV Personal Representative of a living HCV Infected Class Member who is a minor or a mentally incompetent adult at Disease Level 4 or higher whose infection with HCV has caused Past Loss of Net Income prior to attaining age 65. Please note that income loss payments are not generally payable until an HCV Infected Class Member attains the age of major in the province where he or she resides; **OR**
- (c) The HCV Personal Representative of a deceased HCV Infected Class Member who died on or after January 1, 1999, at Disease Level 4 or higher and whose infection with HCV had caused Past Loss of Net Income prior to attaining age 65; **OR**
- (d) The Dependant(s) of a deceased HCV Infected Class Member who died either before or after January 1, 1999, up to the date that the HCV Infected Class Member would have reached age 65. Dependents are eligible only if the HCV Infected Class Member had attained Disease Level 4 or higher prior to death, and HCV materially contributed to his or her death.

**Section A – Personal Information**

**Lines 1, 2 or 3**

- If you are a disabled HCV Infected Class Member described in (a) above, complete line 1 and go to line 4.
- If you are a claimant described in (b) or (c) above, complete line 1 about the HCV Infected Class Member and line 2 about yourself and go to line 4.
- If you are a claimant described in (d) above, complete line 1 about the HCV Infected Class Member and line 3 about yourself and go to line 4.

**Line 4**

- Identify what type of claimant you are and what type of claim you are making.

**Section B – Past Loss Of Income and/or Loss Of Support**

**Questions 1(a), (b), (c)**

These questions help determine whether the HCV Infected Class Member's ability to generate an income earnings history was prevented because of the infection with HCV for one of the following reasons:

- 1) the HCV Infected Class Member was infected before he or she reached the age of 18; and/or
- 2) the HCV Infected Class Member was infected while he or she was in full-time attendance at an accredited educational institution, and before he or she entered the workforce on a permanent and full-time basis.

**Section C – Disability Benefits**

**Question 1 (i), (ii)**

Insurance benefits and income replacement benefits such as Canada Pension Plan benefits, Quebec Pension Plan benefits, workers compensation plan benefits or private sickness, accident or disability insurance benefits may be deductible from loss of income claims. Please fill out this section if applicable.

**Section D – Non - Taxable Disability Benefits**

**Question 1 (i), (ii)**

Non-taxable disability benefits from a private insurance plan, a workers compensation plan and employer's disability plan or any other sickness, accident or disability insurance plan. Please fill out this section if applicable.

## Section E – Past Loss Of Income and/or Loss Of Support

**Normal Employment** means employment for wages, salary, and/or commissions, but does not include Related Employment or Self-Employment as defined below.

**Related Employment** means employment by a spouse, by a company owned by a spouse, or under any other circumstances where the HCV Infected Class Member is exempt from Employment Insurance Contributions, but does not include Self-Employment income as defined below.

**Self-Employment** means operation of a business, professional practice or other venture in which the HCV Infected Class Member is a partner or the sole proprietor, including a business, professional practice or other venture which is operated through a limited company and in which the HCV Infected Class Member is effectively self-employed.

### **Pre-Claim Income**

- If the disabled HCV Infected Class Member is living or if the Claim is being made by the HCV Personal Representative of a deceased HCV Infected Class Member who died on or after January 1, 1999. You must choose three consecutive years of Pre-Claim Income prior to the entitlement to Loss of Income (date of disability) as indicated by the Treating Physician and fill out the Pre-Claim Income Information Section as indicated. Attach complete Federal and Québec, if resident in Québec, Income **Tax Returns and Notices of Assessment** for those years and/or Income Tax Return Information-Regular(s) for those years.
- If the HCV Infected Class Member is deceased and a Claim is being made by Dependants, “Pre-Claim Income” means income earned in any three consecutive years prior to death. Choose three consecutive years of Pre-Claim Income and fill out the Pre-Claim Information Section as indicated. Attach complete Federal and Québec, if resident in Québec, **Income Tax Returns and Notices of Assessment** for those years and/or Income Tax Return Information Regular(s) for those years.
- Note 1: The average income for the three consecutive pre-claim years will be indexed for inflation. The indexation adjustments for each possible three-year period, is attached to these instructions. When choosing the three consecutive Pre-Claim Income years, you should use the chart to determine the indexation impact to ensure that you have selected the most favorable three-year period.
- Note 2: A claimant may submit evidence to establish that on the balance of probabilities, the earned income for any Pre-Claim Income year would have been higher than the average of the three consecutive years but for the HCV Infected Class Member’s infection with HCV.
- Note 3: If the claimant was actively involved, owned or partially owned a corporation, corporate tax returns (T2’s), corporate Notices of Assessments and financial statements must be provided.

### **Post-Claim Income**

- If the disabled HCV Infected Class Member is living or if the Claim is being made by the HCV Personal Representative of a deceased HCV Infected Class Member who died on or after January 1, 1999. “Post-Claim Income” means income earned **after** the HCV Infected Class Member’s entitlement to Loss of Net Income (date of disability) as indicated by the Treating Physician. **Attach complete Federal and Québec, if resident in Québec, Income Tax Returns and Notices of Assessment for those years and/or Income Tax Return Information-Regular(s) for those years.**

**Your claim will be processed more quickly if you attach a complete copy of all required Federal and Québec, if resident of Québec, income tax returns and notices of assessment and/or income tax return Information – Regular(s).**

If you do not have complete Income Tax Returns and Notices of Assessment and/or Income Tax Return Information-Regular(s) for any of the required years, follow these steps in order of priority:

1. Contact the HCV Infected Class Member’s accountant or family members to see if they have or can obtain the required Income Tax Returns, Notices of Assessment and/or Income Tax Return Information-Regular(s). If that is possible, obtain them and send them in with the Loss of Income Form.

2. If you still do not have the complete Income Tax Returns and Notices of Assessment, call the Canada Revenue Agency at 1-800-959-8281 and request that they send you a copy of the required Income Tax Returns and Notices of Assessment and/or Income Tax Return Information-Regular forms. Call 1-800-267-6299 to make similar requests to the Ministère du revenu du Québec.

3. If the Canada Revenue Agency (and the Ministère du revenu du Québec, if applicable) cannot provide the Income Tax Returns and Notices of Assessment and/or Income Tax Information-Regular(s), request a Tax Summary for each of the required incomplete years.

## **Section F – Declaration**

A disabled HCV Infected Class Member, the HCV Personal Representative of a living disabled HCV Infected Class Member who is a minor or mentally incompetent adult, or the HCV Personal Representative who is making a loss of income claim on behalf of the estate of a deceased HCV Infected Class Member must complete Section F.

If the Claim is made by the Dependents of a deceased HCV Infected Class Member for post-death loss of support only, go to Section G.

## **Section G – Dependents Chart - Post-Death Loss of Support Only**

**The Dependant who has undertaken to submit the Claim must complete this chart. Every Spouse, Child, Parent, Sibling, Grandchild, Grandparent, and every 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 the HCV Infected Class Member's death must be listed on this Chart. Each Dependant or the personal representative of each Dependant who is a minor or a mentally incompetent adult must sign the Dependents Chart.**

As per Section 4.04 of the Settlement Agreement, the amounts payable will be allocated as the Dependents may agree, or failing any agreement, as the Administrator so determines based on the extent of support received by each of the Dependents prior to the death of the HCV Infected Class Member.



**Form 9 - Past Loss of Income and/or  
Loss of Support (Compensation to Dependants)**

Strictly Private and Confidential

**PLEASE READ THE FORM 9 INSTRUCTIONS INCLUDED WITH THIS FORM BEFORE COMPLETING FORM 9.**

**If you wish to claim for Past Loss of Services in the Home instead of Past Loss of Income, you must complete FORM 10. Only one claim type may be made for any period of time.**

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

1) The disabled HCV Infected Class Member is living: if you are 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, complete this form and have your Treating Physician complete the "Disability Section" of the Treating Physician Form (FORM 2) to make a Claim for loss of income.

**OR**

2) The disabled HCV Infected Class Member who died on or after January 1, 1999: the HCV Personal Representative must complete this form and have the HCV Infected Class Member's Treating Physician complete the "Disability Section" of the Treating Physician Form (FORM 2) to claim pre-death loss of income on behalf of the estate of the disabled HCV Infected Class Member who has died.

**AND/OR**

3) The HCV Infected Class Member who died either before or after January 1, 1999: Dependants complete this form to claim post-death loss of support only.

**Section A – Personal Information**

**1. 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/Territorial Health Number \_\_\_\_\_ Province/Territory of Health Plan \_\_\_\_\_

Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

**2. HCV Personal Representative**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ Province/Territory \_\_\_\_\_

Postal Code \_\_\_\_\_ Country \_\_\_\_\_

Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

### 3. Dependant

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ Province/Territory \_\_\_\_\_

Postal Code \_\_\_\_\_ Country \_\_\_\_\_

Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

### 4. Claimant Type

- Living disabled HCV Infected Class Member
- HCV Personal Representative for the living disabled HCV Infected Class Member who is a minor or mentally incompetent adult
- HCV Personal Representative for the disabled HCV Infected Class Member who is deceased – pre-death loss of income
- Dependant of the deceased HCV Infected Class Member – post-death loss of support

### Section B – Past Loss of Income and/or Loss of Support

#### 1. HCV Infected Class Member

a) Was the disabled HCV Infected Class Member working prior to his or her infection with HCV?

- Yes     No

b) Was the disabled HCV Infected Class Member infected before his or her eighteenth birthday?

- Yes     No

c) Was the disabled HCV Infected Class Member 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 \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ Province/Territory \_\_\_\_\_ Postal Code \_\_\_\_\_

Date Last Attended \_\_\_\_\_ Program and Level \_\_\_\_\_  
(Month Day Year)

Date of Completion of Studies or Projected Date of Completion \_\_\_\_\_  
(Month Day Year)

Is the HCV Infected Class Member now attending school?     Yes     No

**Section C - Disability Benefits**

1. Is/was the disabled HCV Infected Class Member receiving disability benefits from the Canada Pension Plan or the Québec Pension Plan, a workers compensation plan or any other sickness, accident or disability insurance plan?

Yes     No

If "Yes", complete the following information:

i) Name of Benefit Provider \_\_\_\_\_

Mailing Address of Benefit Provider \_\_\_\_\_

Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Policy Number \_\_\_\_\_

Date Commenced \_\_\_\_\_ Amount per Month \$ \_\_\_\_\_  
(Month Day Year)

ii) Name of Benefit Provider \_\_\_\_\_

Mailing Address of Benefit Provider \_\_\_\_\_

Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Policy Number \_\_\_\_\_

Date Commenced \_\_\_\_\_ Amount per Month \$ \_\_\_\_\_  
(Month Day Year)

**Section D - Non-Taxable Disability Benefits**

1. Is/was the disabled HCV Infected Class Member receiving any non-taxable disability benefits from a private insurance plan, a workers compensation plan, an employer's disability plan or any other sickness, accident or disability insurance plan?

Yes     No

If "Yes", complete the following information:

i) Name of Benefit Provider \_\_\_\_\_

Mailing Address of Benefit Provider \_\_\_\_\_

Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Policy Number \_\_\_\_\_

Date Commenced \_\_\_\_\_ Amount per Month \$ \_\_\_\_\_  
(Month Day Year)

ii) Name of Benefit Provider \_\_\_\_\_

Mailing Address of Benefit Provider \_\_\_\_\_

Phone Number \_\_\_\_\_ Policy Number \_\_\_\_\_

Date Commenced \_\_\_\_\_ Amount per Month \$ \_\_\_\_\_  
(Month Day Year)

Please attach all documentation regarding the above disability benefit.

## Section E – Past Loss of Income and/or Loss Of 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 Class Member's Pre-Claim Income information for three (3) consecutive years of your choosing, so long as the three pre-claim years are before the HCV Infected Class Member's entitlement for Loss of Income (date of disability) as requested in the table below, unless the HCV Infected Class Member has no pre-claim employment income history.

**Year 1:** \_\_\_\_\_ (calendar year) Pre-Claim **gross** earned income amount for:

Normal Employment: \$ \_\_\_\_\_

Related Employment: \$ \_\_\_\_\_

Self-Employment: \$ \_\_\_\_\_

**Year 2:** \_\_\_\_\_ (calendar year) Pre-Claim **gross** earned income amount for:

Normal Employment: \$ \_\_\_\_\_

Related Employment: \$ \_\_\_\_\_

Self-Employment: \$ \_\_\_\_\_

**Year 3:** \_\_\_\_\_ (calendar year) Pre-Claim **gross** earned income amount for:

Normal Employment: \$ \_\_\_\_\_

Related Employment: \$ \_\_\_\_\_

Self-Employment: \$ \_\_\_\_\_

### **IMPORTANT**

- Attach the complete Federal and Québec, if a resident of Québec, Income Tax Return (T1 General) and Notice of Assessment or Income Tax Return Information-Regular for each year chosen above.
- If you are unable to provide a copy of the HCV Infected Class Member's complete Income Tax Return and Notice of Assessment or Income Tax Return Information-Regular for the years selected above, please obtain a Tax Summary from Canada Revenue Agency (and the Ministère du Revenu du Québec, if required) for the years.
- If the HCV Infected Class Member was actively involved or owned a corporation in the years above, please also provide complete T2 Corporate Tax Returns and Corporate Notices of Assessments.

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 Class Member's Post-Claim income tax 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 Class Member is deceased and a pre-death claim for loss of income** is being made, you must provide all relevant tax information for the deceased's Post-Claim Years up to and including the year of death.

Attach the complete Federal and Québec, if a resident of Québec, Income Tax Return and Notice of Assessment or Income Tax Return Information-Regular for each Post-Claim Income year, including the year of death.

**If the HCV Infected Class Member was actively involved or owned a corporation in the years above**, also provide complete T2 Corporate Tax Returns and Corporate Notices of Assessments.

Failure to provide the required documentation, which includes the Dependants Chart, will delay the processing of your claim.

## Section F – Declaration (Post-Death Loss Only – Go To Section G)

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

\_\_\_\_\_  
Date Signed (MM/DD/YYYY)

\_\_\_\_\_  
Signature of HCV Infected Class Member or  
HCV Personal Representative

## Section G - 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 Class Member 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 Dependants Chart of FORM 9.
- 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, 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 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 9 and supporting documentation to the Administrator.

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, and send 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, including signed original counterparts, with the Administrator in a single submission.

Failure to provide the required documentation, which includes 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 Dependents 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

\_\_\_\_\_  
Date Signed (MM/DD/YYYY)

\_\_\_\_\_  
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

\_\_\_\_\_  
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

\_\_\_\_\_  
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

\_\_\_\_\_  
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

\_\_\_\_\_  
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

\_\_\_\_\_  
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

\_\_\_\_\_  
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

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

\_\_\_\_\_  
Signature of Dependant or personal representative  
of minor/mentally incompetent adult Dependant