



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

\$72,000 Fixed Payment where the Primarily Infected Hemophiliac (or person with Thalassemia Major) also infected with HIV died prior to January 1, 1999
For use where one or more of the Claimants is a Minor or a Mentally Incompetent Adult
Strictly Private and Confidential

APPROVED HCV PERSONAL REPRESENTATIVE 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:

PLEASE READ THE FORM INSTRUCTIONS; THE DEFINITIONS INCLUDED WITH THIS FORM AND THE ESTATE CLAIMS FLOW CHARTS CAREFULLY BEFORE COMPLETING THIS FORM.

A HEMO 22M Form is to be completed jointly by the Approved HCV Personal Representative of the deceased Primarily Infected Hemophiliac (or person with Thalassemia Major) also infected with HIV and by every living Family Member and/or Dependant who is a Spouse, Child, Parent, Sibling, Grandparent or Grandchild of the deceased and every living Dependant who is a former Spouse of the deceased to whom the deceased Primarily Infected Hemophiliac (or person with Thalassemia Major) was providing support or was under a legal obligation to provide support on the date of the deceased's death (collectively "the Claimants").

Do not use Form HEMO 22M unless one or more of the Claimants is a minor or a mentally incompetent adult. Call the Administrator to request the Form HEMO 22.

SECTION A – PERSONAL INFORMATION

HCV INFECTED HEMOPHILIAC (OR PERSON WITH THALASSEMIA MAJOR)

1.	First Name	Middle Name/Initial	Last Name	
	Home Address at time of death	City	Province/Territory	Postal Code

APPROVED HCV PERSONAL REPRESENTATIVE

2.	First Name	Middle Name/Initial	Last Name	
	Home Address	City	Province/Territory	Postal Code

SECTION B – CONSENT TO \$72,000 FIXED PAYMENT

The \$72,000 fixed payment is the only amount available under the Plan for Claimants, unless they have satisfactory medical proof that the death of the Primarily Infected Hemophiliac (or person with Thalassemia Major) also infected with HIV was caused by his or her infection with HCV.

Each Claimant must consent to share the \$72,000 fixed payment available pursuant to Section 5.01 (4) of the Hemophiliac HCV Plan.

The \$72,000 fixed **payment will be allocated** by the Administrator in **accordance with a Court approved protocol** or, in some cases, by the Courts.

3.	<p>All persons signing the Chart which is part of this Form (including counterparts as described in paragraph 7 of the Instructions) agree and consent to share the \$72,000 fixed payment available under section 5.01(4) of the Hemophiliac HCV Plan in full satisfaction of all claims pursuant to the Plan except for:</p> <ul style="list-style-type: none"> a) any claims a person may have if he/she qualifies as a Secondarily-Infected Person who is a Spouse of a deceased Primarily-Infected Hemophiliac (or person with Thalassemia Major) in respect of his/her own HCV infection; or b) any claims a person might have if he/she qualifies as a Secondarily-Infected Person who is a Child of a deceased Primarily Infected Hemophiliac (or person with Thalassemia Major) in respect of his/her own HCV infection. <p>EACH CLAIMANT MUST CONFIRM CONSENT BY MARKING AN "X" IN THE CERTIFICATION COLUMN ON THE CHART</p>
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SECTION C – DECLARATIONS

4. All persons signing the Chart which is part of this Form (including counterparts as described in paragraph 7 of the Instructions) declare that they do not know of any living Family Member and/or Dependant who is a Spouse, Child, Parent, Sibling, Grandchild or Grandparent of the deceased Primarily-Infected Hemophiliac (or person with Thalassemia Major) or of any living Dependant who is a former Spouse of the deceased Primarily-Infected Hemophiliac (or person with Thalassemia Major) to whom the deceased was providing support or was under a legal obligation to provide support on the date of the death, other than the persons listed in the Chart.

5. All persons in signing the Chart acknowledge that the \$72,000 fixed payment will be allocated to the Estate and the Claimants by the Administrator in accordance with a Court approved protocol or, in some cases, by the Court.

EACH CLAIMANT MUST CONFIRM CONSENT BY MARKING AN “X” IN THE CERTIFICATION COLUMN ON THE CHART

SECTION D – CHART

The Approved HCV Personal Representative must write the name of every living Family Member and/or Dependant who is a Spouse, Child, Parent, Sibling, Grandchild or Grandparent of the deceased Primarily Infected Hemophiliac (or person with Thalassemia Major) and every living Dependant who is a former Spouse of the deceased Primarily Infected Hemophiliac (or person with Thalassemia Major) to whom the deceased Primarily-Infected Hemophiliac (or person with Thalassemia Major) was providing support or was under a legal obligation to provide support on the date of the deceased’s death, in the Chart and list the required information.

The Administrator cannot process the election until it receives a completed Form HEMO 22M and the Chart signed by all Claimants or, in the case of a minor or a mentally incompetent adult, by his or her Personal Representative. **See HEMO 22M – Instructions paragraph 7 for information about signing counterparts.**

The 1986-1990 Hepatitis C Claims Centre - Tel: 1-877-434-0944

**APPROVED HCV PERSONAL REPRESENTATIVE PLEASE
AFFIX HERE ONE OF THE PRE-PRINTED
LABELS PROVIDED**

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CORRECTIONS ONLY:
Write any name and address corrections below, if any corrections are necessary:

CERTIFICATION-Each Claimant or, in the case of a minor or mentally incompetent adult, his or her Personal Representative must read, sign and date this Chart in the presence of a witness. BY signing this Chart, I certify that: (a) I consent to share the \$72,000 fixed payment as the courts direct; (b) I do not know of any living Family Member and/or Dependant who is a Spouse, Child, Parent, Sibling, Grandchild or Grandparent of the deceased Primarily Infected Hemophiliac (or person with Thalassemia Major) or of any living Dependant who is a former Spouse of the deceased to whom the Primarily Infected Hemophiliac (or person with Thalassemia Major) was providing support or was under a legal obligation to provide support on the date of the deceased's death, other than the persons named below; (c) the information provided in this Chart is true and correct to the best of my knowledge, information and belief; and (d) I am not making any false or exaggerated claims to obtain benefits.

CHART								
Name of Claimant	Home Address	Date of Birth D/M/Y	Social Insurance Number	Relationship to HCV Infected Hemophiliac (or person with Thalassemia Major)	Signature of Claimant or Personal Representative of a minor or mentally incompetent adult	Certification	Date DD/MM/YY	Witness
		/ /				<input type="checkbox"/> Yes I have read, understand and give the Certification set out above	/ /	
								Signature of Witness
								Print Name
		/ /				<input type="checkbox"/> Yes I have read, understand and give the Certification set out above	/ /	
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CHART – CONTINUED

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