



Election for \$50,000 Fixed Payment for Primarily-Infected Hemophiliac (or person with Thalassemia Major) also infected with HIV who is or was alive on or after January 1, 1999

Strictly Private and Confidential

CORRECTIONS ONLY:

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

**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.

PLEASE READ THE INSTRUCTIONS, NOTABLY PARAGRAPHS 3 and 4 CAREFULLY WHEN COMPLETING THIS FORM.

This form is to be completed by the Primarily-Infected Hemophiliac (or person with Thalassemia Major) who is also infected with HIV or, if he or she is a minor or mentally incompetent adult or has died, on his or her behalf by his or her Approved HCV Personal Representative.

SECTION A – PERSONAL INFORMATION

PRIMARILY-INFECTED HEMOPHILIAC (OR PERSON WITH THALASSEMIA MAJOR)

1.	First Name	Middle Name/Initial	Last Name	
	Home Address	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 – ELECTION AND WAIVER

The election of the \$50,000 fixed payment is in full satisfaction of all past, present or future claims including all potential claims by the Estate, Family Members and/or Dependants of the Primarily-Infected Hemophiliac (or person with Thalassemia Major) also infected with HIV. No further amounts will be paid.

3.	I declare that the Primarily-Infected Hemophiliac (or person with Thalassemia Major) is or was also infected with HIV.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	I elect a \$50,000 fixed payment in complete satisfaction of all claims under the Hemophiliac HCV Plan in respect of the Primarily-Infected Hemophiliac (or person with Thalassemia Major), also infected with HIV.	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	I make this election with full knowledge that by electing the \$50,000 fixed payment neither the Primarily-Infected Hemophiliac (or person with Thalassemia Major), nor his or her Estate, Dependants or Family Members will be entitled to any further payments from the Hemophiliac HCV Plan.	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION C –CERTIFICATION

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

Date Signed

Signature of HCV Infected Person or Approved HCV Personal Representative

Signature of Witness

