The 1986-1990 Hepatitis C Claims Centre
PO Box 2370, Station D
Ottawa (Ontario) K1P 5W5
Canada
Tel: 1 877 434-0944
www.hepc8690.ca

Loss of Income/Support – GEN 10 RENEWAL FORM

Strictly Private and Confidential

CLAIMANT PLEASE AFFIX HERE ONE OF THE PREPRINTED LABELS PROVIDED

* If you do not have the labels, call 1 877 434-0944 for instructions.

CORRECTIONS ONLY

Write any name, address or telephone number corrections below, if any are necessary.

PLEASE READ THE INSTRUCTIONS INCLUDED WITH THIS FORM CAREFULLY BEFORE COMPLETING THIS FORM.

This Form is to be completed by the HCV Infected Person or his or her HCV Personal Representative. If you are the HCV Infected Person, please complete line 1. If you are the HCV Personal Representative of the HCV Infected Person, please complete line 1 about the HCV Infected Person and line 2 about yourself.

If you are a Dependant of the HCV Infected Person, please complete line 1 about the HCV Infected Person and line 3 about yourself.

SECTION A – PERSONAL INFORMATION

HCV INFECTED PERSON

1.

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

APPROVED HCV PERSONAL REPRESENTATIVE

2.

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

DEPENDANT

3.

First Name	Middle Name/Initial	Last Name	
Home Address	City/Municipality	Province/Territory	Postal Code
Date of Birth (DD/MM/YYYY)		Telephone Number	

SECTION B – CLAIM DESCRIPTION

4.

Indicate claimant type:	Indicate Claim type:
☐ **Living disabled** HCV Infected Person ☐ Approved HCV Personal Representative for the living disabled HCV Infected Person who is a **minor or mentally incompetent adult** ☐ **Dependant** of the deceased HCV Infected Person – loss of support	☐ Loss of Income ☐ Loss of Support To Claim compensation for **Loss of Services in the Home** you must complete GEN 12 – RENEWAL MASTER FORM. **Only one type of loss can be claimed for any period of time**.

SECTION C – DISABILITY BENEFITS

5. Is/was the disabled HCV Infected Person receiving disability benefits from the Canada Pension Plan or the Quebec Pension Plan, a workers compensation plan or any other sickness, accident or disability insurance plan? If yes, complete the following information:

Name and Phone # of Benefit Provider	Mailing Address of Benefit Provider	Policy Number	Date Commenced DD/MM/YYYY	Amount per Month
			/ /	$
( ) -				
			/ /	$
( ) -				

Please attach all documentation regarding the above disability benefit information.

SECTION D – LOSS OF INCOME / SUPPORT

Year: 2001

Province of Residence on December 31 That Year	Name of Employer		
Address of Employer	City/Municipality	Province/Territory	Postal Code
Position	Essential Task		
Number of Regular Hours Per Week:	☐ Full-time ☐ Part-time		☐ Contract
Did you have a spouse? ☐ Yes ☐ No If so, indicate the date of birth and forward your spouse's Income Tax Return			DD/MM/YYYY / /
Do you have any Dependants?			☐ Yes ☐ No
If so, how many Dependants do you have?			

List the name and date of birth of your Dependant(s):

Name of Dependant	DD/MM/YYYY	Is the Dependant Disabled?
	/ /	☐ Yes ☐ No
	/ /	☐ Yes ☐ No
	/ /	☐ Yes ☐ No
	/ /	☐ Yes ☐ No
	/ /	☐ Yes ☐ No

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 Person's Post-Claim Income Information.

If the HCV Infected Person is deceased and a Claim by Dependants for loss of support is being made, only certain boxes need to be completed. Please read the *Instructions* page in this regard carefully.

Attach the complete Federal and Quebec, if a resident of Quebec, Income Tax Return and Notice of Assessment for this Post-Claim Income year. Dependants who are claiming loss of support must attach the T4A(P) (and, if a resident in Quebec, the RL-2) benefit statement for this Post-Claim year.

Failure to provide income documentation requested throughout will delay the processing of your Claim.

Gross Earned Income for the Post-Claim Year

Post-Claim Gross Earned Income	**Normal Employment**	**Related Employment**	**Self-Employment**
	$	**$**	**$**
(Un) Employment Insurance: Ei/Ui or CPP/QPP Disability Benefits	**Ei/Ui**	**Ei/Ui**	**Ei/Ui**
	$	**$**	**$**
	CPP/QPP	**CPP/QPP**	**CPP/QPP**
	$	**$**	**$**
Income Continuation or Disability Payments	**Taxable**	**Taxable**	**Non-Taxable**
	$	**$**	**$**
All Other Compensation	**Taxable**	**Taxable**	**Non-Taxable**
	$	**$**	**$**

Alimony or Maintenance Payments deducted for Tax purposes? (enter amount)	$
Disability Tax Credit claimed?	☐ Yes ☐ No

SECTION E – DECLARATION BY CERTAIN CLAIMANTS, IF APPLICABLE

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 of Signature

Signature of the disabled HCV Infected Person or the Approved HCV Personal Representative or Dependant

SECTION F – DEPENDANTS CHART 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 Person 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 Dependant Chart of the GEN 10 RENEWAL 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 **legal Guardian**, and provide a copy of the court order appointing such Guardian.

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 loss of support be approved, the adult will be contacted by the Administrator regarding payment.

After this Chart is fully completed and signed and supporting documentation is collected, the Dependant must return this GEN 10 RENEWAL FORM 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, date and sign the Dependants Chart in front of a witness. 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.

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APPROVED HCV PERSONAL REPRESENTATIVE PLEASE AFFIX HERE ONE OF THE PREPRINTED LABELS PROVIDED
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DEPENDANTS CHART

CERTIFICATION – Each Dependant to whom the HCV Infected Person was providing support or was under a legal obligation to provide support must read and sign this Dependants Chart.

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 Person 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 Claims to obtain benefits.

Name of Dependant	Dependant is a mentally incompetent adult	Dependant is a minor	Home Address and Telephone Number (if the Dependant is a mentally incompetent adult or a minor include name of legal Guardian or adult with care custody and control)	Date of Birth D/M/YY	Social Insurance Number	Relationship to HCV Infected Person	Signature of Dependant or Personal Representative of minor/mentally incompetent adult Dependant
	☐ Yes	☐ Yes		/ /			
	☐ Yes	☐ Yes		/ /			
	☐ Yes	☐ Yes		/ /			
	☐ Yes	☐ Yes		/ /			