

The 1986-1990 Hepatitis C Claim Centre

P.O. Box 2370, Station D

Ottawa Ontario, Canada

K1P 5W5

Tel: 1-877-434-0944

GEN 10B



**Supplemental Income/Information Form – PROVINCIAL**  
**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 corrections below, if any corrections are necessary:


Complete **ONLY** if the HCV Infected Person was a **resident** of ONTARIO, BRITISH COLUMBIA, SASKATCHEWAN, MANITOBA, QUEBEC OR NOVA SCOTIA in any Pre-Claim and/or Post-Claim Income year for which you are **unable to provide complete Federal and Quebec, if resident in Quebec, Income Tax Returns** and Notices of Assessment. This Form is not required if the HCV Infected Person was a resident of any other province or territory in those Pre-Claim and/or Post-Claim Income years.

- If the HCV Infected Person is **living**, he or she must complete this Form; OR
- If the HCV Infected Person is living but is a **minor or mentally incompetent adult**, his or her Approved HCV Personal Representative must complete this Form; OR
- If the HCV Infected Person is **deceased**, the Approved HCV Personal Representative claiming **pre-death loss of income** on behalf of the Estate must complete the Pre-Claim Income section and the Post-Claim Income section for each year up to and including the year of death; AND/OR
- If there is a **post-death loss of support** claim, the **Dependants** of the deceased must provide information about the Pre-Claim Income years only.

**ONTARIO, BC, SASK., MANITOBA, QUEBEC AND NOVA SCOTIA RESIDENTS ONLY:**

List all of the children of the HCV Infected Person (born in 1965 or after) and their dates of birth and dates of death, if applicable. Also indicate every Pre-Claim or Post-Claim Income year that the HCV Infected Person claimed any child as an Equivalent-to-Spouse.

Child's full name	Date of Birth DD/MM/YYYY	Date of Death DD/MM/YYYY	Year(s) child was claimed as Equivalent-to-Spouse
1.			
2.			
3.			
4.			
5.			
6.			
7.			

List all of the **disabled dependants** of the HCV Infected Person and their dates of birth and dates of death, if applicable. Also indicate every Pre-Claim or Post-Claim Income year any such Dependant was claimed as an Equivalent-to-Spouse.

Disabled dependant's full name	Date of Birth DD/MM/YYYY	Date of Disability DD/MM/YYYY	Date of Death DD/MM/YYYY	Year(s) child Claimed as Equivalent-to-Spouse
1.				
2.				
3.				
4.				
5.				



<b>MANITOBA &amp; QUEBEC RESIDENTS ONLY:</b>	Year
If the HCV Infected Person has/had a <b>spouse</b> for income tax purposes, provide the spouse's year of birth.	19 ____
For the years 1986 to present- is there any Pre-Claim or Post-Claim Income year that the HCV Infected Person's marital status changed due to <b>1) marriage and/or 2) divorce and/or 3) death</b> ? Please provide details below: _____ _____ _____	

<b>MANITOBA RESIDENTS ONLY:</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
For any Pre-Claim or Post-Claim Income year(s) from 1988 to present - did the HCV Infected Person claim disability for himself/herself or for his/her dependants?		
If yes, indicate the number of people for whom disability was claimed, including the HCV Infected Person, along with the respective Pre-Claim and/or Post-Claim Income years.		
Year(s) Resident in Manitoba on Dec. 31	Number of People	
(start 1988)		

<b>QUEBEC RESIDENTS ONLY:</b>		
For the year(s) 1988 to present - if the HCV infected Person has/had a spouse, indicate the amount of the <b>Tax Reduction for Families</b> claimed by the spouse for each Pre-Claim and/or Post-Claim Income year.		
Year(s) Resident in Quebec on Dec. 31	Amount Claimed by Spouse	
(start 1988)	\$	
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	
If the HCV Infected Person did <b>not</b> have a spouse in any of the Pre-Claim or Post-Claim Income years, did/does the HCV Infected Person <u>live with anyone</u> other than dependant children in any of those years?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, indicate for which Pre-Claim and/or Post-Claim Income years for the <u>1988-1997</u> period only.		



**QUEBEC RESIDENTS ONLY:**

If the HCV Infected Person has/had any dependant children, indicate the amount of the **designated child's** income and the **Income Security Benefits** received for each Pre-Claim and/or Post-Claim Income year.

Year(s) Resident in Quebec on Dec. 31	Designated Child's Income	Income Security Benefits
(start 1988)	\$	
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	

**NOVA SCOTIA RESIDENTS ONLY:**

For the years 1994 to present, if the HCV Infected Person has/had a spouse, did the spouse claim the tax reduction? Yes  No

If yes, please indicate each Post-Claim Income year(s) where the Nova Scotia tax reduction was claimed by the spouse:  
 \_\_\_\_\_  
 \_\_\_\_\_

**BRITISH COLUMBIA RESIDENTS ONLY:**

For the years 1991 to present, if the HCV Infected Person has/had a spouse, did the spouse claim the British Columbia Surtax Reduction? Yes  No

If yes, please indicate each Post-Claim Income year(s) where the B.C. Surtax Reduction was claimed by the spouse:  
 \_\_\_\_\_  
 \_\_\_\_\_

List the children for whom the B.C. Surtax Reduction was claimed by the Spouse  
 \_\_\_\_\_

**DECLARATION**

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

\_\_\_\_\_ **Date Signed**

\_\_\_\_\_ **Signature of Claimant**