KPMG Inc. Use Only Claimant No. _____

Application to Pre-1986/Post-1990 Hepatitis C Settlement Fund

Application Form for Adult Family Claimant Not Under Legal Disability

FORM E

1. Personal Information				
Last Name(s)	First name	Middle Initial	Date of birth (day/month/year)	
Social Insurance Number		Provincial/Territorial Health Insurance Number		
Address		City	Province/Territory	Postal Code
Telephone No. (home)		Telephone No. (business) - optional		
Is the person to whom your claim relates:	☐ A **Primarily Infected Claimant**? (a person who received HCV contaminated blood, blood derivatives or blood products in any Canadian province or territory) ☐ A **Secondarily Infected Claimant**? (a person who was infected with HCV through sexual, perinatal or other contact with a Primarily Infected Claimant)			
2. Information about the Primarily or Secondarily Infected Claimant				
Please provide the following information about the Primarily or Secondarily Infected Claimant to whom your claim relates:				
Last Name(s)	First name	Middle Initial	Date of birth (day/month/year)	
Social Insurance Number		Provincial/Territorial Health Insurance Number		
Address		City	Province/Territory	Postal Code
Telephone No. (home)		Telephone No. (business) - optional		
Please indicate your relationship to this Primarily or Secondarily Infected Claimant: ☐ spouse ☐ sibling ☐ child ☐ grandparent ☐ parent ☐ grandchild				
To KPMG Inc.	I understand that the Pre-1986/Post-1990 Hepatitis C Settlement Fund (the "HCV Fund") may be administered by KPMG Inc. and anyone acting on its behalf. I hereby authorize KPMG Inc., or anyone acting on its behalf for the purpose of administering the HCV Fund to collect any necessary personal information to determine my eligibility for the HCV Fund. I consent to the collection, use and disclosure of any personal information necessary to verify the aforementioned information for the purposes of determining my eligibility for the HCV Fund.			
Signature of Family Claimant		**Date**		