KPMG Inc. Use Only Claimant No. ______________________

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

Application Form for Primarily/Secondarily Infected Claimants

FORM A

1. Personal Information (to be completed by all Claimants)

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	
Are you diagnosed with Hepatitis C (HCV)? ☐ Yes ☐ No		Date of diagnosis (day/month/year) - if known	

Are you:

☐ 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. Primarily Infected Claimants (to be completed only by Primarily Infected Claimants)

Did you receive a transfusion in Canada during any or all of the following period(s):

☐ on or before December 31, 1985 ☐ January 1, 1986 - July 1, 1990 ☐ July 2, 1990 - September 28, 1998 ☐ all

In which province/territory did you receive your transfusion(s)?

☐	Newfoundland	☐	Quebec	☐	Alberta	☐	Nunavut
☐	P.E.I.	☐	Ontario	☐	British Columbia		
☐	Nova Scotia	☐	Manitoba	☐	Yukon Territory		
☐	New Brunswick	☐	Saskatchewan	☐	N.W.T.		

Reason for transfusion

Please provide the name(s) of the hospital(s) where transfusion(s) occurred and provide copies of hospital and/or physicians' records documenting the transfusion(s) (REQUIRED).

Name of hospital (1)	Date of transfusion	City	Province/Territory
Name of hospital (2)	Date of transfusion	City	Province/Territory
Name of hospital (3)	Date of transfusion	City	Province/Territory

Are you a hemophiliac? ☐ Yes ☐ No	If **yes**, did you receive blood products in Canada during any or all of the following time periods: ☐ on or before December 31, 1985 ☐ January 1, 1986 - July 1, 1990 ☐ July 2, 1990 - September 28, 1998 ☐ all

3. Secondarily Infected Claimants (to be completed only by Secondarily Infected Claimants)				
Please provide the following information about the Primarily Infected Claimant from whom you contracted HCV:				
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		

How did you contract HCV from this Primarily Infected Claimant?

- ☐ sexual contact
- ☐ perinatal transmission
- ☐ other (specify) ____________________

4. Applications under other Provincial Assistance Plans (to be completed by all Claimants)

If you are a **Primarily Infected Claimant** have you applied for financial assistance under any of the following provincial plans:

The Ontario Hepatitis C Assistance Plan (OHCAP)?	☐ Yes	☐ No
The Quebec Hepatitis C Assistance Plan?	☐ Yes	☐ No
The Manitoba Hepatitis C Assistance program?	☐ Yes	☐ No

If you were accepted as eligible for assistance under any of these plans, please enclose a copy of your notice of acceptance and your file number (REQUIRED).

If you are a **Secondarily Infected Claimant**, did the Primarily Infected Claimant from whom you contracted HCV apply for financial assistance under any of the following provincial plans:

The Ontario Hepatitis C Assistance Plan (OHCAP)?	☐ Yes	☐ No
The Quebec Hepatitis C Assistance Plan?	☐ Yes	☐ No
The Manitoba Hepatitis C Assistance program?	☐ Yes	☐ No

If he/she was accepted as eligible for assistance under any of these plans, please enclose a copy of their notice of acceptance and their file number. This will facilitate the administration of your claim.

5. Physician Information (to be completed by all Claimants)

Please provide the name(s) of the physician(s) you have consulted who have direct knowledge of:

- your receipt of a blood transfusion
- your contact with a Primarily Infected Claimant
- your HCV infection

Name of physician (1): (Physician who will be completing Physician Application) Business Address:	Telephone:
Name of physician (2): Business Address:	Telephone:
Name of physician (3): Business Address:	Telephone:

6. Family Claimants (to be completed by all Claimants)

In Schedule 1 (*List of Possible Family Claimants*) to this application you **must** provide the names and addresses of all living spouses, children, parents, siblings and grandparents who are under the age of 18 or under a legal disability. **This will serve as their applications for compensation under the HCV Fund. Failure to list all such members could result in your future payments being denied.**

You may also add to this list in Schedule 1 the names of living spouses, children, parents, siblings and grandparents who are not under the age of 18 or under a legal disability, as this will facilitate their claims as Family Claimants should they choose to pursue such a claim. **Listing a family member who is not a minor or under a legal disability on Schedule 1 does not constitute an application for comprensation under the HCV Fund on his or her behalf. Each adult Family Claimant who is not under a disability must submit his or her own application using the special form entitled, *Application Form for Adult Family Claimants Not Under a Disability* - FORM E.**

The amounts payable to Family Claimants are deducted from the amounts payable to the related Primary or Secondary Claimants. In this way, each "family unit" will receive the same total payment. The claims of all Family Claimants pertaining to a Primarily or Secondarily Infected Claimant will be paid once; there will be no subsequent payments.

7. Authorizations/Declarations (to be completed by all Claimants)

If the Claimant is less than 18 years of age or under a legal disability at date of application, this form must be signed by a parent or other legal representative. If you are acting as the parent or other legal representative for the Claimant, please sign below and indicate in which capacity.

I am the parent/legal representative of the Claimant, and confirm that I have the legal authority to sign this application, authorization and consent.
☐ parent
☐ legal guardian
☐ other legal representative (specify status) Signature:

If the Claimant is an estate, the application must be signed by the estate's legal representative. If you are acting as the estate's legal representative, please sign below and indicate in which capacity.

I confirm that the Claimant is an estate, and that I have the legal authority to sign this application, authorization and consent.
☐ executor / executrix of the estate
☐ administrator of the estate
☐ other legal representative (specify status) Signature:
Attach a copy of the will, letters of administration or letters probate (REQUIRED).

If the person signing this application is someone other than the Claimant (such as a parent, guardian or other legal representative) please provide your:

Name	Address
Telephone No. (home)	Telephone No. (business) - optional

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 (and/or that of a related claimant) from any of the physician(s) or hospital(s) named on this application or the hospital(s) named by the physician(s), the Canadian Blood Services, Héma-Québec, any of the provincial Hepatitis C compensation plans, or the Hepatitis C January 1, 1986 - July 1, 1990 Class Actions Settlement. 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 and/or a related claimant (i.e., a Secondarily Infected Claimant who may have contracted HCV from me or a Family Claimant).

To the Hospital I, the undersigned, hereby authorize the hospital(s) noted above to disclose to KPMG Inc. and anyone acting on its behalf for the purpose of administering the Pre-1986/Post-1990 Hepatitis C Settlement Fund (the "HCV Fund") any medical or other information relating to my care in its possession and to provide KPMG Inc. and anyone acting on its behalf for the purpose of administering the HCV Fund with copies of any medical records or notes, charts or other information relating to my care, and for so doing this is good and sufficient authority.

Upon completing this application, attach the necessary document(s) to support your claim of eligibility (e.g., hospital records, other medical records or information, a notice of acceptance for compensation from one of the provincial plans etc.). DO NOT SEND ORIGINALS.

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Signature of Claimant / Legal Representative	Date

Schedule 1 to Form A

List of Possible Family Claimants

1. Name of Primarily/Secondarily Infected Claimant	Name:
2. List of Possible Family Claimants	
You **must** provide the names and addresses of all living spouses, children, parents, siblings and grandparents who are under the age of 18 or under a legal disability. **This will serve as their applications for compensation under the HCV Fund. Failure to list all such members could result in your future payments being denied.** You may also add to this list in Schedule 1 the names of living spouses, children, parents, siblings and grandparents who are not under the age of 18 or under a legal disability, as this will facilitate their claims as Family Claimants should they choose to pursue such a claim. **Listing a family member who is not a minor or under a legal disability on Schedule 1 does not constitute an application for compensation under the HCV Fund on his or her behalf. Each adult Family Claimant who is not under a disability must submit his or her own application using the special form entitled,** ***Application Form forAdult Family Claimants Not Under a Disability*** **- FORM E.** **The amounts payable to Family Claimants are deducted from the amounts payable to the related Primary or Secondary Claimants. In this way, each "family unit" will receive the same total payment. The claims of all Family Claimants pertaining to a Primarily or Secondarily Infected Claimant will be paid once; there will be no subsequent payments.**	
Name (1):	Address: ☐ Under the age of 18 ☐ Under a legal disability
Name (2):	Address: ☐ Under the age of 18 ☐ Under a legal disability
Name (3):	Address: ☐ Under the age of 18 ☐ Under a legal disability
Name (4):	Address: ☐ Under the age of 18 ☐ Under a legal disability
Name (5):	Address: ☐ Under the age of 18 ☐ Under a legal disability
Name (6):	Address: ☐ Under the age of 18 ☐ Under a legal disability
Name (7):	Address: ☐ Under the age of 18 ☐ Under a legal disability
Name (8):	Address: ☐ Under the age of 18 ☐ Under a legal disability
Name (9):	Address: ☐ Under the age of 18 ☐ Under a legal disability

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Name (10):	Address: ☐ Under the age of 18 ☐ Under a legal disability
Name (11):	Address: ☐ Under the age of 18 ☐ Under a legal disability
Name (12):	Address: ☐ Under the age of 18 ☐ Under a legal disability
Name (13):	Address: ☐ Under the age of 18 ☐ Under a legal disability
Name (14):	Address: ☐ Under the age of 18 ☐ Under a legal disability
Name (15):	Address: ☐ Under the age of 18 ☐ Under a legal disability
Name (16):	Address: ☐ Under the age of 18 ☐ Under a legal disability
Name (17):	Address: ☐ Under the age of 18 ☐ Under a legal disability
Name (18):	Address: ☐ Under the age of 18 ☐ Under a legal disability
Name (19):	Address: ☐ Under the age of 18 ☐ Under a legal disability
Name (20):	Address: ☐ Under the age of 18 ☐ Under a legal disability
Name (21):	Address: ☐ Under the age of 18 ☐ Under a legal disability
Name (22):	Address: ☐ Under the age of 18 ☐ Under a legal disability
Name (23):	Address: ☐ Under the age of 18 ☐ Under a legal disability
Name (24):	Address: ☐ Under the age of 18 ☐ Under a legal disability
Name (25):	Address: ☐ Under the age of 18 ☐ Under a legal disability