HEPATITIS C AND HIV COMPENSATION TRIBUNAL

APPLICATION FORM FOR COMPENSATION

FORM 111

STATUTORY BASIS OF CLAIM

This application (Form 111) is to be used for claims under the following sections of the Hepatitis C Compensation Tribunal Act 1997 as amended, by any person who is:

1) **Responsible for the care of a person** who has been diagnosed positive for **Hepatitis C** resulting from the use of Human Immunoglobulin-Anti-D, a blood transfusion or blood product and/or diagnosed positive for **HIV** resulting from the use of a relevant blood product, within the State and/or for the care of the children and/or spouses of such persons who have themselves been diagnosed positive for Hepatitis C and/or HIV and

   Who has incurred or will incur **financial loss** or expenses as a direct result of providing such care arising from the person being cared for having contracted Hepatitis C and/or HIV (Sections 4.1.d and 4.1.i of the Act)

2) **Married** to **or** has for a continuous period of not less than three years **lived with** a person who has been diagnosed positive for Hepatitis C resulting from the use of Human Immunoglobulin-Anti-D, a blood transfusion or blood product and/or HIV resulting from the use of a relevant blood product, in respect of the **loss of consortium** of the person, including impairment of sexual relations with the person arising from the risk of transmission of Hepatitis C or HIV (Section 4.1.h of the Act).

A. Details of Applicant

1. **Surname** _____

2. **First Name(s)** _____

3. **Date of Birth** _____
   day month year

4. **Permanent Address** _____

   _____

   _____

5. **Occupation** _____

B. Details of person(s) for whom you are responsible and/or in respect of whom you are claiming a loss of consortium.

6. (a) **Please give the name(s), address(es) and date(s) of birth of the person(s) for whom you are responsible.**

Name	Address	Date of Birth

6. (b) **Name of person in respect of whom you are claiming a loss of consortium.**

_____

7. **Has the person(s) for whom you are responsible and/or in respect of whom you are claiming a loss of consortium, applied to the Tribunal for compensation?**

Yes/No

If Yes provide details of Tribunal reference number and date of hearing.

If No please provide full details of diagnosis for Hepatitis C/HIV, name of Doctor making diagnosis, date of diagnosis and relevant supporting documentation.

8 (a) **Have you previously made a claim to the Tribunal?**

Yes/No

If Yes provide details.

(b) **Did you or the person for whom you are responsible receive payment under the 1991 settlement?**

Yes/No

If Yes provide details.

C. Particulars of any Earnings Lost

9. Have you lost earnings as a result of caring for a person who contracted Hepatitis C/HIV.

Yes/No

If Yes, please give details.

_____

_____

_____

_____

10. Please detail any out of pocket expenses you may have incurred as a result of caring for a person who contracted Hepatitis C/HIV. (exclude any payments received under the ex-gratia expenses scheme operated by the Irish Blood Transfusion Service)

_____

_____

_____

11. If claiming loss of consortium under 4.1 (h) please provide relevant details.

_____

_____

_____

D. Any further relevant matters

12. Have civil proceedings been taken or are such proceedings pending or contemplated?

Yes/No

If Yes, please give details _____

_____

_____

13. Please indicate whether you are:

(a) applying to the Tribunal to have aggravated or exemplary damages assessed by it.

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OR

(b) applying to have an amount (which shall be 20% of the total amount of the award or settlement paid to you) paid out of the Reparation Fund in accordance with Section 11 of the Hepatitis C Compensation Tribunal Act, 1997, as amended.

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Please see Section 4.14 of the Hepatitis C Compensation Tribunal Acts 1997 and 2002 for time limits within which one may make application to the Tribunal.

CERTIFICATE OF AUTHORITY

(a) **I declare that all the information given in this form is true and complete to the best of my knowledge and belief. I undertake to notify the Tribunal of any change of circumstances which may affect the Tribunal's decision as to my entitlement to or the assessment of compensation.**

(b) **I agree to give the Tribunal all reasonable assistance, which they may require, whether in relation to any medical reports or otherwise.**

(c) **I authorise:**

(i) **The Public Departments from which I receive(d) Benefits, or the Health Board from which I receive(d) free health services, or the Blood Transfusion Service Board from which I received payments under the ex-gratia expenses scheme to give the Tribunal information relevant to my application;**

(ii) **My employer(s) to give the Tribunal information as to my earnings and any other matters relevant to my application;**

(iii) **The Voluntary Health Insurance Board to give the Tribunal information in relation to any claim made by me in respect of a medical condition of a person for whom I am responsible resulting from contracting Hepatitis C;**

(iv) **My Accountant (if you are self-employed) to give the Tribunal all information in support of my claim for loss of earnings;**

(v) **The Revenue Commissioners to give the Tribunal all information in respect of my claim for loss of earnings.**

(vi) **My medical practitioner to provide any appropriate medico / legal report.**

(d) **I understand that the Tribunal may notify the authorities mentioned above that I have submitted an application and may inform them of the Tribunal's decision.**

Signature of applicant _____

Date _____

day **month** **year**