

Canadian Thalidomide Survivors Support Program Ongoing Support Payments Form

Please complete this form to tell us how you want to receive your Canadian Thalidomide Survivors Support Program Ongoing Payments. **Any change to your payment preferences will take effect following the Administrator's approval of this form.**

Please check one (1) box: New Enrollment Change Request

Section 1: Thalidomide Survivor Contact Information

First Name:	
Middle Name(s):	
Last Name:	
Date of Birth (mm/dd/yyyy):	
Sex at Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Gender Identity:	<input type="checkbox"/> Man <input type="checkbox"/> Woman <input type="checkbox"/> Other _____
Mailing Address:	
City/Town:	
Province/Territory/State/Country:	
Postal Code/Zip Code:	
Primary Telephone Number:	() -

Section 2: Legally Appointed Personal Representative Information (Leave this section blank if the Survivor does not have a Legally Appointed Personal Representative)

This section is to be completed **only** if you have been **legally** appointed to administer the Survivor's affairs. You **MUST** provide proof of your authority to act as the Personal Representative of the Thalidomide Survivor. Please complete both Section 1 for the Survivor and Section 2 below for yourself.

I have enclosed a certified true photocopy of one (1) of:	Check (✓) the applicable box: <input type="checkbox"/> Authority to Act <input type="checkbox"/> Court Order <input type="checkbox"/> Other: _____ <input type="checkbox"/> Authority to Act was previously submitted to the Administrator and has not changed (If this box is checked, no need to resend Authority to Act).
First Name:	
Last Name:	
Mailing Address:	
City/Town:	
Province/Territory/State/Country:	
Postal Code/Zip Code:	
Primary Telephone Number:	() -
Relationship to Survivor	

Section 3: Please tell us how and when you want to receive your ongoing payments

You must choose between receiving your ongoing payment each year as one lump sum once per year or by installment once per month per year.

When choosing between yearly or monthly payments, please note that in the event of the death of a Survivor after the payment process begins, the Survivor's Estate will be permitted to keep the payment received in the month that the Survivor passed away if the Survivor chose to receive payments monthly. Thereafter Survivor payments would stop to the Estate. If a Survivor chose to receive a lump sum annual amount, the Estate will be permitted to keep the full amount for that year regardless of the date of death of the Survivor. Then Survivor payments would stop.

Please check (✓) the boxes below to tell us when and how you want to receive your ongoing payments:

- In one (1) lump sum once per year by cheque or direct deposit
or
 By installment once per month per year by cheque or direct deposit

Future ongoing payments will continue as indicated unless you tell us otherwise.

Section 4: Please tell us who is to receive the ongoing payments

Payments **will always be** in the name of the Thalidomide Survivor; however, may be sent to another party upon submission of legal documentation authorizing this direction of payment.

Please check (✓) **one (1)** of the boxes below to tell us who is to receive the ongoing payment on behalf of the Survivor:

- Send to Survivor
or
 Send to Personal Representative
or
 Send to Other. Please complete Section 5 on the next page.

QUESTIONS? NEED HELP?

1-877-507-7706 • 1-877-627-7027 (TTY) • www.tsspcanada.ca

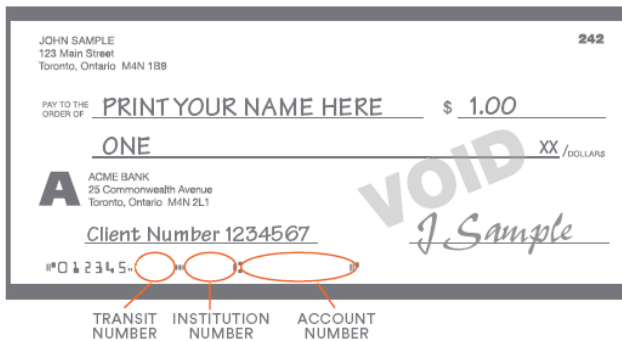
Section 5: Other (Complete this section only if ongoing payments are being sent to someone other than the Survivor or the Personal Representative)

First Name:	
Last Name:	
Mailing Address:	
City/Town:	
Province/Territory/State/Country:	
Postal Code/Zip Code:	
Primary Telephone Number:	() -

Section 6: Payments by Direct Deposit

Complete Section 6 below only if you have chosen to receive your Ongoing Payments by direct deposit rather than by cheque. Please submit a void cheque with your form.

Bank Account Detail (Please answer all boxes)



Institution Name	
Institution Account #	Institution #
Transit #	

Completing this form authorizes the Canadian Thalidomide Survivors Support Program Administrator to deposit my Canadian Thalidomide Survivors Support Program money directly to my _____ Account as detailed above.
(insert name of banking institution)

Survivor/Authorized Representative Signature:

Date: Month: _____ Day: _____ Year: _____

Section 7: Declaration and Signature

Section 7 must be completed by the Thalidomide Survivor or the Personal Representative with the legal authority to act on behalf of the Survivor. Please read the following declaration carefully before signing.

Declaration: I have completed the Canadian Thalidomide Survivors Support Program Ongoing Support Payments form and I understand that the Administrator will be reviewing my form for completeness and may need to contact me to request additional information. I understand that the information provided in this form is to be used to issue my annual ongoing support payments in the manner that I have indicated until I tell the Administrator otherwise.

I agree to the sharing of my personal information, including but not limited to my contact information, with the Administrator, the Government of Canada and necessary authorized third parties, only for the purpose of processing my ongoing support payments.

By signing below, I indicate my agreement to the contents of this Declaration.

Thalidomide Survivor/Personal Representative:

Print Name: _____

Signature: _____

Date: _____
(mm/dd/yyyy)

All Thalidomide Survivors or legally appointed Personal Representatives must sign or sign with a mark in Sections 6 and 7 in the presence of a witness who may be a relative. The witness must complete the Witness information and sign the Witness Declaration below.

Witness' First Name	Witness' Last Name
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City/Town	Province/Territory/State	Country
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Relationship to Thalidomide Survivor/Personal Representative

Witness Declaration: I have witnessed the signature or mark of the Thalidomide Survivor or legally appointed Personal Representative. Where the Thalidomide Survivor or legally appointed Personal Representative signed with a mark, I have read the content of this Canadian Thalidomide Survivors Support Program Ongoing Payment form to the Thalidomide Survivor and/or his/her Personal Representative, who signed with a mark, who understands and confirms the information.

Print Name: _____

Signature: _____

Date: _____
(mm/dd/yyyy)

Please make sure the following has been included with your completed Ongoing Payments Form when returning it to the Administrator:

- For those choosing direct deposit, a photocopy of a void cheque where the deposit is to be made
- Photocopy of one (1) piece of Government Issued identification for Survivor which includes date of birth
- Photocopy of one (1) piece of Government issued identification for legally Authorized Representative which includes date of birth (if applicable)
- Certified true copy of authority to act on behalf of the Survivor (if applicable)

Please return the completed Canadian Thalidomide Survivors Support Program Ongoing Payments Form to the Administrator **by mail, email or fax** to:

Canadian Thalidomide Survivors Support Program
PO Box 507 STN B
Ottawa, ON, K1P 5P6
info@tsspcanada.ca; Fax: 1-866-262-0816

Deadline to return the completed form is by March 15th for the change to apply to the issuance of the Ongoing Support payment for the next fiscal year.