



NOTICE OF PROPOSED TERMS OF SETTLEMENT

Pursuant to section 13 of the
Health Care Costs Recovery Act

Personal information on this form is collected under the authority of the *Health Care Costs Recovery Act*. The information will be used to identify recoverable health care costs as a result of a third party liability incident. If you have any questions about the collection of this information, contact Third Party Liability's email at hlth.tpl@gov.bc.ca or call (250) 952-2034. Personal information is protected from unauthorized use and disclosure in accordance with the *Health Care Costs Recovery Act* and the *Freedom of Information and Protection of Privacy Act*.

The payor's legal counsel may complete and send this form on behalf of the payor

PART A - BENEFICIARY

Last Name of Beneficiary		Given Name(s)	
Date of Incident (YYYY / MM / DD)	Date of Birth if known (YYYY / MM / DD)	Personal Health Number (PHN)	

PART B - PAYOR

Full Name		
Address		Postal Code
Contact Phone Number (include area code)	Email Address	

PART C - PAYOR'S COUNSEL

Name and Address		
Phone Number (include area code)	Email Address	
Name(s) of Parties to Proposed Settlement		
Total Amount of Settlement \$	Amount Proposed for Health Care Costs \$	Is the claim continuing against any other wrongdoer? <input type="checkbox"/> Yes <input type="checkbox"/> No

PART D - ATTACHMENTS

<input type="checkbox"/> Proposed Settlement Terms, Draft Terms of Settlement or Settlement Agreement
<input type="checkbox"/> Releases / Covenants not to sue (if applicable)
<input type="checkbox"/> Consent Dismissal Order / Discontinuance (if applicable)

Signature	Print Name and Title	OFFICE USE ONLY
	Date Signed (YYYY / MM / DD)	
Phone Number (include area code)	Email Address	
Full Mailing Address		

This form, including attachments, is sufficiently served if scanned and emailed to the following address: hlth.tpl@gov.bc.ca

– OR – Please send registered mail or traceable courier to: Third Party Liability, Ministry of Health
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