OMB Control Number: 0915-0334
Expiration Date: 3/31/2023

COUNTERMEASURES INJURY COMPENSATION PROGRAM
REQUEST FOR BENEFITS FORM

The Countermeasures Injury Compensation Program (CICP) provides certain medical and lost employment income benefits for individuals who were administered or used a covered countermeasure (such as 2009 H1N1 vaccine, Tamiflu®, Relenza®, and peramivir, mechanical ventilator, N-95 Filter Mask, anthrax vaccine, smallpox vaccine, etc.) and suffered a serious physical injury as a result. Individuals have one year from the date they were administered or used the covered countermeasure to submit a Request for Benefits Form (Request Form) in order to be considered for benefits. Although the CICP needs all the medical documentation that supports the injury in order to process the request, **requesters may submit only this Form in order to meet the filing deadline.** The CICP may also provide death benefits to certain survivors. The estate of a deceased individual may also qualify for certain medical and lost employment income benefits.

Read the instructions before completing this Request for Benefits Form.

SECTION A. INJURED COUNTERMEASURE RECIPIENT

Fill in information about the person who was administered or used a covered countermeasure and may have had a serious injury from the countermeasure.

First Name: (b) (6); 552a(b) Middle Initial: (b) (6); 552a(b) Last Name: (b) (6); 552a(b)

Date of Birth: (b) (6); 552a(b)

Address: (b) (6); 552a(b)

City: (b) (6); 552a(b) State: (b) (6); 552a(b) Zip or Postal Code: (b) (6); 552a(b)

Country (if other than the United States of America):

Telephone Number(s): (b) (6); 552a(b)

Email address: (b) (6); 552a(b)

Type of countermeasure (e.g., 2009 H1N1 vaccine): (b) (6); 552a(b)

Date(s) of the countermeasure administration or use that may have caused the injury: (b) (6); 552a(b)

Geographic location in which the countermeasure was administered or used (e.g., city, State): (b) (6); 552a(b)

Continued on next page

Describe the purpose for receiving the countermeasure (e.g., "There was an outbreak in my community"):
(b) (6); 552a(b)

Who administered it? (e.g., doctor, hospital, clinic, local health department): (b) (6); 552a(b)

Date of onset of the injury: (b) (6); 552a(b)

Describe the injury that may have resulted from the countermeasure:
(b) (6); 552a(b)

If you are the **injured countermeasure recipient**, go to Section E and sign this Request Form.

If you are a **survivor of a deceased injured countermeasure recipient** who may have died as a result of the countermeasure, go to Section B (Yellow).

If you are the **executor or administrator of the estate of a deceased injured countermeasure recipient**, regardless of the cause of death, go to Section C (Blue).

If you are the legal or **personal representative (including parent or guardian) of a person applying for Program benefits**, go to Section D (Orange).

SECTION D. LEGAL OR PERSONAL REPRESENTATIVE (including parent or guardian)

If you are the legal or personal representative of a minor or adult who does not have legal capacity to receive payments, complete Section D. Otherwise, a person requesting benefits does not need to have a legal or personal representative, but may choose to do so. All communications will generally be conducted with the representative, if one is identified. The CICP reserves the right to communicate with the requester if necessary.

The CICP will not pay or reimburse any fees or costs incurred by using a representative.

All Information in Section D refers to the legal or personal representative.

First Name: (b) (6); 552a(b) Middle Initial: (b) (6); 552a(b) Last Name: (b) (6); 552a(b)

Address: (b) (6); 552a(b)

City: (b) (6); 552a(b) State: (b) (6); 552a(b) Zip or Postal Code: (b) (6); 552a(b)

Country (if other than the United States of America): _____

Telephone Number(s): (b) (6); 552a(b)

Email address: (b) (6); 552a(b)

Relationship to the person applying for Program benefits (e.g., parent, lawyer): (b) (6); 552a(b)

Is the person you are representing a minor or an adult who does not have the legal capacity to receive payments?

(b) (6); 552a(b)

Go to **Section E** to sign this Request Form.

SECTION E. SIGNATURE

To be signed by the requester who is: (a) the injured countermeasure recipient identified in Section A; or (b) the survivor identified in Section B; or (c) the executor or administrator of the estate identified in Section C. If the requester does not have the legal capacity to receive a Program payment, then the personal or legal representative identified in Section D must sign on his or her behalf.

By signing this Form:

1) I hereby certify that the information provided in this Request Form is true and accurate to the best of my knowledge. Further, I understand that false statements or claims made in connection with this Request Form, including subsequent information and documentation submitted in connection with this Request Form, may result in fines, imprisonment and/or any other remedy, including civil remedies, available by law to the United States.

2) I will provide updated information (including, but not limited to medical records, employment income records, and change of address) until the Program has made its final decision.

3) (**Check one**):

[redacted]

Name (Print clearly): [redacted]

Signature: [redacted] Date: [redacted]

(b) (6); 552a(b)

(b) (6); 552a(b)

1000

(b) (6); 552a(b)

CERTIFIED MAIL

RETURN RECEIPT REQUESTED

(b) (6); 552a(b)

(b) (6); 552a(b) 2021

Health Resources & Services Admin.
Countermeasures Injury Compensation Program
5600 Fishers Lane, 08N146B
Rockville, MD 20857

(b) (6); 552a(b)

OMB Control Number: 0915-0334
Expiration Date: 3/31/2023

COUNTERMEASURES INJURY COMPENSATION PROGRAM
REQUEST FOR BENEFITS FORM

The Countermeasures Injury Compensation Program (CICP) provides certain medical and lost employment income benefits for individuals who were administered or used a covered countermeasure (such as 2009 H1N1 vaccine, Tamiflu®, Relenza®, and peramivir, mechanical ventilator, N-95 Filter Mask, anthrax vaccine, smallpox vaccine, etc.) and suffered a serious physical injury as a result. Individuals have one year from the date they were administered or used the covered countermeasure to submit a Request for Benefits Form (Request Form) in order to be considered for benefits. Although the CICP needs all the medical documentation that supports the injury in order to process the request, **requesters may submit only this Form in order to meet the filing deadline**. The CICP may also provide death benefits to certain survivors. The estate of a deceased individual may also qualify for certain medical and lost employment income benefits.

Read the instructions before completing this Request for Benefits Form.

SECTION A. INJURED COUNTERMEASURE RECIPIENT

Fill in information about the person who was administered or used a covered countermeasure and may have had a serious injury from the countermeasure.

First Name (b) (6); 552a(b) Middle Initial: (b) (6); 552a(b) Last Name: (b) (6); 552a(b)

Date of Birth: (b) (6); 552a(b)

Address: (b) (6); 552a(b)

City: (b) (6); 552a(b) State: (b) (6); 552a(b) Zip or Postal Code: (b) (6); 552a(b)

Country (if other than the United States of America):

Telephone Number(s): (b) (6); 552a(b)

Email address: (b) (6); 552a(b)

Type of countermeasure (e.g., 2009 H1N1 vaccine): (b) (6); 552a(b)

Date(s) of the countermeasure administration or use that may have caused the injury: (b) (6); 552a(b)

Geographic location in which the countermeasure was administered or used (e.g., city, State): (b) (6); 552a(b)

Continued on next page

OMB Control Number: 0915-0334
Expiration Date: 3/31/2023

Describe the purpose for receiving the countermeasure (e.g., "There was an outbreak in my community"):

(b) (6); 552a(b)

Who administered it? (e.g., doctor, hospital, clinic, local health department) (b) (6); 552a(b)

Date of onset of the injury: (b) (6); 552a(b)

Describe the injury that may have resulted from the countermeasure:

(b) (6); 552a(b)

If you are the **injured countermeasure recipient**, go to Section E and sign this Request Form.

If you are a **survivor of a deceased injured countermeasure recipient** who may have died as a result of the countermeasure, go to Section B (Yellow).

If you are the **executor or administrator of the estate of a deceased injured countermeasure recipient**, regardless of the cause of death, go to Section C (Blue).

If you are the legal or **personal representative (including parent or guardian) of a person applying for Program benefits**, go to Section D (Orange).

OMB Control Number: 0915-0334
Expiration Date: 3/31/2023

SECTION D. LEGAL OR PERSONAL REPRESENTATIVE (including parent or guardian)

If you are the legal or personal representative of a minor or adult who does not have legal capacity to receive payments, complete Section D. Otherwise, a person requesting benefits does not need to have a legal or personal representative, but may choose to do so. All communications will generally be conducted with the representative, if one is identified. The CICP reserves the right to communicate with the requester if necessary.

The CICP will not pay or reimburse any fees or costs incurred by using a representative.

All Information in Section D refers to the legal or personal representative.

First Name: (b) (6); 552a(b) Middle Initial: _____ Last Name: (b) (6); 552a(b)

Address: (b) (6); 552a(b)

City: (b) (6); 552a(b) State: (b) (6); 552a(b) Zip or Postal Code: (b) (6); 552a(b)

Country (if other than the United States of America): _____

Telephone Number(s): (b) (6); 552a(b)

Email address: (b) (6); 552a(b)

Relationship to the person applying for Program benefits (e.g., parent, lawyer): (b) (6); 552a(b)

Is the person you are representing a minor or an adult who does not have the legal capacity to receive payments?

(b) (6); 552a(b)

Go to **Section E** to sign this Request Form.

SECTION E. SIGNATURE

To be signed by the requester who is: (a) the injured countermeasure recipient identified in Section A; or (b) the survivor identified in Section B; or (c) the executor or administrator of the estate identified in Section C. If the requester does not have the legal capacity to receive a Program payment, then the personal or legal representative identified in Section D must sign on his or her behalf.

By signing this Form:

1) I hereby certify that the information provided in this Request Form is true and accurate to the best of my knowledge. Further, I understand that false statements or claims made in connection with this Request Form, including subsequent information and documentation submitted in connection with this Request Form, may result in fines, imprisonment and/or any other remedy, including civil remedies, available by law to the United States.

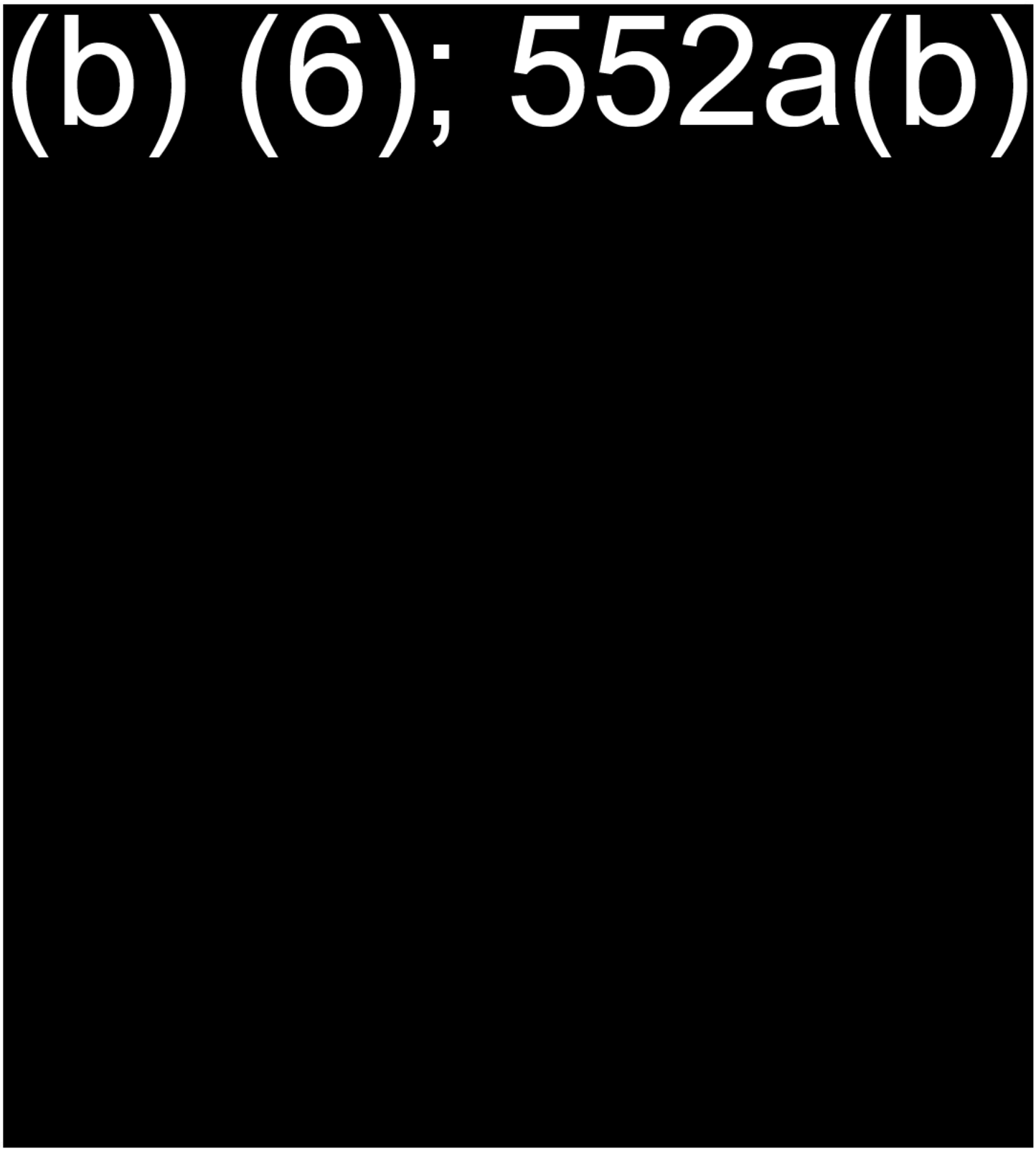
2) I will provide updated information (including, but not limited to medical records, employment income records, and change of address) until the Program has made its final decision.

3) (**Check one**):

(b) (6); 552a(b)

Name (Print clearly): (b) (6); 552a(b)

Signature (b) (6); 552a(b) Date: (b) (6); 552a(b)


(b) (6); 552a(b)

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UNITED STATES POSTAL SERVICE

1000

20857

[redacted] (b) (6); 552a(b)

Health Resources + Services Admin.
Countermeasures Injury Comp. Prog.
5600 Fishers Lane, 08N146B
Rockville, MD 20857

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Resources and Services Administration
Countermeasures Injury Compensation Program
Rockville, Maryland 20857
Health Systems Bureau

September 23, 2021

(b) (6); 552a(b)

CICP Case Number: (b) (6); 552a(b)

Dear (b) (6); 552a(b)

The Countermeasures Injury Compensation Program (CICP or the Program) has determined that you are medically eligible for benefits, as stated in our [DATE] decision letter to you. Please review your decision letter, which identifies the injuries that are eligible for CICP benefits. The Program will now proceed to calculate reimbursement or payment for eligible past, current, and/or future medical expenses and/or lost employment income resulting from your covered injury(ies). The description of documentation required by the CICP to calculate benefits is attached (see Attachment 1). *See* 42 C.F.R. §§ 110.60-110.61. The Program requests that you send all documentation within **60 days** of the date of this letter. Please inform the Program if you need more time.

The information provided below explains the types of Program benefits available, and their limitations.

Benefits for Unreimbursed Medical Expenses

The CICP may reimburse or pay reasonable costs for past, current, and future medical services and/or items that are reasonable and necessary to diagnose or treat your covered injury and to diagnose, treat, or prevent its health complications. *See* 42 C.F.R. §§ 110.31 and 110.80. With respect to future medical services or items, the CICP may make such payments or reimbursements if they are likely to be needed in the future. In making determinations about which medical services and items are reasonable and necessary, the CICP may consider whether those medical services and items were prescribed or recommended by a healthcare provider, and may consider whether the applicable service or item is within the standard of care for that condition.

If you continue to receive medical care for a covered injury or its health complications and plan to request payment for current and future services or items, you must submit information to

support this request. The original Authorization to Disclose Health Information Form(s) you submitted with your Request Package may have expired. Therefore, the Program may ask you to complete and sign a new set of forms for each of your healthcare providers so that the CICP can communicate directly with them, as necessary.

Lost Employment Income Benefits

The CICP may also pay for lost employment income resulting from a covered injury. *See* C.F.R. §§ 110.32 and 110.81. The period of time requested for lost employment income benefits must be supported by the severity of the covered injury as demonstrated by medical and employment records. In order to qualify for lost employment income benefits, you must have been absent from work for more than five (5) days in an unpaid status. The days of lost income do not have to be consecutive, and partial days may be added together. Please also note the following:

- You may be compensated for ten or more days of work lost if you lost employment income for those days as a result of the covered injury (or its health complications). If the number of days of lost employment income due to the covered injury (or its health complications) is fewer than ten, the number of lost work days will be reduced by five days. If you lost employment income for a period of five days or fewer, no benefits for lost employment income will be paid. In other words, if you lost five days or less of income, there would be no reimbursement; if you lost six to nine days of income, the calculation would be based on the number of days lost minus five; and if you lost ten or more days of income, the lost employment benefit would be calculated based on the entire number of days.

- If you used days of paid leave, those days will be considered days of work for which employment income was received. Therefore, you would not qualify for lost employment income for those days. The Program can only pay for lost employment income for unpaid leave. However, if you reimburse your employer for the paid leave taken and the employer restores that leave, then you may be eligible for lost employment income benefits for those days that have been changed to unpaid leave. It is your responsibility to follow your employers' procedures to change paid leave to unpaid leave.

- Benefits for employment income lost as a result of your covered injury or its health complications are paid as a percentage of the amount of gross employment income (including income from self-employment, if applicable) earned at the time of your injury. If you had no dependents at the time your covered injury was sustained, the lost employment benefits are $66^{2}/_{3}$ percent of your gross employment income. If you had one or more dependents (as defined by the Internal Revenue Service) at the time that your covered injury was sustained, the benefits are 75 percent of your gross employment

income. CICP's lost employment income benefit has a maximum of $50,000 per year, and cannot be paid after the injured countermeasure recipient reaches the age of 65, with a lifetime cap. If you are fully disabled (as defined by the Social Security Act) by your covered injury, then there is no lifetime cap on the amount of lost employment income you can receive.

- The CICP may not consider projected future earnings in the calculation of lost employment income, except for injured countermeasure recipients who are minors.

Payer of Last Resort

The CICP is the payer of last resort and can only reimburse or pay for medical services, items or lost employment income that are other third-party payers have not paid and/or are not obligated to pay.

Third-party payers are organizations which are responsible for paying some or all of your medical expenses or lost employment income, such as a private insurance company (e.g., health or disability insurance plans), your employer (e.g., workmen's compensation), or a government program (e.g., Medicaid, Medicare, Veteran's benefit).

If you become aware that a third-party payer may have an obligation to pay for or provide any medical services or items and/or lost employment income for injuries that are eligible for compensation under the CICP, you must inform the Program within ten business days of obtaining this information, even after benefits have been paid by the CICP.

Sincerely,

Tamara Overby

9/23/2021

Tamara Overby,
Acting Director, Division of Injury Compensation Programs

Date

Enclosures:
Attachment 1 – Documentation Required to Reimburse or Pay for Medical Expenses and/or Lost Employment Income
Attachment 2 – Certification of Status: Unreimbursed Medical Expenses
Attachment 3 – Certification of Status: Lost Employment Income Benefits

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Resources and Services Administration
Countermeasures Injury Compensation Program
Rockville, Maryland 20857
Health Systems Bureau

September 23 2021

(b) (6); 552a(b)

CICP Case Number: (b) (6); 552a(b)

Dear (b) (6); 552a(b),

The Countermeasures Injury Compensation Program (CICP or the Program) has reviewed the Request for Benefits Package you submitted.

To be eligible for compensation under the CICP, requesters must demonstrate that a serious injury or death occurred as the direct result of the administration or use of a covered countermeasure. Such proof must be based on compelling, reliable, valid, medical and scientific evidence. 42 C.F.R. § 110.20(c). The CICP's regulations define "serious injury" as a serious physical injury. 42 C.F.R. §110.3(z). Physical biochemical alterations leading to physical changes and serious functional abnormalities at the cellular or tissue level in any bodily function may, in certain circumstances, be considered serious injuries. As a general matter, only injuries that warranted hospitalization (whether or not the person was actually hospitalized) or injuries that led to a significant loss of function or disability (whether or not hospitalization was warranted) will be considered serious injuries.

On your Request for Benefits Form, you alleged that you experienced an (b) (6); 552a(b) from the (b) (6); 552a(b) vaccine (b) (6); 552a(b)
(b) (6); 552a(b)

Based on our medical review, the CICP has determined that you are eligible for Program benefits. The CICP requires "compelling, reliable, valid, medical and scientific evidence" showing that the covered countermeasure directly caused the serious injury. We have determined that, in your case, you have proved that the (b) (6); 552a(b) COVID-19 vaccine directly caused your (b) (6); 552a(b). You will receive a separate letter that will outline the next steps and the documentation you will need to submit to determine the Program benefits that may be available to you.

Tamara Overby

Tamara Overby,
Acting Director, Division of Injury Compensation Programs

9/23/2021
Date

OMB Control Number: 0915-0334
Expiration Date: 3/31/2023

COUNTERMEASURES INJURY COMPENSATION PROGRAM
REQUEST FOR BENEFITS FORM

The Countermeasures Injury Compensation Program (CICP) provides certain medical and lost employment income benefits for individuals who were administered or used a covered countermeasure (such as 2009 H1N1 vaccine, Tamiflu®, Relenza®, and peramivir, mechanical ventilator, N-95 Filter Mask, anthrax vaccine, smallpox vaccine, etc.) and suffered a serious physical injury as a result. Individuals have one year from the date they were administered or used the covered countermeasure to submit a Request for Benefits Form (Request Form) in order to be considered for benefits. Although the CICP needs all the medical documentation that supports the injury in order to process the request, **requesters may submit only this Form in order to meet the filing deadline.** The CICP may also provide death benefits to certain survivors. The estate of a deceased individual may also qualify for certain medical and lost employment income benefits.

Read the instructions before completing this Request for Benefits Form.

SECTION A. INJURED COUNTERMEASURE RECIPIENT

Fill in information about the person who was administered or used a covered countermeasure and may have had a serious injury from the countermeasure.

First Name (b) (6); 552a(b) Middle Initial (b) (6); 552a(b) Last Name: (b) (6); 552a(b)

Date of Birth: (b) (6); 552a(b)

Address: (b) (6); 552a(b)

City: (b) (6); 552a(b) State: (b) (6); 552a(b) Zip or Postal Code: (b) (6); 552a(b)

Country (if other than the United States of America):

Telephone Number(s): (b) (6); 552a(b)

Email address (b) (6); 552a(b)

Type of countermeasure (e.g., 2009 H1N1 vaccine): (b) (6); 552a(b)

Date(s) of the countermeasure administration or use that may have caused the injury: (b) (6); 552a(b)

Geographic location in which the countermeasure was administered or used (e.g., city, State) (b) (6); 552a(b)
(b) (6); 552a(b)

Continued on next page

Describe the purpose for receiving the countermeasure (e.g., "There was an outbreak in my community"):

(b) (6); 552a(b)

Who administered it? (e.g., doctor, hospital, clinic, local health department): (b) (6); 552a(b)

Date of onset of the injury: (b) (6); 552a(b)

Describe the injury that may have resulted from the countermeasure:

(b) (6); 552a(b)

If you are the **injured countermeasure recipient**, go to Section E and sign this Request Form.

If you are a **survivor of a deceased injured countermeasure recipient** who may have died as a result of the countermeasure, go to Section B (Yellow).

If you are the **executor or administrator of the estate of a deceased injured countermeasure recipient**, regardless of the cause of death, go to Section C (Blue).

If you are the legal or **personal representative (including parent or guardian) of a person applying for Program benefits**, go to Section D (Orange).

OMB Control Number: 0915-0334
Expiration Date: 3/31/2023

SECTION B. SURVIVOR OF DECEASED INJURED COUNTERMEASURE RECIPIENT WHO MAY HAVE DIED AS A RESULT OF THE COVERED COUNTERMEASURE

All information in Section B refers only to the survivor(s) of the individual identified in Section A, who is/are requesting death benefits.

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____

Address: _____

City: _____ State: _____ Zip or Postal Code: _____

Country (if other than the United States of America): _____

Telephone Number(s): _____

Email address: _____

The date the injured countermeasure recipient identified in Section A died: _____

In order to be considered for Program benefits, a survivor must be in one of the categories described below. **Check** the box that describes the person identified in Section B in relation to the individual identified in Section A.

☐ Spouse
☐ Eligible child (described in the instructions)
☐ Dependent younger than the age of 18 (described in the instructions)
☐ Beneficiary named in most recently executed life insurance policy (and there are no survivors in the categories described above)
☐ Parent (and there are no survivors in the categories described above)
☐ Legal guardian of a deceased minor (and there are no survivors in the categories listed above)
☐ Adult child (and there are no survivors in the categories described above)

Check the first box below if the requester is a sole survivor or the second box if there are other survivors described above.

☐ To the best of my knowledge, there are no other survivors who may be eligible for a CICP death benefit payment; or

☐ There are other survivors who may be eligible for a CICP death benefits payment. I am providing their names and their relationship to the person we survived. If this box is checked, list survivors. Use additional sheet(s), if necessary. (Eligible survivor categories are listed above.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Go to **Section C (Blue)** if you are also the executor or the administrator of the estate.

Go to **Section D (Orange)** if there is a legal or personal representative; **otherwise**, go to **Section E** to sign this Request Form.

SECTION C. EXECUTOR OR ADMINISTRATOR OF THE ESTATE OF A DECEASED INJURED COUNTERMEASURE RECIPIENT

The Program may provide medical and/or lost employment income benefits to the estate of a deceased individual described in Section A, regardless of the cause of death. All information requested in Section C refers to the executor or administrator of the estate only.

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip or Postal Code: _____

Country (if other than the United States of America): _____

Telephone Number(s): _____

Email address: _____

Go to **Section D (Orange)** if there is a legal or personal representative; **otherwise**, go to **Section E** to sign this Request Form.

OMB Control Number: 0915-0334
Expiration Date: 3/31/2023

SECTION D. LEGAL OR PERSONAL REPRESENTATIVE (including parent or guardian)

If you are the legal or personal representative of a minor or adult who does not have legal capacity to receive payments, complete Section D. Otherwise, a person requesting benefits does not need to have a legal or personal representative, but may choose to do so. All communications will generally be conducted with the representative, if one is identified. The CICP reserves the right to communicate with the requester if necessary.

The CICP will not pay or reimburse any fees or costs incurred by using a representative.

All information in Section D refers to the legal or personal representative.

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip or Postal Code: _____

Country (if other than the United States of America): _____

Telephone Number(s): _____

Email address: _____

Relationship to the person applying for Program benefits (e.g., parent, lawyer): _____

Is the person you are representing a minor or an adult who does not have the legal capacity to receive payments?

☐ Yes
☐ No

Go to **Section E** to sign this Request Form.

SECTION E. SIGNATURE

To be signed by the requester who is: (a) the injured countermeasure recipient identified in Section A; or (b) the survivor identified in Section B; or (c) the executor or administrator of the estate identified in Section C. If the requester does not have the legal capacity to receive a Program payment, then the personal or legal representative identified in Section D must sign on his or her behalf.

By signing this Form:

1) I hereby certify that the information provided in this Request Form is true and accurate to the best of my knowledge. Further, I understand that false statements or claims made in connection with this Request Form, including subsequent information and documentation submitted in connection with this Request Form, may result in fines, imprisonment and/or any other remedy, including civil remedies, available by law to the United States.

2) I will provide updated information (including, but not limited to medical records, employment income records, and change of address) until the Program has made its final decision.

3) **(Check one):** (b) (6); 552a(b)

Name (Print clearly): (b) (6); 552a(b)

Signature (b) (6); 552a(b) Date: (b) (6); 552a(b)

You can submit your Request Form and all the required documentation to the CICP by U.S. mail, a private courier service, or commercial carrier to:

U.S. Department of Health and Human Services
Health Resources and Services Administration
Countermeasures Injury Compensation Program
5600 Fishers Lane, 08N146B
Rockville, MD 20857

For Program information and to obtain an additional copy of this Form and the instructions for completing it, visit the CICP Web site at www.hrsa.gov/cicp, call 1-855-266-2427 (1-855-266-CICP), or email: CICP@hrsa.gov. Check the Program Web site to see if this Form can be submitted electronically.

PRIVACY ACT STATEMENT

Section 319F-4 of the Public Health Service Act (PHS Act), Public Law 109-148 (42 U.S.C. 247d-6e), and the Debt Collection Improvement Act of 1996 authorize collection of this information. It will be used to determine your eligibility to receive benefits. This information will be disclosed to the U.S. Department of Health and Human Services and its consultants; and Federal, State, or local law enforcement agencies, if the Government becomes aware of a possible violation of civil or criminal law; and for certain medical research purposes when consistent with the purposes for which the Program was formed, i.e., to make determinations concerning alleged covered countermeasure injury associations and to provide compensation to individuals injured by covered countermeasures. Furnishing the information on this Form is voluntary, but failure to do so may delay or prevent the receipt of a payment. The information collected will be maintained confidentially pursuant to the Privacy Act, 5 USC Section 552a, as amended.

PUBLIC BURDEN STATEMENT

Public Burden Statement: The purpose of this data collection is to gather information to allow the Secretary of Health and Human Services to determine if requesters are eligible for Countermeasure Injury Compensation Program (CICP) benefits. Requesters (or their representatives) must submit appropriate documentation forms and relevant medical records as specified in Section 42 CFR 110.50-110.53 to the CICP. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this information collection is 0915-0334 and it is valid until 03/31/2023. This information collection is required to obtain or retain a benefit (42 CFR Part 110). Access to these records is strictly limited to authorized users who are aware of their responsibilities under the Privacy Act and who are required to maintain Privacy Act safeguards with respect to such records. The System of Records Notice for Injury Compensation Programs, HHS/HRSA/HSB, System No. 09–15–0056, identifies authorized users. Public reporting burden for this collection of information is estimated to average 3.5 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N136B, Rockville, Maryland, 20857 or paperwork@hrsa.gov

OMB Control Number: 0915-0334
Expiration Date: 3/31/2023

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration
Countermeasures Injury Compensation Program

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

PLEASE COMPLETE ALL APPLICABLE SECTIONS, SIGN, AND DATE

I. PATIENT IDENTIFICATION *(Injured Countermeasure Recipient)*	***FOR OFFICIAL CICP USE ONLY*** **CICP No.**
NAME *(Last)* (b) (6); 552a(b)	*(First)* (b) (6); 552a(b) *(MI)* (b) (6)
ADDRESS (b) (6); 552a(b)	
CITY/STATE/ZIPCODE (b) (6); 552a(b)	DATE OF BIRTH (b) (6); 552a(b)

II. _____
Personal Representative, if applicable, for injured countermeasure recipient/ patient in section I
(e.g. parent of a minor or guardian, administrator for estate)

III. The information is to be disclosed by:	**And is to be provided to:**
Name of Facility/Provider (b) (6); 552a(b) Address (b) (6); 552a(b) City/State/Zip Code (b) (6); 552a(b)	U.S. Department of Health and Human Services Health Resources and Services Administration Countermeasures Injury Compensation Program 5600 Fishers Lane, Room 08N146B Rockville, MD 20857

IV. The information to be disclosed from the patient's, as identified in section I, health record *(check appropriate box(es))*.
(b) (6); 552a(b)

The purpose or need for this disclosure is to determine eligibility for benefits from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Countermeasures Injury Compensation Program (CICP). This information may be used for certain medical research purposes when consistent with the purposes for which the CICP was formed, e.g., gathering and sharing de-identified data regarding countermeasures adverse events.

V. I understand that I may revoke this authorization in writing at any time by contacting my facility/provider, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated.

_____
(Enter Date of Termination or Expiration if different from one year after date below)

VI. SIGNATURE OF PATIENT (b) (6); 552a(b)	DATE (b) (6); 552a(b)
VII. SIGNATURE OF PERSONAL REPRESENTATIVE (if applicable)	DATE
VIII. SIGNATURE OF WITNESS (if signature is thumbprint or mark, or if State law)	DATE

Consenting to this authorization of disclosure of records is voluntary and health provider(s) shall not condition treatment upon the individual's signature of such authorization for use or disclosure of health information. This information is subject to release for the purposes stated in Section IV and may not be used by the recipient for any other purpose unless permitted by federal law. I understand that information disclosed by this authorization, except for alcohol and drug abuse patient records as defined in 42 CFR Part 2, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule (45 CFR Part 164), and the Privacy Act of 1974 (5 USC 552a).

OMB Control Number: 0915-0334
Expiration Date: 3/31/2023

Section III – Provide the name and address of the facility or provider releasing the information. This is the facility or provider of health care services to the injured countermeasure recipient.

Section IV – Check the appropriate box as applicable. The CICP will provide direction as to which records are needed.

1. **Entire Medical Record – the complete medical record from the identified facility or provider from one (1) year prior to administration or use of the covered countermeasure that may have caused the injury. Please enter this date.**
2. **Only information related to – specify diagnosis, injury, operations special therapies, etc. within a specific date range. (Only complete this section if instructed to do so by the CICP).**
3. **Other (specify) – e.g., insurance coverage, billing, etc. (Only complete this section if instructed to do so by the CICP).**

Section V – The requester may revoke this authorization at any time by notifying the Health Information Management (Health Records) Department of the facility/provider in Section III, in writing. If a different expiration date is desired, specify a new date. You may consider providing a date longer than one year if you have an ongoing CICP covered injury that has not resolved or may not be resolved soon.

Section VI – Patient (i.e., the injured countermeasure recipient) signs and dates the form here.

Section VII – A personal representative (e.g., parent, legal guardian, power of attorney etc.), if one has been designated, signs and dates the form here.

Section VIII – A witness signs and dates the form here, if necessary (e.g., if the patient signature is a thumbprint or mark or if required by State law).

Send a copy of the completed form to the facility/provider identified, and, at the same time, also mail a copy of the completed form to the CICP at the address below:

Health Resources and Services Administration
Countermeasures Injury Compensation Program
5600 Fishers Lane, Room 11C-06
Rockville, MD 20857

If you have questions contact the CICP at:

1-855-266-2427 (855-266-CICP); or
HRSA.gov/CICP

Form No: CICP-2

OMB Control Number: 0915-0334
Expiration Date: 3/31/2023

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration
Countermeasures Injury Compensation Program

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

PLEASE COMPLETE ALL APPLICABLE SECTIONS, SIGN, AND DATE

I. PATIENT IDENTIFICATION *(Injured Countermeasure Recipient)*	***FOR OFFICIAL CICP USE ONLY*** **CICP No.**
NAME *(Last)* (b) (6); 552a(b)	*(First)* (b) (6) *(MI)* (b) (6)
ADDRESS (b) (6); 552a(b)	
CITY/STATE/ZIPCODE (b) (6); 552a(b)	DATE OF BIRTH (b) (6); 552a(b)

II. _____
Personal Representative, if applicable, for injured countermeasure recipient/ patient in section I
(e.g. parent of a minor or guardian, administrator for estate)

III. The information is to be disclosed by:	**And is to be provided to:**
Name of Facility/Provider (b) (6); 552a(b) Address (b) (6); 552a(b) City/State/Zip Code (b) (6); 552a(b)	U.S. Department of Health and Human Services Health Resources and Services Administration Countermeasures Injury Compensation Program 5600 Fishers Lane, Room 08N146B Rockville, MD 20857

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(b) (6); 552a(b)

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V. I understand that I may revoke this authorization in writing at any time by contacting my facility/provider, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated.

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Consenting to this authorization of disclosure of records is voluntary and health provider(s) shall not condition treatment upon the individual's signature of such authorization for use or disclosure of health information. This information is subject to release for the purposes stated in Section IV and may not be used by the recipient for any other purpose unless permitted by federal law. I understand that information disclosed by this authorization, except for alcohol and drug abuse patient records as defined in 42 CFR Part 2, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule (45 CFR Part 164), and the Privacy Act of 1974 (5 USC 552a).

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration
Countermeasures Injury Compensation Program

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

PRIVACY ACT STATEMENT

Section 319F-4 of the Public Health Service Act (PHS Act), Public Law 109-148 (42 U.S.C. 247d-6e), and the Debt Collection Improvement Act of 1996 authorize collection of this information. It will be used to determine your eligibility to receive benefits. This information will be disclosed to the U.S. Department of Health and Human Services and its consultants; and Federal, State, or local law enforcement agencies, if the Government becomes aware of a possible violation of civil or criminal law; and for certain medical research purposes when consistent with the purposes for which the Program was formed, i.e., to make determinations concerning alleged covered countermeasure injury associations and to provide compensation to individuals injured by covered countermeasures. Furnishing the information on this Form, including the social security number, is voluntary, but failure to do so may delay or prevent the receipt of a payment. The information collected will be maintained confidentially pursuant to the Privacy Act, 5 USC Section 552a, as amended.

PUBLIC BURDEN STATEMENT

Public Burden Statement: The purpose of this data collection is to gather information to allow the Secretary of Health and Human Services to determine if requesters are eligible for Countermeasure Injury Compensation Program (CICP) benefits. Requesters (or their representatives) must submit appropriate documentation forms and relevant medical records as specified in Section 42 CFR 110.50-110.53 to the CICP. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this information collection is 0915-0334 and it is valid until 03/31/2023. This information collection is required to obtain or retain a benefit (42 CFR Part 110). Access to these records is strictly limited to authorized users who are aware of their responsibilities under the Privacy Act and who are required to maintain Privacy Act safeguards with respect to such records. The System of Records Notice for Injury Compensation Programs, HHS/HRSA/HSB, System No. 09–15–0056, identifies authorized users. Public reporting burden for this collection of information is estimated to average 3.5 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N136B, Rockville, Maryland, 20857 or paperwork@hrsa.gov.

Instructions for Completing HRSA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Type or print legibly in all fields using dark ink.

Section I – Provide the name, address, and date of birth of the injured countermeasure recipient.

Section II – Provide the name of the personal representative such as a parent of a minor, or a guardian, or an attorney, if applicable. If there is no personal representative then section II should be left blank.

OMB Control Number: 0915-0334
Expiration Date: 3/31/2023

Section III – Provide the name and address of the facility or provider releasing the information. This is the facility or provider of health care services to the injured countermeasure recipient.

Section IV – Check the appropriate box as applicable. The CICP will provide direction as to which records are needed.

1. **Entire Medical Record – the complete medical record from the identified facility or provider from one (1) year prior to administration or use of the covered countermeasure that may have caused the injury. Please enter this date.**
2. **Only information related to – specify diagnosis, injury, operations special therapies, etc. within a specific date range. (Only complete this section if instructed to do so by the CICP).**
3. **Other (specify) – e.g., insurance coverage, billing, etc. (Only complete this section if instructed to do so by the CICP).**

Section V – The requester may revoke this authorization at any time by notifying the Health Information Management (Health Records) Department of the facility/provider in Section III, in writing. If a different expiration date is desired, specify a new date. You may consider providing a date longer than one year if you have an ongoing CICP covered injury that has not resolved or may not be resolved soon.

Section VI – Patient (i.e., the injured countermeasure recipient) signs and dates the form here.

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Send a copy of the completed form to the facility/provider identified, and, at the same time, also mail a copy of the completed form to the CICP at the address below:

Health Resources and Services Administration
Countermeasures Injury Compensation Program
5600 Fishers Lane, Room 11C-06
Rockville, MD 20857

If you have questions contact the CICP at:

1-855-266-2427 (855-266-CICP); or
HRSA.gov/CICP

Form No: CICP-2

OMB Control Number: 0915-0334
Expiration Date: 3/31/2023

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration
Countermeasures Injury Compensation Program

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

PLEASE COMPLETE ALL APPLICABLE SECTIONS, SIGN, AND DATE

I. PATIENT IDENTIFICATION *(Injured Countermeasure Recipient)*	***FOR OFFICIAL CICP USE ONLY*** **CICP No.**
NAME *(Last)* (b) (6); 552a(b)	*(First)* (b) (6); 552a(b) *(MI)* (b) (6); 552a(b)
ADDRESS (b) (6); 552a(b)	
CITY/STATE/ZIPCOD (b) (6); 552a(b)	DATE OF BIRTH (b) (6); 552a(b)

II. _____
Personal Representative, if applicable, for injured countermeasure recipient/ patient in section I (e.g. parent of a minor or guardian, administrator for estate)

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Name of Facility/Provider (b) (6); 552a(b) Address (b) (6); 552a(b) City/State/Zip Code (b) (6); 552a(b)	U.S. Department of Health and Human Services Health Resources and Services Administration Countermeasures Injury Compensation Program 5600 Fishers Lane, Room 08N146B Rockville, MD 20857

IV. The information to be disclosed from the patient's, as identified in section I, health record *(check appropriate box(es))*.

(b) (6); 552a(b)

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration
Countermeasures Injury Compensation Program

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

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Instructions for Completing HRSA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Type or print legibly in all fields using dark ink.

Section I – Provide the name, address, and date of birth of the injured countermeasure recipient.

Section II – Provide the name of the personal representative such as a parent of a minor, or a guardian, or an attorney, if applicable. If there is no personal representative then section II should be left blank.

OMB Control Number: 0915-0334
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Section III – Provide the name and address of the facility or provider releasing the information. This is the facility or provider of health care services to the injured countermeasure recipient.

Section IV – Check the appropriate box as applicable. The CICP will provide direction as to which records are needed.

1. **Entire Medical Record – the complete medical record from the identified facility or provider from one (1) year prior to administration or use of the covered countermeasure that may have caused the injury. Please enter this date.**
2. **Only information related to – specify diagnosis, injury, operations special therapies, etc. within a specific date range. (Only complete this section if instructed to do so by the CICP).**
3. **Other (specify) – e.g., insurance coverage, billing, etc. (Only complete this section if instructed to do so by the CICP).**

Section V – The requester may revoke this authorization at any time by notifying the Health Information Management (Health Records) Department of the facility/provider in Section III, in writing. If a different expiration date is desired, specify a new date. You may consider providing a date longer than one year if you have an ongoing CICP covered injury that has not resolved or may not be resolved soon.

Section VI – Patient (i.e., the injured countermeasure recipient) signs and dates the form here.

Section VII – A personal representative (e.g., parent, legal guardian, power of attorney etc.), if one has been designated, signs and dates the form here.

Section VIII – A witness signs and dates the form here, if necessary (e.g., if the patient signature is a thumbprint or mark or if required by State law).

Send a copy of the completed form to the facility/provider identified, and, at the same time, also mail a copy of the completed form to the CICP at the address below:

Health Resources and Services Administration
Countermeasures Injury Compensation Program
5600 Fishers Lane, Room 11C-06
Rockville, MD 20857

If you have questions contact the CICP at:

1-855-266-2427 (855-266-CICP); or
HRSA.gov/CICP

COUNTERMEASURES INJURY COMPENSATION PROGRAM
REQUEST FOR BENEFITS FORM

The Countermeasures Injury Compensation Program (CICP) provides certain medical and lost employment income benefits for individuals who were administered or used a covered countermeasure (such as 2009 H1N1 vaccine, Tamiflu®, Relenza®, and peramivir, mechanical ventilator, N-95 Filter Mask, anthrax vaccine, smallpox vaccine, etc.) and suffered a serious physical injury as a result. Individuals have one year from the date they were administered or used the covered countermeasure to submit a Request for Benefits Form (Request Form) in order to be considered for benefits. Although the CICP needs all the medical documentation that supports the injury in order to process the request, **requesters may submit only this Form in order to meet the filing deadline**. The CICP may also provide death benefits to certain survivors. The estate of a deceased individual may also qualify for certain medical and lost employment income benefits.

Read the instructions before completing this Request for Benefits Form.

SECTION A. INJURED COUNTERMEASURE RECIPIENT

Fill in information about the person who was administered or used a covered countermeasure and may have had a serious injury from the countermeasure.

First Name: (b) (6); 552a(b) Middle Initial: (b) (6); 552a(b) Last Name: (b) (6); 552a(b)

Date of Birth (b) (6); 552a(b)

Address: (b) (6); 552a(b)

City: (b) (6); 552a(b) State: (b) (6); 552a(b) Zip or Postal Code: (b) (6); 552a(b)

Country (if other than the United States of America):

Telephone Number(s): (b) (6); 552a(b)

Email address: (b) (6); 552a(b)

Type of countermeasure (e.g., 2009 H1N1 vaccine): (b) (6); 552a(b)

Date(s) of the countermeasure administration or use that may have caused the injury: (b) (6); 552a(b)

Geographic location in which the countermeasure was administered or used (e.g., city, State) (b) (6); 552a(b)

Continued on next page

Describe the purpose for receiving the countermeasure (e.g., "There was an outbreak in my community"):
(b) (6); 552a(b)

Who administered it? (e.g., doctor, hospital, clinic, local health department) (b) (6); 552a(b)

Date of onset of the injury: (b) (6); 552a(b)

Describe the injury that may have resulted from the countermeasur (b) (6); 552a(b)

(b) (6); 552a(b)

If you are the **injured countermeasure recipient**, go to Section E and sign this Request Form.

If you are a **survivor of a deceased injured countermeasure recipient** who may have died as a result of the countermeasure, go to Section B (Yellow).

If you are the **executor or administrator of the estate of a deceased injured countermeasure recipient**, regardless of the cause of death, go to Section C (Blue).

If you are the legal or **personal representative (including parent or guardian) of a person applying for Program benefits**, go to Section D (Orange).

SECTION B. SURVIVOR OF DECEASED INJURED COUNTERMEASURE RECIPIENT WHO MAY HAVE DIED AS A RESULT OF THE COVERED COUNTERMEASURE

All information in Section B refers only to the survivor(s) of the individual identified in Section A, who is/are requesting death benefits.

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____

Address: _____

City: _____ State: _____ Zip or Postal Code: _____

Country (if other than the United States of America): _____

Telephone Number(s): _____

Email address: _____

The date the injured countermeasure recipient identified in Section A died: _____

In order to be considered for Program benefits, a survivor must be in one of the categories described below. **Check** the box that describes the person identified in Section B in relation to the individual identified in Section A.

☐ Spouse
☐ Eligible child (described in the instructions)
☐ Dependent younger than the age of 18 (described in the instructions)
☐ Beneficiary named in most recently executed life insurance policy (and there are no survivors in the categories described above)
☐ Parent (and there are no survivors in the categories described above)
☐ Legal guardian of a deceased minor (and there are no survivors in the categories listed above)
☐ Adult child (and there are no survivors in the categories described above)

Check the first box below if the requester is a sole survivor or the second box if there are other survivors described above.

☐ To the best of my knowledge, there are no other survivors who may be eligible for a CICP death benefit payment; or

☐ There are other survivors who may be eligible for a CICP death benefits payment. I am providing their names and their relationship to the person we survived. If this box is checked, list survivors. Use additional sheet(s), if necessary. (Eligible survivor categories are listed above.)

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Go to **Section C (Blue)** if you are also the executor or the administrator of the estate.

Go to **Section D (Orange)** if there is a legal or personal representative; **otherwise**, go to **Section E** to sign this Request Form.

OMB Control Number: 0915-0334
Expiration Date: 3/31/2023

SECTION C. EXECUTOR OR ADMINISTRATOR OF THE ESTATE OF A DECEASED INJURED COUNTERMEASURE RECIPIENT

The Program may provide medical and/or lost employment income benefits to the estate of a deceased individual described in Section A, regardless of the cause of death. All information requested in Section C refers to the executor or administrator of the estate only.

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip or Postal Code: _____

Country (if other than the United States of America): _____

Telephone Number(s): _____

Email address: _____

Go to **Section D (Orange)** if there is a legal or personal representative; **otherwise**, go to **Section E** to sign this Request Form.

SECTION D. LEGAL OR PERSONAL REPRESENTATIVE (including parent or guardian)

If you are the legal or personal representative of a minor or adult who does not have legal capacity to receive payments, complete Section D. Otherwise, a person requesting benefits does not need to have a legal or personal representative, but may choose to do so. All communications will generally be conducted with the representative, if one is identified. The CICP reserves the right to communicate with the requester if necessary.

The CICP will not pay or reimburse any fees or costs incurred by using a representative.

All Information in Section D refers to the legal or personal representative.

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip or Postal Code: _____

Country (if other than the United States of America): _____

Telephone Number(s): _____

Email address: _____

Relationship to the person applying for Program benefits (e.g., parent, lawyer): _____

Is the person you are representing a minor or an adult who does not have the legal capacity to receive payments?

☐ Yes
☐ No

Go to **Section E** to sign this Request Form.

SECTION E. SIGNATURE

To be signed by the requester who is: (a) the injured countermeasure recipient identified in Section A; or (b) the survivor identified in Section B; or (c) the executor or administrator of the estate identified in Section C. If the requester does not have the legal capacity to receive a Program payment, then the personal or legal representative identified in Section D must sign on his or her behalf.

By signing this Form:

1) I hereby certify that the information provided in this Request Form is true and accurate to the best of my knowledge. Further, I understand that false statements or claims made in connection with this Request Form, including subsequent information and documentation submitted in connection with this Request Form, may result in fines, imprisonment and/or any other remedy, including civil remedies, available by law to the United States.

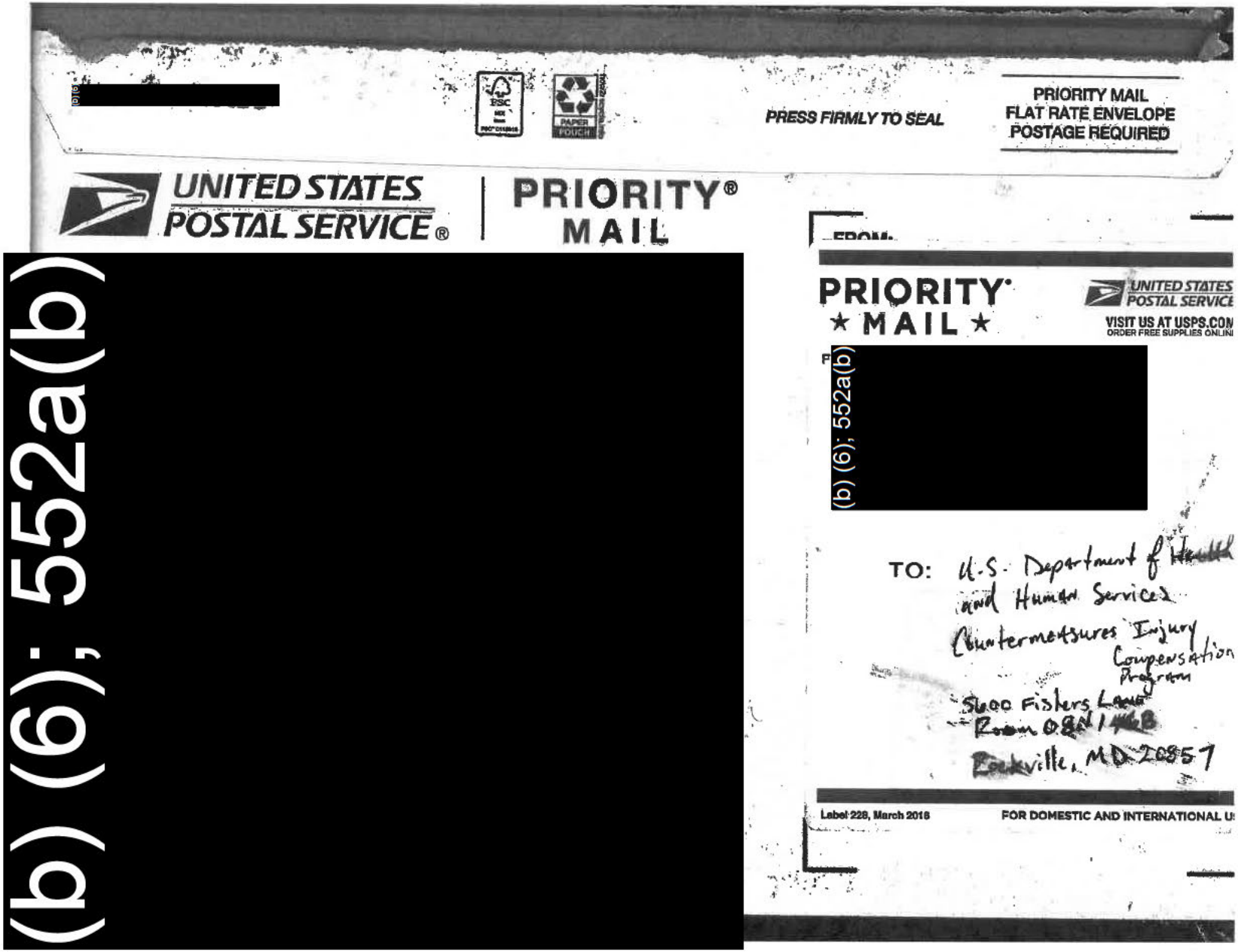
2) I will provide updated information (including, but not limited to medical records, employment income records, and change of address) until the Program has made its final decision.

3) **(Check one)**:

(b) (6); 552a(b)

Name (Print clearly): (b) (6); 552a(b)

Signature: (b) (6); 552a(b) Date: (b) (6); 552a(b)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TO: U.S. Department of Health and Human Services
Countermeasures Injury Compensation Program
5600 Fishers Lane
Rockville, MD 20857
Label 228, March 2016
FOR DOMESTIC AND INTERNATIONAL U

OMB Control Number: 0915-0334
Expiration Date: 3/31/2023

COUNTERMEASURES INJURY COMPENSATION PROGRAM
REQUEST FOR BENEFITS FORM

The Countermeasures Injury Compensation Program (CICP) provides certain medical and lost employment income benefits for individuals who were administered or used a covered countermeasure (such as 2009 H1N1 vaccine, Tamiflu®, Relenza®, and peramivir, mechanical ventilator, N-95 Filter Mask, anthrax vaccine, smallpox vaccine, etc.) and suffered a serious physical injury as a result. Individuals have one year from the date they were administered or used the covered countermeasure to submit a Request for Benefits Form (Request Form) in order to be considered for benefits. Although the CICP needs all the medical documentation that supports the injury in order to process the request, **requesters may submit only this Form in order to meet the filing deadline.** The CICP may also provide death benefits to certain survivors. The estate of a deceased individual may also qualify for certain medical and lost employment income benefits.

Read the instructions before completing this Request for Benefits Form.

SECTION A. INJURED COUNTERMEASURE RECIPIENT

Fill in information about the person who was administered or used a covered countermeasure and may have had a serious injury from the countermeasure.

First Name (b) (6); 552a(b) Middle Initial (b) (6); 552a(b) Last Name: (b) (6); 552a(b)

Date of Birth: (b) (6); 552a(b)

Address (b) (6); 552a(b)

City: (b) (6); 552a(b) State: (b) (6); 552a(b) Zip or Postal Code: (b) (6); 552a(b)

Country (if other than the United States of America):

Telephone Number(s): (b) (6); 552a(b)

Email address: (b) (6); 552a(b)

Type of countermeasure (e.g., 2009 H1N1 vaccine): (b) (6); 552a(b)

Date(s) of the countermeasure administration or use that may have caused the injury: (b) (6); 552a(b)

Geographic location in which the countermeasure was administered or used (e.g., city, State): (b) (6); 552a(b)

Continued on next page

Describe the purpose for receiving the countermeasure (e.g., "There was an outbreak in my community"):
(b) (6); 552a(b)

Who administered it? (e.g., doctor, hospital, clinic, local health department (b) (6); 552a(b)

Date of onset of the injury: (b) (6); 552a(b)

Describe the injury that may have resulted from the countermeasure:
(b) (6); 552a(b)

If you are the **injured countermeasure recipient**, go to Section E and sign this Request Form.

If you are a **survivor of a deceased injured countermeasure recipient** who may have died as a result of the countermeasure, go to Section B (Yellow).

If you are the **executor or administrator of the estate of a deceased injured countermeasure recipient**, regardless of the cause of death, go to Section C (Blue).

If you are the legal or **personal representative (including parent or guardian) of a person applying for Program benefits**, go to Section D (Orange).

OMB Control Number: 0915-0334
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SECTION B. SURVIVOR OF DECEASED INJURED COUNTERMEASURE RECIPIENT WHO MAY HAVE DIED AS A RESULT OF THE COVERED COUNTERMEASURE

All information in Section B refers only to the survivor(s) of the individual identified in Section A, who is/are requesting death benefits.

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____

Address: _____

City: _____ State: _____ Zip or Postal Code: _____

Country (if other than the United States of America): _____

Telephone Number(s): _____

Email address: _____

The date the injured countermeasure recipient identified in Section A died: _____

In order to be considered for Program benefits, a survivor must be in one of the categories described below. **Check** the box that describes the person identified in Section B in relation to the individual identified in Section A.

☐ Spouse
☐ Eligible child (described in the instructions)
☐ Dependent younger than the age of 18 (described in the instructions)
☐ Beneficiary named in most recently executed life insurance policy (and there are no survivors in the categories described above)
☐ Parent (and there are no survivors in the categories described above)
☐ Legal guardian of a deceased minor (and there are no survivors in the categories listed above)
☐ Adult child (and there are no survivors in the categories described above)

Check the first box below if the requester is a sole survivor or the second box if there are other survivors described above.

☐ To the best of my knowledge, there are no other survivors who may be eligible for a CICP death benefit payment; or

☐ There are other survivors who may be eligible for a CICP death benefits payment. I am providing their names and their relationship to the person we survived. If this box is checked, list survivors. Use additional sheet(s), if necessary. (Eligible survivor categories are listed above.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Go to **Section C (Blue)** if you are also the executor or the administrator of the estate.

Go to **Section D (Orange)** if there is a legal or personal representative; **otherwise**, go to **Section E** to sign this Request Form.

OMB Control Number: 0915-0334
Expiration Date: 3/31/2023

SECTION C. EXECUTOR OR ADMINISTRATOR OF THE ESTATE OF A DECEASED INJURED COUNTERMEASURE RECIPIENT

The Program may provide medical and/or lost employment income benefits to the estate of a deceased individual described in Section A, regardless of the cause of death. All information requested in Section C refers to the executor or administrator of the estate only.

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip or Postal Code: _____

Country (if other than the United States of America): _____

Telephone Number(s): _____

Email address: _____

Go to **Section D (Orange)** if there is a legal or personal representative; **otherwise**, go to **Section E** to sign this Request Form.

SECTION D. LEGAL OR PERSONAL REPRESENTATIVE (including parent or guardian)

If you are the legal or personal representative of a minor or adult who does not have legal capacity to receive payments, complete Section D. Otherwise, a person requesting benefits does not need to have a legal or personal representative, but may choose to do so. All communications will generally be conducted with the representative, if one is identified. The CICP reserves the right to communicate with the requester if necessary.

The CICP will not pay or reimburse any fees or costs incurred by using a representative.

All Information in Section D refers to the legal or personal representative.

First Name: (b) (6); 552a(b) Middle Initial: (b) (6); 552a(b) Last Name: (b) (6); 552a(b)

Address: (b) (6); 552a(b)

City: (b) (6); 552a(b) State: (b) (6); 552a(b) Zip or Postal Code: (b) (6); 552a(b)

Country (if other than the United States of America): _____

Telephone Number(s): (b) (6); 552a(b)

Email address: (b) (6); 552a(b)

Relationship to the person applying for Program benefits (e.g., parent, lawyer): (b) (6); 552a(b)

Is the person you are representing a minor or an adult who does not have the legal capacity to receive payments?

(b) (6); 552a(b)

Go to **Section E** to sign this Request Form.

SECTION E. SIGNATURE

To be signed by the requester who is: (a) the injured countermeasure recipient identified in Section A; or (b) the survivor identified in Section B; or (c) the executor or administrator of the estate identified in Section C. If the requester does not have the legal capacity to receive a Program payment, then the personal or legal representative identified in Section D must sign on his or her behalf.

By signing this Form:

1) I hereby certify that the information provided in this Request Form is true and accurate to the best of my knowledge. Further, I understand that false statements or claims made in connection with this Request Form, including subsequent information and documentation submitted in connection with this Request Form, may result in fines, imprisonment and/or any other remedy, including civil remedies, available by law to the United States.

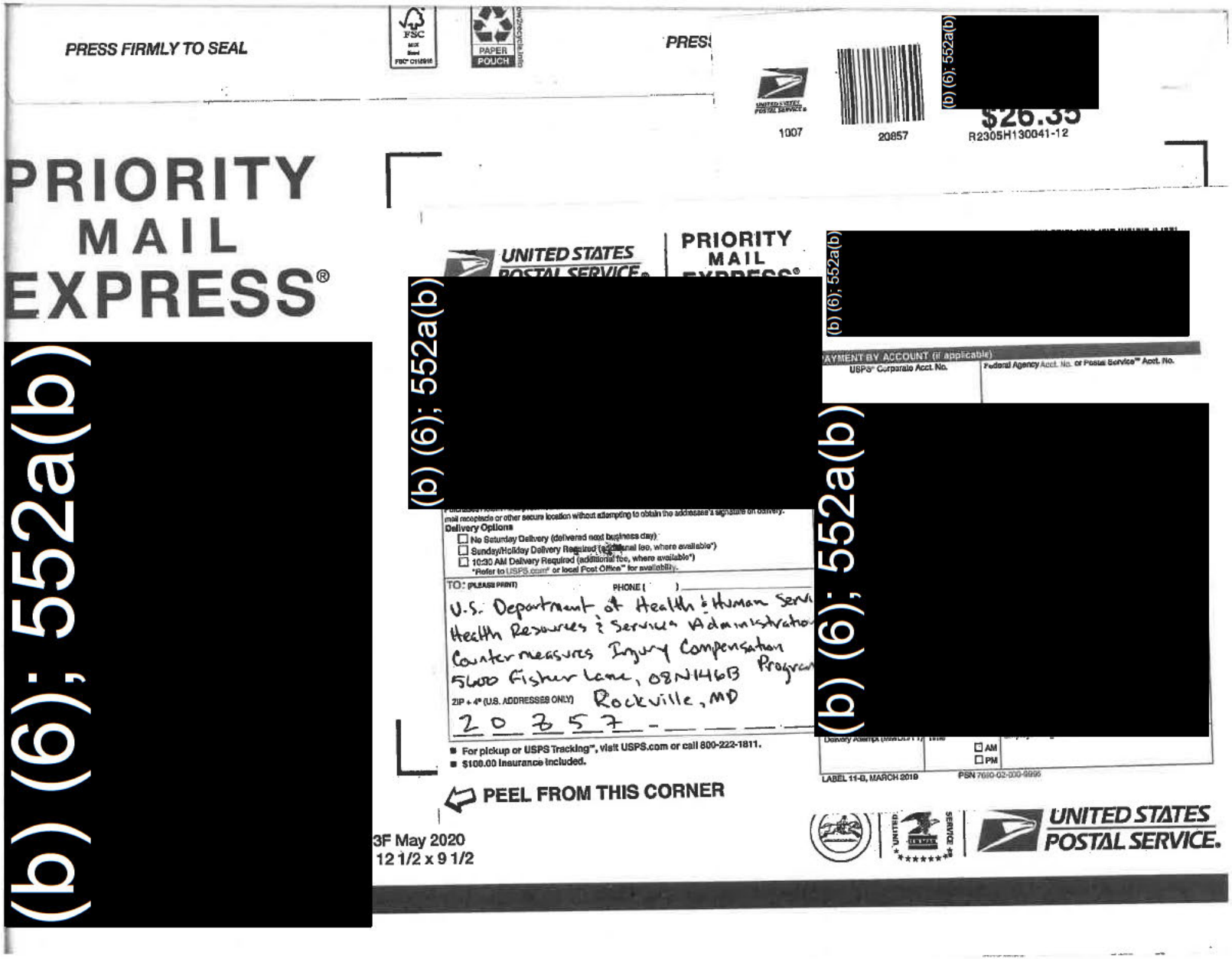
2) I will provide updated information (including, but not limited to medical records, employment income records, and change of address) until the Program has made its final decision.

3) **(Check one):**

[redacted]

Name (Print clearly): [redacted]

Signature: [redacted] Date: [redacted]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COUNTERMEASURES INJURY COMPENSATION PROGRAM
REQUEST FOR BENEFITS FORM

The Countermeasures Injury Compensation Program (CICP) provides certain medical and lost employment income benefits for individuals who were administered or used a covered countermeasure (such as 2009 H1N1 vaccine, Tamiflu®, Relenza®, and peramivir, mechanical ventilator, N-95 Filter Mask, anthrax vaccine, smallpox vaccine, etc.) and suffered a serious physical injury as a result. Individuals have one year from the date they were administered or used the covered countermeasure to submit a Request for Benefits Form (Request Form) in order to be considered for benefits. Although the CICP needs all the medical documentation that supports the injury in order to process the request, **requesters may submit only this Form in order to meet the filing deadline.** The CICP may also provide death benefits to certain survivors. The estate of a deceased individual may also qualify for certain medical and lost employment income benefits.

Read the instructions before completing this Request for Benefits Form.

SECTION A. INJURED COUNTERMEASURE RECIPIENT

Fill in information about the person who was administered or used a covered countermeasure and may have had a serious injury from the countermeasure.

First Name: (b) (6); 552a(b) Middle Initial: (b) (6); 552a(b) Last Name: (b) (6); 552a(b)

Date of Birth: (b) (6); 552a(b)

Address: (b) (6); 552a(b)

City: (b) (6); 552a(b) State: (b) (6); 552a(b) Zip or Postal Code: (b) (6); 552a(b)

Country (if other than the United States of America): _____

Telephone Number(s): (b) (6); 552a(b)

Email address: (b) (6); 552a(b)

Type of countermeasure (e.g., 2009 H1N1 vaccine): (b) (6); 552a(b)

Date(s) of the countermeasure administration or use that may have caused the injury: (b) (6); 552a(b)

Geographic location in which the countermeasure was administered or used (e.g., city, State): (b) (6); 552a(b)

Continued on next page

Describe the purpose for receiving the countermeasure (e.g., "There was an outbreak in my community"):

There was an outbreak in the U.S.

Who administered it? (e.g., doctor, hospital, clinic, local health department): (b) (6); 552a(b)

Date of onset of the injury: (b) (6); 552a(b)

Describe the injury that may have resulted from the countermeasure:

(b) (6); 552a(b)

If you are the **injured countermeasure recipient**, go to Section E and sign this Request Form.

If you are a **survivor of a deceased injured countermeasure recipient** who may have died as a result of the countermeasure, go to Section B (Yellow).

If you are the **executor or administrator of the estate of a deceased injured countermeasure recipient**, regardless of the cause of death, go to Section C (Blue).

If you are the legal or **personal representative (including parent or guardian) of a person applying for Program benefits**, go to Section D (Orange).

SECTION C. EXECUTOR OR ADMINISTRATOR OF THE ESTATE OF A DECEASED INJURED COUNTERMEASURE RECIPIENT

The Program may provide medical and/or lost employment income benefits to the estate of a deceased individual described in Section A, regardless of the cause of death. All information requested in Section C refers to the executor or administrator of the estate only.

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip or Postal Code: _____

Country (if other than the United States of America): _____

Telephone Number(s): _____

Email address: _____

Go to **Section D (Orange)** if there is a legal or personal representative; **otherwise,** go to **Section E** to sign this Request Form.

OMB Control Number: 0915-0334
Expiration Date: 3/31/2023

SECTION B. SURVIVOR OF DECEASED INJURED COUNTERMEASURE RECIPIENT WHO MAY HAVE DIED AS A RESULT OF THE COVERED COUNTERMEASURE

All information in Section B refers only to the survivor(s) of the individual identified in Section A, who is/are requesting death benefits.

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____

Address: _____

City: _____ State: _____ Zip or Postal Code: _____

Country (if other than the United States of America): _____

Telephone Number(s): _____

Email address: _____

The date the injured countermeasure recipient identified in Section A died: _____

In order to be considered for Program benefits, a survivor must be in one of the categories described below. **Check** the box that describes the person identified in Section B in relation to the individual identified in Section A.

☐ Spouse
☐ Eligible child (described in the instructions)
☐ Dependent younger than the age of 18 (described in the instructions)
☐ Beneficiary named in most recently executed life insurance policy (and there are no survivors in the categories described above)
☐ Parent (and there are no survivors in the categories described above)
☐ Legal guardian of a deceased minor (and there are no survivors in the categories listed above)
☐ Adult child (and there are no survivors in the categories described above)

Check the first box below if the requester is a sole survivor or the second box if there are other survivors described above.

☐ To the best of my knowledge, there are no other survivors who may be eligible for a CICP death benefit payment; or

☐ There are other survivors who may be eligible for a CICP death benefits payment. I am providing their names and their relationship to the person we survived. If this box is checked, list survivors. Use additional sheet(s), if necessary. (Eligible survivor categories are listed above.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Go to **Section C (Blue)** if you are also the executor or the administrator of the estate.

Go to **Section D (Orange)** if there is a legal or personal representative; **otherwise**, go to **Section E** to sign this Request Form.

SECTION D. LEGAL OR PERSONAL REPRESENTATIVE (including parent or guardian)

If you are the legal or personal representative of a minor or adult who does not have legal capacity to receive payments, complete Section D. Otherwise, a person requesting benefits does not need to have a legal or personal representative, but may choose to do so. All communications will generally be conducted with the representative, if one is identified. The CICP reserves the right to communicate with the requester if necessary.

The CICP will not pay or reimburse any fees or costs incurred by using a representative.

All Information in Section D refers to the legal or personal representative.

First Name: (b) (6); 552a(b) Middle Initial: (b) (6); 552a(b) Last Name: (b) (6); 552a(b)

Address: (b) (6); 552a(b)

City: (b) (6); 552a(b) State: (b) (6); 552a(b) Zip or Postal Code: (b) (6); 552a(b)

Country (if other than the United States of America): _____

Telephone Number(s): (b) (6); 552a(b)

Email address: (b) (6); 552a(b)

Relationship to the person applying for Program benefits (e.g., parent, lawyer): (b) (6); 552a(b)

Is the person you are representing a minor or an adult who does not have the legal capacity to receive payments?

(b) (6); 552a(b)

Go to **Section E** to sign this Request Form.

SECTION E. SIGNATURE

To be signed by the requester who is: (a) the injured countermeasure recipient identified in Section A; or (b) the survivor identified in Section B; or (c) the executor or administrator of the estate identified in Section C. If the requester does not have the legal capacity to receive a Program payment, then the personal or legal representative identified in Section D must sign on his or her behalf.

By signing this Form:

1) I hereby certify that the information provided in this Request Form is true and accurate to the best of my knowledge. Further, I understand that false statements or claims made in connection with this Request Form, including subsequent information and documentation submitted in connection with this Request Form, may result in fines, imprisonment and/or any other remedy, including civil remedies, available by law to the United States.

2) I will provide updated information (including, but not limited to medical records, employment income records, and change of address) until the Program has made its final decision.

3) **(Check one):**

(b) (6); 552a(b)

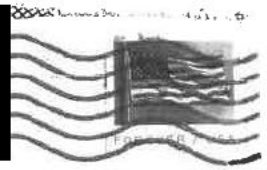
(b) (6); 552a(b)

Name (Print clearly): (b) (6); 552a(b)

Signature: (b) (6); 552a(b) Date: (b) (6); 552a(b)

(b) (6); 552a(b) [redacted]

(b) (6); 552a(b) [redacted]



U.S. Department of Health and Human Services
Health Resources and Services Administration
Countermeasures Injury Compensation Program
5600 Fishers Lane, 08N 146B
Rockville, MD 20857

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