

## 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: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip or Postal Code: \_\_\_\_\_

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

Telephone Number(s): \_\_\_\_\_

Email address: \_\_\_\_\_

Type of countermeasure (e.g., 2009 H1N1 vaccine): \_\_\_\_\_

Date(s) of the countermeasure administration or use that may have caused the injury: \_\_\_\_\_

Geographic location in which the countermeasure was administered or used (e.g., city, State): \_\_\_\_\_

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

Who administered it? (e.g., doctor, hospital, clinic, local health department): \_\_\_\_\_

Date of onset of the injury: \_\_\_\_\_

Describe the injury that may have resulted from the countermeasure: \_\_\_\_\_

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: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

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 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  
 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)

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 CICIP death benefit payment;  
or  
 There are other survivors who may be eligible for a CICIP 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.

**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 CICIP reserves the right to communicate with the requester if necessary.

**The CICIP 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):**

- I have the legal capacity to receive Program payments; or  
 I represent someone who does not and I am signing below.

Name (Print clearly): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**You can submit your Request Form and all the required documentation to the CICIP 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, 11C-06  
Rockville, MD 20857

For Program information and to obtain an additional copy of this Form and the instructions for completing it, visit the CICIP Web site at <http://www.hrsa.gov/countermeasurescomp>, call 1-888-275-4772 (1-888-ASK-HRSA), or email: [CICIP@hrsa.gov](mailto:CICIP@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, 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**

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 project is 0915-0334. Public reporting burden for this collection of information is estimated to average 5 hours per respondent annually, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, 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 10-33, Rockville, Maryland, 20857