OMB No 0915-0282
Expiration Date:

SMALLPOX VACCINE INJURY COMPENSATION PROGRAM REQUEST FORM

This Request Form is to be used by injured smallpox vaccine recipients or vaccinia contacts, their survivors, their estates, or their representatives who are seeking the payment of benefits from the Smallpox Vaccine Injury Compensation (SVIC) Program under the Smallpox Emergency Personnel Protection Act of 2003. Refer to the instructions and the documentation checklist for the supporting documentation that you must provide in order to be deemed eligible for payment. **The Request Form and supporting documentation are subject to audit by the U.S. Department of Health and Human Services' Office of Inspector General, the U.S. Department of Justice, the U.S. Department of Labor, and/or the General Accounting Office.**

Refer to the Request Form Instructions. All terms, such as "smallpox vaccine recipient," "vaccinia contact," and "covered injury," are described in the instructions as well as the procedures for a requester to submit a Request Package to the SVIC Program.

BENEFITS SOUGHT

To be completed by all individuals who submit a Request Form.

Injured individuals or their estates may be eligible for medical benefits, lost employment income benefits or both. Survivors are eligible for death benefits only. Check all that apply:

[ ] Medical benefits
[ ] Lost employment income benefits
[ ] Death benefits

SECTION A. SMALLPOX VACCINE RECIPIENT OR VACCINIA CONTACT WHO SUSTAINED AN INJURY

Refer to the instructions for Section A.

If you are a smallpox vaccine recipient, or the survivor, representative, or representative of the estate of one, complete section A1.

If you are a vaccinia contact, or the survivor, representative, or representative of the estate of one, complete section A2.

A1. THIS SECTION DESCRIBES THE INJURED SMALLPOX VACCINE RECIPIENT

Name:_____
_

Social Security Number: _____ Date of Birth:
_____

Type of injury from the vaccination or other covered countermeasure: _____

The number of days of lost employment income that resulted from the medical injury: _____

Check here [ ] if the smallpox vaccine recipient had a dependent under the age of 18 at the date of the onset of the medical injury.

If the smallpox vaccine recipient is no longer living, provide date of death: _____

Complete address information if smallpox vaccine recipient is living:

Address: _____

City: _____ State: _____ Zip Code:_____

Daytime telephone number(s):_____

A2. THIS SECTION DESCRIBES THE INJURED VACCINIA CONTACT

Name:_____
_

Social Security Number: _____ Date of Birth:
_____

Type of injury from the vaccinia: _____

Date of first symptom of the medical injury: _____

The number of days of lost employment income that resulted from the medical injury: _____

Check here [ ] if the vaccinia contact had a dependent under the age of 18 at the date of the onset of the medical injury.

If the vaccinia contact is no longer living, provide date of death: _____

Complete address information if the vaccinia contact is living:

Address: _____

City: _____ State: _____ Zip Code:_____

Daytime telephone number(s):_____

SOURCE OF EXPOSURE TO VACCINIA

Check one of the boxes below and provide the appropriate information:

Check here [ ] If the individual contracted vaccinia from a smallpox vaccine recipient, then provide the name of that smallpox vaccine recipient _____; or

Check here [ ] if the individual contracted vaccinia from another contact; then provide the name of that contact: _____
and the name of the smallpox vaccine recipient from whom that contact contracted vaccinia: _____; or

Check here [ ] if the identity of the person from whom the individual contracted vaccinia is unknown. Attach a narrative explaining why this information cannot be provided and the circumstance surrounding the accidental vaccinia exposure (that led to the contracting of vaccinia).

SECTION B. SURVIVOR(S) OF A SMALLPOX VACCINE RECIPIENT OR A VACCINIA CONTACT

Refer to the instructions for Section B.

Name:_____
_

Social Security Number: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code:_____

Daytime telephone number(s):_____

Check the box that describes the Survivor's Relationship to the Individual in Section A

[ ] Spouse
[ ] Eligible Child (described in the instructions)
[ ] Dependent younger than the age of 18
[ ] Beneficiary 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 box that indicates if the survivor is a sole survivor or if there are other survivors who may be eligible for benefits payment

[ ] To the best of my knowledge, there are no other survivors who may be eligible for payment under the Act.
[ ] There are other survivors who may be eligible for benefits payment under the Act. I am providing all of their names and their relationship to the person we survived.
(If this box is checked, list survivors. Use additional sheet, if necessary. Eligible survivors are described above).

Name:_____ Name: _____

Relationship: _____ Relationship: _____

Name:_____ Name: _____

Relationship: _____ Relationship: _____

[ ] Check this box if this is a Request Form filed on behalf of multiple survivors and submit with the Request Form the names, addresses, Social Security Numbers, and daytime telephone numbers of all the survivors to be included in this Request Form.

SECTION C. REPRESENTATIVE(S) OF THE ESTATE OF A SMALLPOX VACCINE RECIPIENT OR A VACCINIA CONTACT

Refer to the instructions for Section C.

Name:_____
_

Address: _____

City: _____ State: _____ Zip Code:_____

Daytime telephone number(s): _____

SECTION D. PERSONAL REPRESENTATIVE

Complete this section if you are the attorney or other representative for the requester. ***If this section is completed, all communications will be made only to the personal representative.*** *Refer to the instructions for Section D.*

Name:_____

Address: _____

City: _____State: _____ Zip Code:_____

Daytime telephone number(s): _____

Does the person you are representing have the legal capacity to receive payments?
[ ] Yes - or -
[ ] No. (e.g., a minor or an individual who is otherwise legally incompetent)
If no, please explain: _____

If a personal representative seeks a death benefit on behalf of one or more minor dependents who are also surviving children, then the legal guardian must select one of the two payment options below on behalf of all the dependents for whom he or she is the legal guardian. **Refer to instructions for a description of the options.**
[ ] Death Benefit under the Standard Calculation, or
[ ] Death Benefit under the Alternative Calculation

SECTION E. SIGNATURE

TO BE SIGNED BY THE REQUESTER. *If the requester does not have the legal capacity to receive payments, then the Request Form is to be signed by the legal guardian of the requester. Refer to the instructions for Section E*.

Reminder: Attach all necessary documentation. See instructions.
Acknowledgement of Continuing Obligation to Correct, Amend and Supplement Information, and Certification of Accuracy of Information

I hereby acknowledge that the United States will rely on the information contained in the Request Form, and the documentation submitted in connection with the Request Form, and I have a continuing obligation to correct, amend and/or supplement the information provided in connection with this Request Form if any of the material information, which I have submitted, should change.

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.

If there is a personal representative identified in Section D, I affirm that I am legally competent and that I have authorized that person to submit a Request Form on my behalf.

Name (type or print clearly): _____

Signature: _____ Date: _____

You can submit your Request Form and all the required documentation to the SVIC Program by U.S. mail, by a private courier service or commercial carrier. Use one of the two addresses specified below.

For U.S. mail only:
Smallpox Vaccine Injury Compensation Program Office
5600 Fishers Lane, Room 16C-17
Rockville, MD 20857

For private courier service or commercial carrier only:
Smallpox Vaccine Injury Compensation Program Office
5600 Fishers Lane, 10th Floor
Rockville, MD 20857

PRIVACY ACT STATEMENT

Section 2 of Public Law 108-20 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. 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.