COUNTERMEASURES INJURY COMPENSATION PROGRAM

REQUEST FOR BENEFITS FORM INSTRUCTIONS

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You have one year to apply for Program benefits after the administration or use of a covered countermeasure associated with the injury.

I. Background

The Countermeasures Injury Compensation Program (CICP) is a Federal government program that administers the compensation Program specified by the Public Readiness and Emergency Preparedness Act (PREP Act). The PREP Act provides compensation to individuals for serious physical injuries or deaths from pandemic, epidemic, or security countermeasures identified in declarations issued by the Secretary pursuant to section 319F-3(b) of the Public Health Service Act (PHS Act) (42 U.S.C. § 247d-6d).

A "PREP Act declaration" by the Secretary of the Department of Health and Human Services (Secretary) specifies the categories of health threats or conditions for which countermeasures are recommended, the effective time-period, and the covered populations and geographic areas.

As of November 2009, there are declarations for pandemic influenza countermeasures, such as 2009 H1N1 vaccine, mechanical ventilators, certain antivirals (e.g. Tamiflu®, Relenza®, and peramivir), smallpox, anthrax, radiation and botulism countermeasures. The declarations are subject to change. Copies of the declarations are available at the Program Web site: www.hrsa.gov/countermeasurescomp.

In order to be considered for Program benefits, an injured countermeasure recipient must have been administered or used a covered countermeasure according to the terms of a declaration (or in a good faith belief of such). The injured countermeasure recipient must also have sustained a serious physical injury or died as a result of the covered countermeasure. The PREP Act also allows certain

survivors of an injured countermeasure recipient to be eligible to receive death benefits if the death resulted from the administration or use of the covered countermeasure. Also the estate of a deceased injured countermeasure recipient may be eligible for certain benefits, regardless of the cause of death.

II. Program Benefits

- **Medical Benefits:** CICP provides certain medical benefits determined to be reasonable and necessary to diagnose or treat a covered injury or to diagnose, treat, or prevent its health complications. There is no limit on the amount of reasonable medical benefits.

- **Lost employment income benefits:** Lost employment income benefits are 66 2/3% of an individual's unreimbursed gross income (75% if the individual had dependent(s) at the time of injury). There is a maximum of $50,000 for lost employment income per year and this benefit may be paid until the individual reaches the age of 65.

- **Death benefits:** CICP provides death benefits to certain survivors of a deceased injured countermeasure recipient who died as a result of the administration or use of a covered countermeasure. In most cases, the death benefit amount is based on the Public Safety Officers' Benefit (PSOB) Program and the amount may change annually.

For medical, lost employment and certain death benefits the CICP is the payer of last resort.

III. Individuals Eligible for Program Benefits

A. **The injured countermeasure recipient:** An individual who was administered or who used a covered countermeasure may be eligible for out-of-pocket, unreimbursable medical and lost employment income benefits.

B. **The survivor of a deceased injured countermeasure recipient:** To be a survivor eligible for death benefits, the injured countermeasure recipient must have died as a direct result of his or her injuries resulting from the administration or use of a covered countermeasure. An eligible survivor may receive death benefits, but not other benefits.

C. **The estate of a deceased injured countermeasure recipient:** The estate may be eligible for Program benefits if the injured countermeasure recipient died, regardless of the cause of death. The estate may receive medical and/or lost employment income benefits that the injured countermeasure recipient would have received for benefits accrued prior to death.

IV. Use of a Legal or Personal Representative

The use of a legal or personal representative is optional except for certain circumstances described in Section IX below. **The CICP will not pay or reimburse any fees or costs incurred by using a representative**.

V. Filing Deadline

You have **ONE YEAR** to apply for Program benefits after the administration or use of a covered countermeasure associated with the injury. **In order to meet the filing deadline, you only need to submit the Request for Benefits Form (Request Form)**. However, the CICP cannot process your request without having all the necessary documentation.

VI. Instructions for All Requesters (Section A of Request Form)

1. All requesters must complete Section A of the Request Form, which requires information regarding the injured countermeasure recipient, **and Section E,** the Signature section.

2. The Request Form and all documentation must be submitted by U.S. mail, private courier service, or commercial carrier to the following address:

U.S. Department of Health and Human Services
Health Resources and Services Administration
Countermeasures Injury Compensation Program
5600 Fishers Lane, Room 11C-06
Rockville, MD 20857

The postmark or its equivalent (e.g., the delivery date provided by the commercial carrier) will be considered the date of filing to determine if you met the filing deadline.

Check the Program Web site, www.hrsa.gov/countermeasurescomp, to see if this Form can be submitted electronically. If you can, then the filing date is the date the Request Form is submitted electronically.

To obtain an additional copy of this Form and the instructions for completing it, visit the CICP Web site at http://www.hrsa.gov/countermeasurescomp, call 1-855-266-2427 (855-266-CICP), or email: CICP@hrsa.gov.

3. For your own records, keep a copy of all Forms and documentation that you submit.

Updates in Information Provided

If there are any updates in the information you provided in your Request Form or in your documentation (such as new medical records or a new address), you are required to submit the updated information to the CICP as soon as possible.

Request Form Instructions

SECTION A. INJURED COUNTERMEASURE RECIPIENT

This section must be completed by all requesters, including survivors, estates, and legal or personal representatives.

- First Name: The first name of the injured countermeasure recipient.
- Middle Initial: The middle initial of the injured countermeasure recipient.
- Last Name: The family name or surname of the injured countermeasure recipient.
- Date of Birth: The birth date of the injured countermeasure recipient (month, day, and 4-digit year, e.g., October 23, 1960).

- Address: The injured countermeasure recipient's mailing address. If the injured countermeasure recipient is deceased, enter "NA."
- City, State, and Zip or Postal Code: The city, State, and zip or postal code associated with the address. If the injured countermeasure recipient is deceased, enter "NA."
- Country if other than the United States of America: If the injured countermeasure recipient is deceased, enter "NA."
- Telephone Number(s): The phone number(s) by which the injured countermeasure recipient can be reached, including home phone, office phone, and/or cell phone if available. If the injured countermeasure recipient is deceased, enter "NA."
- Email address: The injured countermeasure recipient's email address. This field is optional. If the injured countermeasure recipient is deceased or if there is no email address, enter "NA."
- Type of covered countermeasure: Describe the covered countermeasure that was administered or used, such as 2009 H1N1 vaccine or anthrax vaccine, that may have caused the injury.
- Date(s) of receipt or use of the covered countermeasure that may have caused the injury: The month, day, and 4-digit year on which the injured countermeasure recipient received the covered countermeasure. For example, if an individual had two 2009 H1N1 vaccinations, then both dates should be provided. If there is only one use of a covered countermeasure, then provide that date. If the covered countermeasure was used over a period of time then provide the time period, (for example, I was given Tamiflu from September 1-7, 2009).
- Geographic location in which the covered countermeasure was used (e.g. city, State): The city, county, State, where the covered countermeasure was administered or used. If abroad, include the country and other pertinent information (e.g., a military base or U.S. Embassy).
- Describe the purpose for receiving the covered countermeasure: Each declaration identifies the purpose by which an individual can be administered or can use a covered countermeasure and receive Program benefits. The information in this field could be, "I received the covered countermeasure because of the swine flu pandemic."
- Who administered it to you (e.g., doctor, hospital, clinic, local health department): For example, one might enter in this field, "The Montgomery County Health Department in Pennsylvania."
- Date of onset of injury. The month, day, and 4-digit year on which the injured countermeasure recipient first became symptomatic or ill.
- Describe the injury that may have resulted from the covered countermeasure: Briefly describe the illness or injury that can be supported by medical documentation. For example: "I developed a rash and hives within an hour after receiving the 2009 H1N1 vaccine and my doctor treated me for a severe allergic reaction. I was put in the hospital for a week."

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 covered 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).

VII. Additional Instructions for a Survivor of Deceased Injured Countermeasure Recipient who May Have Died as a Result of the Covered Countermeasure (Section B of the Request Form)

Certain survivors may be eligible for death benefits, such as the deceased injured countermeasure recipient's spouse, child, minor dependent, beneficiary named in the most recently executed life insurance policy, parent, or, if the deceased is a minor, the legal guardian. There is a priority order for survivors, specifically:

1. **Spouse, child(ren), and minor dependent(s):** The spouse may receive 50% of the death benefit and the child(ren) and minor dependent(s) may receive a percentage.

2. **Beneficiary named in the most recently executed life insurance policy:** This individual may receive the entire death benefit if there is no spouse, no child, and no minor dependent.

3. **Parent:** Parents may receive the death benefit in equal shares only if there is no spouse, no child, and no minor dependent, and no beneficiary of a life insurance policy. If there is only one surviving parent, that parent may receive the entire death benefit.

4. **Legal guardian of a deceased minor:** If the deceased injured countermeasure recipient was a minor, then his or her legal guardian if other than a parent (such as a grandparent) may receive the death benefit if there are no other survivors as listed above.

If the deceased injured countermeasure recipient died as a result of an injury caused by the counter measure, provide the following information about the survivor:

- First Name: The first name of the survivor.
- Middle Initial: The middle initial of the survivor.
- Last Name: The family name or surname of the survivor.
- Date of Birth: The birth date of the survivor (month, day, and 4-digit year, e.g., October 23, 1960).
- Address: The survivor's mailing address.
- City, State, and Zip or Postal Code: The city, State, and zip or postal code associated with the address.
- Country if other than the United States of America.
- Telephone Number(s): The phone number(s) at which the survivor can be reached, including home phone, office phone, and/or cell phone if available.
- Email address: The survivor's email address. This field is optional.
- The date on which the deceased injured countermeasure recipient identified in Section A died: Provide the month, day, and 4-digit year on which the injured countermeasure recipient died.

In order to be considered for death benefits, the survivor must be in one of the categories listed on the Form.
Indicate which best describes the survivor in relation to the deceased injured countermeasure recipient:

- Spouse: The spouse. A spouse (lawful husband, wife, widow, or widower) will qualify if he or she qualifies as a spouse under the PSOB. Certain common law marriages will qualify in those States that recognize common law marriages. An eligible spouse who is separated but not legally divorced may be considered for death benefits.
- Eligible child - a natural, illegitimate, adopted, or posthumous child, or stepchild of a deceased injured countermeasure recipient who, at the time of the recipient's death, is:
    - 18 years old or under, or

  - between 19 and 22 and a full-time student, or
  - incapable of self-support due to a physical or mental disability.
- Dependent younger than the age of 18: This category covers dependents other than children, for example, nieces, nephews, foster children or other minors.
- Beneficiary named in the most recently executed life insurance policy: In the event that the injured countermeasure recipient dies without a spouse, child, or dependent minor, then the person named in the most recently executed insurance policy may be eligible for death benefits.
- Parent: In the event that there is no spouse, no child, no minor dependent, and no beneficiary of a life insurance policy, then the two parents may divide the death benefit into equal shares. If there is only one parent, then he or she would receive the entire benefit. Step-parents are not considered parents for this purpose.
- Legal guardian of a deceased minor: If the deceased injured countermeasure recipient is a minor who died as a result of a covered countermeasure, then the legal guardian (such as grandparent) may be eligible for benefits if there are no other eligible survivors.

There may be one or more survivors who are eligible for death benefits. If you are the sole survivor, check the first box. If there are other survivors, check the second box and provide a list of their names and their relationship to the individual identified in Section A of the Request Form. The Request Form provides space for up to four survivors in addition to yourself. If there are more than four, attach an additional piece of paper and provide their names and their relationships to the individual identified in Section A as well.

If there are multiple eligible survivors and one (or more) of them dies before the Program pays the death benefit, then you can amend your Request Form to remove him, her, or them; provide a copy of that person or persons' death certificate(s).

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).

VIII. Additional Instructions for an Executor or Administrator of the Estate of a Deceased Injured Countermeasure Recipient (Section C of Request Form)

If the injured countermeasure recipient dies, **regardless of cause of death**, then the estate may receive certain medical and/or lost employment income benefits. For example:

- The injured countermeasure recipient died before filing a Request Form; or
- The injured countermeasure recipient submitted a Request Form, which was in review or was approved for Program benefits, but died before receiving CICP payments in full.

In order to be an executor or an administrator of an estate, one must have a letter of administration or other documentation from a court of competent jurisdiction. The executor or administrator is required to provide this documentation to the Program in order for the estate to be considered for benefits. However, the executor or administrator can submit the Request Form within the filing deadline, and then provide the documentation when it is available.

All information requested in this section pertains to the executor or administrator of the estate.

- First Name: The first name of the executor or the administrator of the estate.
- Middle Initial: The middle initial of the executor or the administrator of the estate.
- Last Name: The family name or surname of the executor or administrator.
- Address: The mailing address for the executor or administrator of the estate.
- City, State, and Zip or Postal Code: The city, State, and zip or postal code associated with the address.
- Country if other than the United States of America.
- Telephone Number(s): The phone number(s) at which the executor or administrator of the estate can be reached, including home phone, office phone, and/or cell phone if available.
- Email address: The email address of the executor or administrator of the estate. This is optional.

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

IX. Additional Instructions for a Legal or Personal Representative (Section D of Request Form)

A requester may choose to use a legal representative (such as a lawyer) or a personal representative (such as a relative, friend, or colleague) if he or she has the legal capacity to receive Program benefits. If the requester does not have the legal capacity, then a legal or personal representative must submit a Request Form on his or her behalf. **The Program does not pay or reimburse any fees or costs incurred by using a legal or personal representative.**

All information requested in this section pertains to the legal or personal representative.

- First Name: The first name of the legal or personal representative.
- Middle Initial: The middle initial of the legal or personal representative.
- Last Name: The family name or surname of the legal or personal representative.
- Address: The mailing address of the legal or personal representative.
- City, State, and Zip or Postal Code: The city, State, and zip or postal code associated with the address.
- Country if other than the United States of America.
- Telephone Number(s): The phone number(s) at which the legal or personal representative can be reached, including home phone, office phone, and/or cell phone if available.
- Email address: The email address of the legal or personal representative. This is optional.
- Relationship to the person applying for Program benefits: Describe how the legal or personal representative is related to the requester (such as parent, grandparent, friend, lawyer, etc.)

The Program needs to know if the person represented has the legal capacity to receive a payment.

- Select the first box if the person is legally competent (for example, an adult or emancipated minor as determined by State law or a court).

- Select the second box if the person is a minor or if a court has determined that the person is not legally competent (i.e., does not have the legal capacity to receive Program benefits).

Go to Section E to sign the Request Form.

X. Instructions for the Signature Section (Section E of Request Form)

All requesters must sign and date the Request Form unless they do not have the legal capacity to sign, in which case the legal or personal representative must sign on his or her behalf.
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- Type your name or print it clearly.
- Provide your signature.
- Date: The date that you signed the Request Form.

Submit your completed Form and all the required documentation using 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, Room 11C-06
Rockville, MD 20857

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

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