

Countermeasures Injury Compensation Program (CICP)

**Certification of Survivor Relationship to Deceased Injured Countermeasure Recipient**

Case Number: [CICPXXXXXXXXXX]

This Certification will assist the Countermeasures Injury Compensation Program (CICP) in determining benefits. Please complete the statement below that applies to your case, and print and sign your name below. For guidance on which statement to complete, see the letter detailing the information the CICP needs to determine your benefits. Potentially eligible survivors are listed on the CICP letter dated [insert date], under: **“Categories of Eligible Survivors and the Order of Priority for Payments of Death Benefits”**.

**Option 1**

I certify that I am the \_\_\_\_\_  
(state your relationship to the survivor, e.g. wife, mother, daughter, etc.)

of [recipient name] and there are **no** other eligible survivors.

**Option 2**

I certify that I am the \_\_\_\_\_  
(state your relationship to the survivor, e.g. wife, mother, daughter, etc.)

Of [recipient name] and there are other eligible survivors.

Please list other eligible survivors and their relationship to [recipient name]. If you need more space, attach a separate sheet of paper that lists additional eligible survivors and their relationship to [recipient name].

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

*By signing this form, I hereby certify that the information provided in this Certification is true and accurate to the best of my knowledge. Further, I understand that false statements or claims made in connection with this Certification, including subsequent information and documentation submitted in connection with this Certification, may result in any remedy, including civil remedies, available by law to the United States. 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 benefits decision.*

\_\_\_\_\_  
Name of Requester (Please print)

\_\_\_\_\_  
Name of Representative (if applicable)

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Signature of Requester or Representative

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Date