ATTACHMENT 3

OMB Number: 0915-0334
Expiration date: 4/30/2026

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".**

The CICP requests that you send all documentation within 60 days of the date of this letter. Please submit the requested form online at **injurycompensation.hrsa.gov (preferred)**. If you cannot submit the form electronically, you can return the form to the CICP at the following address:

Health Resources and Services Administration
Countermeasures Injury Compensation Program
5600 Fishers Lane, 8W-25A
Rockville, MD 20857

If you have questions, please call 1-855-266-2427, email CICPBenefits@HRSA.gov ~~CICP@HRSA.gov~~, or mail them to the address above.

Option 1

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

of [Deceased Injured Countermeasure Recipient's 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 [Deceased Injured Countermeasure Recipient's name] and there are other eligible survivors.

Please list other eligible survivors and their relationship to [Deceased Injured Countermeasure Recipient's name]. If you need more space, attach a separate sheet of paper that lists additional eligible survivors and their relationship to [Deceased Injured Countermeasure Recipient's 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)
_____	_____
Signature of Requester or Representative	Date