

**Countermeasures Injury Compensation Program (CICP)
Identifying Eligible Survivors
Requester Category: Survivor**

Case Number: _____ (starts with CICP#)

This form ~~helps CICP in identifying~~ individuals ~~that who~~ may be eligible for death benefits. Please complete the form below. Then, print your name, sign the form, and submit it with the required documents as described in Countermeasures Injury Compensation Program: Survivor Benefits Eligibility and Priority (Attachment 1)~~Attachment 1~~.

Eligible Survivors

~~Requester's Your~~ Name: _____

~~Requester's Your~~ relationship with the deceased _____ (See ~~See~~ ~~insert title of Attachment 1~~ for examples of survivors including: spouse, child (including natural, illegitimate, adopted, posthumous, or step- child), minor dependent, parent, sister, legal guardian of surviving deceased minor)

Select the appropriate box below ~~telling CICP of identifying~~ all eligible survivors of the deceased countermeasure recipient who may be eligible for death benefits. (Select only one)

- I certify there are **no** other eligible survivors who may be eligible to receive the death benefit.
- I certify there **are** other eligible survivors who may be eligible to receive the death benefit ~~other than myself~~, and they are listed below.

List them below:

<u>Family Member's Name</u>	<u>Relationship to Deceased</u>	<u>Contact Information (Home Address)</u>
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

Need more space? Use a separate sheet.

Final Attestation and Acknowledgement

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By signing this form, I hereby certify that the information provided ~~in this Identifying Eligible Survivors form 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 ~~form Certification~~, including subsequent information and documentation submitted in connection with this ~~form Certification~~, may result in fines, imprisonment and/or any other ~~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 Deceased Countermeasure Recipient (Please print)

Name of Requester Survivor of Deceased Countermeasure Recipient (Please print)

Signature of Survivor/Requester

Date

PUBLIC BURDEN STATEMENT The purpose of this data collection is to gather information to allow the Secretary of Health and Human Services to determine if requesters are eligible for Countermeasure Injury Compensation Program (CICP) benefits. Requesters (or their representatives) must submit appropriate documentation forms and relevant medical records as specified in Section 42 CFR 110.50-110.53 to the CICP. 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 information collection is 0915-0334 and it is valid until 4/30/2026. This information collection is required to obtain or retain a benefit (42 CFR Part 110). Access to these records is strictly limited to authorized users who are aware of their responsibilities under the Privacy Act and who are required to maintain Privacy Act safeguards with respect to such records. The System of Records Notice for Injury Compensation Programs, HHS/HRSA/HSB, System No. 09-15-0056, identifies authorized users. Public reporting burden for this collection of information is estimated to average ~~105+~~ hours per response, including the time for reviewing instructions, searching existing data sources, 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 14N136B, Rockville, Maryland, 20857 or paperwork@hrsa.gov. Please do not send documents related to an individual claim to paperwork@hrsa.gov.