SCHEDULE 2 TO
PROTOCOL FOR COVID-19 VACCINE FACILITY NO-FAULT COMPENSATION SCHEME

CLAIM FORM
UNDER THE
COVID-19 VACCINE FACILITY NO-FAULT COMPENSATION SCHEME[1]

INSTRUCTIONS / IMPORTANT NOTICES FOR CLAIMANTS:

1. **When to use this Form:** Use this Claim Form to file a claim for compensation under the Scheme in the event that you consider that you (as the Patient), or the Patient which you are duly authorised to represent, has suffered an Injury following the administration of a Vaccine. Before completing and submitting a Claim, please carefully read the Scheme's Protocol and the "How to Submit a Claim" instructions, available on the Scheme's website at www.C19VaccineNFC.com. If you have questions about the Scheme, this Claim Form or any other Scheme forms, please contact the Scheme's Administrator by email at nofaultclaims@esis.com.

2. **Submission with Supporting Evidence required:** You should submit this Claim Form together with the Supporting Evidence required by Schedule 3 of the Scheme's Protocol.

3. **Waiting period:** Except in the case described below, a waiting period of 30 days following the administration of a Vaccine to the Patient must be observed, before any steps towards initiating a Claim for compensation under the Scheme can be taken. In this regard, please do not complete and submit a Claim and do not obtain Supporting Evidence as required by Schedule 3 to the Protocol, if less than 30 days have passed since the Vaccine was administered, as in that case the Claim will not be accepted or considered.

    - **Exception:** The 30-day waiting period described above does not apply in case the Patient has died following the administration of a Vaccine, and the Patient's death is considered by a Registered Healthcare Professional to have been caused by this Vaccine or its administration.

4. **Accepted languages:** This Claim Form must be completed and submitted in English only. If this Claim is completed or submitted in any other languages, it cannot be accepted or

[1] Version dated 24 March 2022.

considered. However, any documents required under Section 8 of this Claim can be submitted in another language, if they are not available in English.

5. **Claimant to complete this Claim Form:** You should complete all sections/questions under this Claim. Please provide as much detail and information as possible.

6. **Name, signature and date required:** You should insert your full name, sign and date in the spaces provided in Section 14 of this Claim.

7. Failure (i) to complete all sections in this Claim Form, or (ii) to sign, date and insert your full name in the spaces provided under Section 14 of this Claim, will lead to the rejection of this Claim or to delays in processing it.

8. **Deadline for submission:** Please submit this Claim (together with all of the documents mentioned in Section 8 of this Claim) and all Supporting Evidence required by Schedule 3 to the Protocol to the Scheme's Administrator, before the end of the applicable Reporting Period (as indicated in Schedule 1 to the Scheme's Protocol). If this Claim is submitted after the end of the applicable Reporting Period, the Claim may not be accepted or considered under the Scheme.

9. **How to submit this Claim:** Once this Claim has been duly completed, signed and dated, you must submit this Claim (together with the documents mentioned in Section 8 of this Claim) and the Supporting Evidence required by Schedule 3 of the Protocol to the Scheme's Administrator, by any of the following means:

   - By uploading them to the Scheme's web portal, available at www.C19VaccineNFC.com;
   - By emailing them to nofaultclaims@esis.com; or
   - By sending them by regular mail to one of the Scheme's Regional Centres, whose addresses appear on Annex 1 (Contact Information of Regional Centres) attached to this Claim Form and are also available on the Scheme's web portal at www.C19VaccineNFC.com.

10. **Definitions:** Capitalised terms used but not defined in this Claim have the meaning given to them in the Scheme's Protocol, available at www.C19VaccineNFC.com.

[Claim Form continued on the next page]

1. **Details of the Patient.** Please provide the following information about the Patient (i.e. the beneficiary of a Vaccine that is either: (i) procured and/or delivered by UNICEF on a Participating Country's behalf; (ii) donated to a Participating Country through UNICEF; or (iii) formally included into the Scheme (but otherwise procured and/or delivered but not by or through UNICEF), who claims, or in respect of whom it is claimed, that he has suffered or sustained a Serious Adverse Event which is associated with a Vaccine or its administration, and which, in turn, has resulted in an Injury). **If you are submitting this Claim directly for yourself, you are the Patient and you do not need to complete Section 2 below.**

Full name of the Patient, including any middle names	
Mailing address (including city, zip code and country)	
Country of citizenship	
Country of residence	
Date of birth (day/month/year)	
Place of birth: City	
Place of birth: Country	
Sex	
National insurance number (or other social security number, passport number or	

similar identification number), if any	
Mobile/WhatsApp phone number, if any	
Secondary phone number, if any	
Email address, if any	

2. **Details of the person who has the legal power to submit this Claim for the Patient**

If the Patient: (a) has died; or (b) is disabled to the extent that the Patient cannot submit a Claim himself or herself; or (c) is a child; or (d) does not have legal capacity for any reason to submit a Claim himself or herself, then another person who has the legal power to submit this Claim for the Patient must do so.

In the above cases, please provide below the details of the person with the legal power to submit this Claim for the Patient, as well the nature of that power and details of that person's relationship with the Patient.

Full name, including any middle names, of the person submitting the Claim for the Patient	
Mailing address (including city, zip code and country)	
Date of birth (day/month/year)	
Place of birth	
National insurance number (or other social security number, passport number or similar identification number), if any	

Mobile/WhatsApp phone number, if any	
Secondary phone number, if any	
Email address, if any	
Relationship with the Patient	
Nature of the person's authority to make this Claim for the Patient	
If the Patient has died, state the nature of the person's right to make this Claim for the deceased Patient and to represent all legal heirs	

3. **Confirmations by the Claimant**

The Claimant (i.e. the Patient directly submitting this Claim for himself or herself, or the person submitting this Claim for the Patient in the cases outlined in Section 2 of this Claim Form, as applicable) should please respond to all of the following questions and, if necessary, provide relevant details:

A. Has the Claimant waited at least 30 days after the Vaccine that resulted in the Injury was administered, before completing this Claim Form and obtaining the Supporting Evidence referred to in Section 8 of this Claim Form? **NOTE:** The 30-day waiting period described above does not apply in the event the Patient has died following the administration of a Vaccine, and the Patient's death is considered by a Registered Healthcare Professional to have been caused by this Vaccine or its administration. Yes _____ No _____ (check only one answer) If "no", please provide details:

B. Has any previous claim for compensation under the Scheme been made for the Injury to which this Claim relates?

Yes _____ No _____ (check only one answer)

If "yes", provide details:

C. Has any prior payment from any other public source, including from any governmental or publically funded no-fault compensation scheme, been made as compensation for the Injury to which this Claim relates?

Yes _____ No _____ (check only one answer)

If "yes", provide details:

D. Is the Claimant eligible to receive compensation from any other source for the Injury to which this Claim relates?

Yes _____ No _____ (check only one answer)

If "yes", provide details of the nature and extent of Claimant's eligibility to receive compensation from another source for the Injury:

E. Has the Claimant previously applied for compensation for the Injury from any other vaccine injury compensation programme(s)?

Yes _____ No _____ (check only one answer)

If "yes", provide details:

F. Are there any pending lawsuits or claims for compensation for the Injury to which this Claim relates?

Yes _____ No _____ (check only one answer)

If “yes”, provide details:

4. **Details of the Vaccine administered to the Patient:**

Did the Patient (or in the case of birth defects, the Patient’s mother) receive a Vaccine that is listed in Schedule 1 of the Protocol? [2]	
Date (Day/Month/Year) when the Vaccine was administered to the Patient or in the case of birth defects, to the Patient’s mother	
What is the name of the Vaccine?	
Batch or lot number of the Vaccine, as provided by the immuniser(s) (person or entity/organisation) who administered the Vaccine to the Patient or in the case of birth defects, to the Patient’s mother	
Name of immuniser(s) (person or entity/organisation) who administered the Vaccine to Patient or in the case of birth defects, to the Patient’s mother	
Exact location/place where the Vaccine was administered to the Patient or in the case of birth defects, to the Patient’s mother	

[2] Please see the list of Vaccines listed in Schedule 1 to the Protocol, available on the Scheme’s website at www.C19VaccineNFC.com

5. **Details of other medication/vaccination, to the extent known:**

(a) Please list any medicines or other vaccines taken by or administered to the Patient in the 6 weeks before, or any time after, the administration of a Vaccine dose.

(b) In the case of birth defects, please list any medicines taken by, and/or any other vaccines administered to, the Patient's mother during the pregnancy and/or 6 weeks before the start of the pregnancy:

6. **Details of previous long-term medication, to the extent known:**

Please list any medicines not described above that were taken by the Patient for a consecutive period of more than 3 weeks, during the 24 months before the Vaccine dose(s) was/were administered to the Patient:

7. **Describe what happened after the Vaccine dose(s) was/were administered to the Patient or in the case of birth defects, to the Patient's mother. Please be as precise and complete as possible.**

In the space provided below, please describe in your own words what happened after the Vaccine was administered to the Patient or in the case of birth defects, to the Patient's mother. Please state:

(i) the nature of injury or illness suffered by the Patient to which this Claim relates;

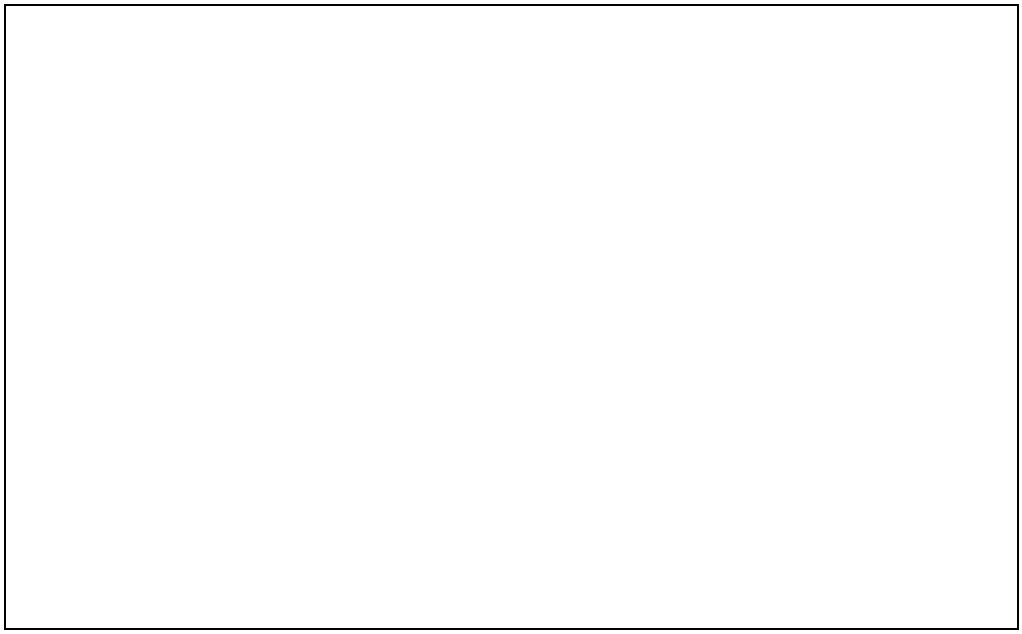
(ii) the date(s) when symptoms first started;

(iii) a description of the symptoms;

(iv) what you believe caused the injury or illness suffered by the Patient to which this Claim relates;

(v) whether the Patient ever had the same injury or illness in the past (or in the case of birth defects, whether the Patient's mother had another unborn or new-born child with a congenital birth injury or illness) and, if yes, provide further explanation including dates; and

(vi) whether you know of a close family member of the Patient, such as brother, sister, parent, child, aunt, uncle, or first cousin, who suffered any similar injury or illness before, and if yes, please indicate which close family member and describe the similar injury or illness.



8. **Additional documents required to be submitted with this Claim**

The following documents must be submitted by the Claimant together with this Claim Form, in order for this Claim to be considered complete. Please note that failure or delay in submitting ALL of the following documents may lead to the rejection of this Claim and/or delays in considering this Claim:

a. The duly completed and signed Supporting Evidence form attached as Schedule 3 to the Scheme's Protocol. The Supporting Evidence form must be completed and signed by one or more Registered Healthcare Professional(s)[3].

b. Invoices, receipts or other proof of payment of any medical expenses (including hospital fees) required as a consequence of the injury or illness suffered by the Patient for which this Claim is made.

c. If the Patient (1) has died, or (2) is disabled to the extent that the Patient cannot submit this Claim himself or herself, or (3) is a child, or (4) does not have legal capacity for any other reason to submit this Claim for himself or herself, then the person submitting this Claim for the Patient pursuant to Section 2 of this Claim Form must also submit a power of attorney and/or statement that has been notarised by a notary public or other public official legally authorised to provide notarisation or legalisation services within the territory where the Vaccine was administered to the Patient or in the case of birth defects, to the Patient's mother, confirming that:

[3] The term "Registered Healthcare Professional" means any healthcare professional, including physicians, surgeons, nurses, midwives, nurse practitioners, physicians' assistants, psychiatrists, physical therapists, occupational therapists, dentists and pharmacists, who is duly licensed or legally authorised to practice the profession in the country in which the Patient resides and received the Vaccine or in the case of birth defects, where the Patient's mother resides and received the Vaccine.

i. the person submitting the Claim for the Patient is the legally recognised parent, guardian, heir or legal representative, as the case may be, of the Patient; and

ii. in the event the Patient has died, the person submitting this Claim on behalf of the Patient: (A) is the duly-authorised and legally recognised representative of all legal heirs of the Patient, as listed in the power of attorney or statement; and (B) has all necessary rights, powers and authority to represent, act for and bind all of such legal heirs; and (C) there are no other legal heirs of the Patient other than those legal heirs who are listed in the power of attorney or statement.

9. **Contact details of hospitals, Registered Healthcare Professionals and others who can provide additional information about the injury or illness suffered by the Patient**

In the space provided below, please provide the names and contact details (e.g., address, telephone or mobile number, email address) of any third parties who the Claimant agrees can be contacted for further information about the injury or illness suffered by the Patient for which this Claim is made. By way of example, such third parties may include any treating hospitals or medical clinics, any Registered Healthcare Professionals who administered the Vaccine to the Patient or in the case of birth defects, to the Patient's mother, or who otherwise treated the Patient, the Patient's employer or school, etc.

10. **Consent for the sharing of medical information and release of medical and/or professional secrecy**

By signing in the space provided under Section 14 of this Claim, the Claimant hereby:

a. consents to the Administrator, the Administrator's Senior Vice President of Risk Consulting, the members of the Review Panel, the members of the Appeals Panel and/or any other persons representing and/or advising any of them to have access to, and examine the Patient's medical or other relevant records in connection with this Claim for the purposes of determining whether a compensation payment under the Scheme is due; and

b. agrees that the Administrator, the Administrator's Senior Vice President of Risk Consulting, the members of the Review Panel, the members of the Appeals Panel and/or any other persons representing and/or advising any them may ask any of the persons and/or organisations mentioned in this Claim and/or any documents attached to this Claim (including, without limitation, in the Supporting Evidence form) for any information which is needed to process and evaluate the Claim or any subsequent appeals; and

c. releases any and all of the aforesaid the persons and organisations from any applicable medical and/or professional secrecy under any applicable law.

11. **Personal data processing - consent**

By signing in the space provided under Section 14 of this Claim, the Claimant hereby: (i) consents to all necessary processing of Patient's Personal Data (including sensitive Personal Data such as medical data) for the purposes of administering the Scheme as detailed more fully in the ESIS Inc. Privacy Policy for the Covid-19 Vaccine Facility No-Fault Compensation Scheme (and in the case of birth defects, acknowledges that all reasonable endeavours have been taken to ensure that the Patient's mother has consented to and understands such processing, including where possible through reading the Privacy Policy); and (ii) consents to the fact that any such Personal Data, as well as any other information and documentation contained or referred to in, or otherwise provided in connection with this Claim and/or any documents attached to or relating to this Claim and/or any subsequent appeals or other proceedings arising from or in connection with this Claim (including, without limitation, in the Supporting Evidence form) may be shared with:

a. the members of the Review Panel, the members of the Appeals Panel and/or any other persons representing and/or advising any them;

b. any local health services and/or any local law enforcement or other government agencies, any intergovernmental organisations and any international institutions as may be required from time to time for the purposes of law enforcement, the detection of criminal activity, risk profiling of vaccines or any other reasonably proportionate activity which may from time to time be required in connection with the Claim or any appeals or other proceedings arising from or relating to it; or

c. with any other third party anticipated by the ESIS Inc. Privacy Policy for Covid-19 Vaccine Facility No-Fault Compensation Scheme or required by applicable laws.

The Claimant understands that consent may be withdrawn at any time, but that doing so means that it may not be possible to continue processing the Claim under the Scheme.

The Claimant also understands that, to the extent permitted or required by Applicable Law, such Personal Data may be processed based on certain legal grounds other than consent in the event consent is not appropriate, as is set out in full detail in the ESIS Inc. Privacy Policy for the Covid-19 Vaccine Facility No-Fault Compensation Scheme.

12. **Acknowledgements by Claimant**

By signing in the space provided under Section 14 of this Claim, the Claimant acknowledges and agrees as follows:

a. He/she has fully read and understood, or has had read and explained to him/her, the terms and conditions of the Scheme's Protocol and its Schedules, available at www.C19VaccineNFC.com. This Claim (together with any subsequent appeals or other proceeding arising from or relating to it) will be subject to and dealt in accordance with the terms and conditions of the Scheme's Protocol and its Schedules;

b. For the entire duration of the assessment process of this Claim and any subsequent appeals or other proceedings arising from or relating to it, the Claimant (which includes the Patient and the individual, if any, submitting this Claim for the Patient), shall not file or commence, or cause or allow to be filed or commenced, any other application or claim for compensation or damages under the Scheme or against any other governmental or publically funded no-fault compensation scheme, in relation to the injury or illness suffered by the Patient for which this Claim is made. In the event that any such other application or claim is commenced or comes to the attention of the Administrator, this Claim shall automatically be suspended by the Administrator and the Administrator shall have the discretion to reject the Claim and the right to enforce Section 10 of the Scheme's Protocol.

c. If any compensation under the Scheme is agreed to be paid to Claimant (which includes the Patient and the individual, if any, submitting this Claim for the Patient), such a payment shall only be made if the Claimant timely fulfils all of the following conditions within the applicable deadline under the Protocol:

    i. returns to the Administrator a duly signed, dated, and certified Release Agreement, which will be provided by the Administrator; and

ii. returns to the Administrator a duly completed, signed and dated Payment Election Form, which will be provided by the Administrator.

d. All complaints and disputes arising out of or relating to this Claim and/or the Protocol (including, but not limited to, the interpretation or application thereof) shall be submitted in writing to the Administrator. The Administrator will acknowledge the complaint and/or dispute in writing, and the Administrator's Vice President of Claims will conduct an investigation into the complaint or dispute within 30 days of receipt. Following the investigation, the Vice President of Claims will provide a written response to the Claimant, as the case may be. If the Claimant is dissatisfied with the decision, the Claimant has the option to submit the matter to binding arbitration as provided herein below.

e. Any dispute arising out of or relating to this Claim and/or the Protocol (including, but not limited to, their interpretation or application) shall, unless amicably resolved, be settled by arbitration. The arbitration shall be conducted in accordance with the rules of arbitration of the International Chamber of Commerce. The parties shall accept the arbitral award as final and binding on them.

f. If there is any conflict or inconsistency between the English language version of this Claim Form and any translations, the English language version shall control and prevail in all respects.

13. **Declaration of truth and correctness**

By signing in the space provided under Section 14 of this Claim, the Claimant, hereby: (i) certifies that the statements, facts and answers contained in this Claim and/or any documents submitted with this Claim, are true, complete and correct to the best of his/her knowledge and belief; and (ii) understands and agrees that:

(a) If, whether fraudulently or otherwise, any person[4] falsifies or misrepresents any material information or fails to disclose any material fact and, in consequence of the falsification, misrepresentation or failure, a Payment is made, then the person to whom the Payment was made shall be liable to repay that Payment amount to the Administrator; and

(b) Any person who, for the purpose of obtaining any Payment under the Scheme, whether for himself or herself or some other person: (1) knowingly makes any false statement or representation, or (2) produces or furnishes, or causes or knowingly allows to be produced or furnished, any document or information which he knows to be false in a material particular, shall have committed an offence punishable to the extent the law permits within the relevant country.

4 For purposes of this Section 13, the term "person" includes, but is not limited to: (i) the Claimant or the individual submitting the Claim on behalf of the Claimant; (ii) the author of any evidence in support of this Claim, any Supporting Evidence or any notice of appeal under this Claim, and/or (iii) any Notary Official certifying the Release Agreement, if any.

14. **Signature, name and date**

The Claimant (i.e., the Patient or the individual submitting this Claim for the Patient, as applicable), has signed this Claim Form as of the date set forth below:

Full Name: _____

Signature: _____

Date: _____

Place: _____

Annexes:

Annex 1 – Contact Information for the Scheme's Regional Centres (attached)

Annex 1 – Contact information for the Scheme's Regional Centres

In the table below, you can find the name, address and direct (at-cost) telephone number* of the Regional Centres under the Scheme where you can:

- contact the Scheme's Administrator if you have any questions about the Scheme or need help in completing or submitting an Claim Form or other Scheme Forms; and

- submit to the Scheme's Administrator (by sending via registered mail): (1) the Supporting Evidence Form at Schedule 3 to this Protocol, and all other documents required to be submitted under the terms of these forms; (2) the other Scheme forms; and (3) any other documents that are required or permitted to be submitted under the Scheme's forms.

*There is also a Global Telephone Hotline for the Scheme, which is 00-1-404-905-8883. The telephone number for the Global Telephone Hotline may be toll-free or at-cost to you, depending on which Country you are calling from. You should verify whether or not any calling charges apply before calling the Global Telephone Hotline.

IMPORTANT NOTE: Each Regional Centre listed below services only those Countries that are listed in the relevant table. Please ensure that you only contact, and that you only submit Scheme forms and other documents to, the correct Regional Centre - i.e. the Regional Centre that services the Participating Country in which the Vaccine was administered to you, or to the Patient on whose behalf you are submitting a Claim, as applicable.

AUSTRALIA REGIONAL CENTRE

Participating Countries serviced by Australia Regional Centre	Contract Address	Contact Phone
Fiji	Broadspire by Crawford & Company GPO Box 1016, Brisbane QLD 4004, Australia	**+61 7 3223 3100**
Kiribati		
Nauru		
Papua New Guinea		
Samoa		
Solomon Islands		
Tonga		
Tuvalu		
Vanuatu		

SINGAPORE REGIONAL CENTRE

Participating Countries serviced by Singapore Regional Centre	Contact Address	Contact Phone
Cambodia	8 Shenton Way #03-01 AXA Tower Singapore 068811	**+65 6632 8639**
Indonesia		
Lao People's Democratic Republic		
Myanmar		
Timor-Leste		
Vietnam		
Philippines		
Malaysia		
Thailand		

[END OF THE CLAIM FORM]