

**Countermeasures Injury Compensation Program (CICP)  
Request for Lost Employment Income  
Requester Category: Estate**

Case Number: \_\_\_\_\_ (starts with CICP)

This ~~benefits~~ form ~~will assist the Countermeasures Injury Compensation Program (CICP) is used to determine eligibility for in determining~~ benefits for lost employment income ~~and the amount of any such benefits that may be owed eligible to for~~ the estate of a deceased injured countermeasure recipient. ~~The E~~estates of the deceased injured countermeasure recipient may be eligible to receive lost employment income benefits ~~which that~~ the injured countermeasure recipient would have been ~~paid by the CICP~~eligible to receive prior to death, but ~~had not been~~which they did not received in full ~~by from the CICP~~ during ~~his or her~~their lifetime. Please complete the statements that apply to your case. Then, print your name, sign the form, and submit it with the required documents as described in each section below.

**A. Lost Employment Income**

**What ~~A~~ are you requesting lost employment income? (Check one)**

**YES** - I am requesting reimbursement ~~or~~ payment for **PAST** lost employment income where lost income was a result of a covered injury or its health complications for a specified period of time, greater than five days.

If you selected YES, please let us know if the deceased injured countermeasure recipient had dependents at the time of the injury, by checking one of the following.

~~YES, they~~They had one or more dependents as indicated on their Federal tax return.

~~NO, I~~they did not have dependents.

~~If you are requesting reimbursement or payment for lost employment income, please carefully read and complete the Required Documents Checklist included in this letter.~~

~~If you are requesting reimbursement or payment for lost employment income, please carefully read and complete the all steps below and submit the required documents.~~

**NO** - I am **not** requesting reimbursement or payment for lost employment income on behalf of the estate.

~~a. If you checked YES: Proceed to fill out B: Third-Party Payer Information. Complete all steps below.~~

~~a.~~  
**b. If you checked NO: Skip to D. Final Attestation and Acknowledgment and sign the form and submit to CICP.**

~~e. If you checked YES: Complete all steps below.~~

~~If you are requesting reimbursement or payment for lost employment income, please carefully read and complete the Required Documents Checklist included in this letter.~~

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**A-B. Third-Party Payer Information**

Check one:

I certify I do not have or know of any third-party payers that did have paid or will may be obligated to pay for lost employment income on behalf of the deceased injured countermeasure recipient.

I certify that the table below includes all third-party payers that did have paid or will may be obligated to pay for lost employment income or provide disability benefits.

If there are third-party payers, complete the table below listing any and all third-party payers which may include, Workers' Compensation, ~~or~~ disability insurance, Uniform Services Retirement Board determinations, and Department of Veterans Affairs determinations.

If there are/were third-party payers, list them here:

<u>Third-Party Payer Organization</u>	<u>Account Number</u>	<u>Dates of Coverage</u>	<u>Sponsor's Name</u>
Example: Aetna	123456789-0	1/1/1998-present	John Doe

If you need additional space, you may attach a separate page

I certify I do not have or know of any third-party payers that have paid or may be obligated to pay for lost employment income on behalf of the deceased injured countermeasure recipient.

**B-C. Secondary Payer of Last Resort Acknowledgement**

**Understanding CICP as Secondary Payer**

I understand benefits from the CICP are secondary to benefits received or receivable paid or payable from third-party payers, and it may be possible that certain requesters deemed eligible will have no eligible lost employment income.

**C-D. Final Attestation and Acknowledgment**

By signing this form, I hereby certify that the information provided in this Certification Request for Lost Employment Income form is true and accurate to the best of my knowledge. Further, I understand that any person who knowingly falsifies, conceals or covers up a material fact, makes a materially false, fictitious, or fraudulent statement or representation or makes or uses a false writing or document knowing it contains a materially false, fictitious or fraudulent statement or entry to obtain compensation under the CICP, or who knowingly accepts compensation to which that person is not entitled, may be subject to civil, administrative, and

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*felony criminal penalties, which may be punishable by a fine, imprisonment or both. I will provide updated information (including, but not limited to, employment income records, and change of address) until the Program has made its final benefits decision. I am also signing with the understanding that the CICP is a secondary payer to benefits received or receivable from third party payers, and it may be possible that certain requesters deemed eligible will have no eligible benefits.*

\_\_\_\_\_  
Name of Injured Countermeasure Recipient (Please print)

\_\_\_\_\_  
Signature of 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 5.1 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 14N126B, Rockville, Maryland, 20857 or [paperwork@hrsa.gov](mailto:paperwork@hrsa.gov). Please do not send documents related to an individual claim to [paperwork@hrsa.gov](mailto:paperwork@hrsa.gov).

**LOST EMPLOYMENT INCOME REQUIRED DOCUMENTS**

Name: \_\_\_\_\_ Case #: \_\_\_\_\_

**PROOF OF THE ADMINISTRATOR OF THE ESTATE**

The following documents are required:

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~~Please send a~~ [Copy of the death certificate for the deceased injured countermeasure recipient.](#)

~~Please send a~~ Documentation showing that you are executor or administrator of the deceased [injured](#) countermeasure recipient's estate (e.g., a court order or letters of administration) ~~is required.~~

### PROOF OF NUMBER OF DAYS LOST

If you are requesting payment for lost employment income, ~~CICP must receive~~ [you must submit](#) documents showing the number of days of lost employment income (unpaid days). Please submit documents showing the number of days (including partial days) of work missed. Examples may include:

- Time sheets showing pay periods
- Pay stubs showing pay periods
- Summary of how many total days missed in unpaid leave status (optional)

### PROOF OF INCOME AT THE TIME OF THE INJURY

If you are requesting payment for lost employment income, ~~CICP must receive~~ [you must submit](#) documents showing gross income at the time of the covered injury. ~~Please submit~~ [Examples may include](#) the following ~~information:~~

- Federal tax return (required if there are dependents)
- Pay stubs
- Time sheets

### THIRD-PARTY PAYERS

If there are third-party payers, CICP must receive documents of the third-party payers that paid or ~~will be obligated to pay~~ for lost employment income, ~~or provide~~ [This may include](#) disability, ~~and/or~~ retirement benefits, ~~or such as~~ workers' compensation, ~~payments~~ [disability insurance programs, Uniformed Services Retirement Board determinations, and Department of Veterans Affairs determinations, as follows.](#)

- Documents of payments made
- Documents of payments that will be made in the future
- A written summary of how many days of unpaid work was missed and what was or will be paid by third party payers, if applicable

### How to send your forms and documents:

Option 1: (Preferred Method) Submit online:

1. Go to: <https://cicpsubmit.hrsa.gov>.
2. Upload your forms on the website.

Health Resources and Services Administration  
Countermeasures Injury Compensation Program  
5600 Fishers Lane, ~~14W-188W-25A~~  
Rockville, MD 20857

Option 2: Send your forms via ~~posted~~ [postal](#) mail -to:

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