SCHEDULE 2 TO
PROTOCOL FOR COVAX NO-FAULT COMPENSATION PROGRAM FOR AMC ELIGIBLE ECONOMIES

APPLICATION FORM

INSTRUCTIONS / IMPORTANT NOTICES FOR APPLICANTS:

1. Definitions: For the meaning of capitalized terms used in this form, such as for example "Applicant", "Injury", "Vaccine", "AMC Eligible Economy", "Registered Healthcare Professional", "Patient", etc., please consult the Program Definitions, available at www.covaxclaims.com.

2. When to Use this Form: You should use this form to submit an application for compensation under the Program. You (as the Applicant) can submit an application for compensation if you (or the person you represent) has suffered an Injury following the administration of a Vaccine in an AMC Eligible Economy. To find out which are the AMC Eligible Economies covered by the Program, please refer to the list under Question 5 of the Program's Frequently Asked Questions (available at www.covaxclaims.com). Before completing this form, we suggest you consult the Program's Protocol, Frequently Asked Questions, and the "How to Submit an Application" instructions, available on the Program's website at www.covaxclaims.com. If you have questions, you can contact: (i) the Program's relevant Regional Center by email, telephone or regular mail (see Annex 1 to this Application form); or (ii) the Program's Administrator by email at covaxclaims@esis.com. It is also recommended that you consult and complete the Checklist for Applicants, before submitting your Application.

3. Supporting Evidence: You should submit this Application form together with: (i) the Supporting Evidence form (Schedule 3 of the Program's Protocol); and (ii) the other required documents mentioned in Section 8 of this Application form.

4. Waiting Period: Please note that except if the person you represent has died, you should wait 30 days following the administration of the Vaccine dose that is deemed to have resulted in the Injury, before completing this form and asking a Registered Healthcare Professional to complete the Supporting Evidence form (Schedule 3 to the Protocol).

5. Accepted Languages**:** This Application form must be completed in English, French or Spanish only, and not in any other language. Any documents mentioned in Section 8 of this form can however be submitted in another language, if they are not available in either English, French or Spanish.

6. Completeness: Please complete this form as much as possible, and provide as much information as possible. Please also insert your full name, sign and date in the spaces provided in Section 14 of this form.

7. Deadline for Submission**:** Please note that there is a deadline for the submission of your application materials (i.e. the fully completed Application form (Schedule 2) and Supporting Evidence form (Schedule 3), together with the other required documents). Your application materials should be submitted in the Reporting Period that applies to you (or the person you represent). If you need help with determining what is the Reporting Period in which you should submit your application materials, please contact the Program's relevant Regional Center by email, telephone or regular mail, or the Program's Administrator by email at covaxclaims@esis.com. If you submit your application after the end of the Reporting Period, your application may not be accepted. Please also note that the Program's application process will come to an end on 30 June 2027. No application can be submitted after this

date).

8. How to Submit your application materials: You can submit your application materials, by any of the following means:
    - By uploading these documents on the Program's web portal at www.covaxclaims.com;
    - By emailing these documents to covaxclaims@esis.com; or
    - By sending these documents by regular mail to the Program's relevant Regional Centers. The addresses of these Regional Centers are indicated in Annex 1 (Contact Information of Regional Centers) attached to this Application Form and are also available on the Program's web portal at www.covaxclaims.com.

[Application Form continued on the next page]

SCHEDULE 2 TO
PROTOCOL FOR COVAX NO-FAULT COMPENSATION PROGRAM FOR AMC ELIGIBLE ECONOMIES

APPLICATION FORM

1. Details of the Patient. Please provide the following information about the Patient**.**

If you are submitting this Application 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	
Country where Vaccine was administered	
Date of birth (day/month/year)	
Gender	
National insurance number (or other social security number or similar identification number), if any	
Home phone number, if any	
Mobile phone number, if any	
Email address, if any	

2. Details of the person who has the legal authority to submit this Application for the Patient

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

In the above cases, please provide below the details of the person with the legal authority to submit this Application for the Patient, and the details of that person's relationship with the Patient.

Full name, including any middle names, of the person submitting the Application for the Patient	
Mailing address (including city, zip code and country)	
Date of birth (day/month/year)	
National insurance number (or other social security number or similar identification number), if any	
Home phone number, if any	
Mobile phone number, if any	
Email address, if any	
Relationship with the Patient (For example: Are you the parent or legal guardian of the Patient who is a child (minor)? Or did the Patient die, and are you the duly-authorized and legally recognized representative of all legal heirs of the Patient?)	

3. Confirmations by the Applicant

The **Applicant** (i.e., the Patient directly submitting this Application for himself, or the person submitting this Application for the Patient) should please respond to all of the following questions and, if necessary, provide relevant details:

A. Have you waited at least 30 days after the administration of the Vaccine dose that you believe has resulted in the Injury, before completing this Application and before asking a Registered Healthcare Professional(s) to complete the Supporting Evidence 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.

Yes _____ No _____ (check only one answer)

If "no", please provide details:

B. Have you, or has any other person, submitted any previous application for compensation under the Program for the Injury described in this Application?

Yes _____ No _____ (check only one answer)

If "yes", provide details:

C. Has any payment already been received from any other source, as compensation for the Injury described in this Application? This could for example include an award from a court or arbitral tribunal, a settlement payment, etc.

Yes _____ No _____ (check only one answer)

If "yes", please provide the amount and (to the best of your ability) details of all such prior payments:

D. Is the Applicant/Patient eligible to receive payment from any other vaccine injury compensation program as compensation for the Injury described in this Application?

Yes _____ No _____ (check only one answer)

If "yes", please provide (to the best of your ability) details of all such other vaccine injury compensation program(s):

E. Has the Applicant/Patient previously applied for compensation for the Injury from any other vaccine injury compensation program(s)?

Yes _____ No _____ (check only one answer)

If "yes", please provide the following:

1. A copy of the final decision(s) of the other vaccine injury compensation program(s); and
2. If compensation has been awarded by the other vaccine injury compensation program(s), then please provide: (a) the compensation amount(s) awarded, (b) a description of the nature of the compensation (for example: was the amount provided as a lump-sum compensation for the Injury, and/or as a compensation for lost revenue, and/or as compensation for medical expenses, etc.), and (c) an indication how the compensation amount has been or will be paid (for example, has or will the compensation amount be provided as a single payment or in instalments?). If you are unable to provide all this information, please provide the name of, and contact details for, the other vaccine injury compensation program(s) in question.

F. Are there any pending legal proceedings, demands or claims for compensation for the Injury described in this Application (including any pending claims for the Injury before any other vaccine injury compensation program)? Yes _____ No _____ (check only one answer) If "yes", provide details of all such pending legal proceedings, demands or claims (including of all pending claims before any other vaccine injury compensation program(s)):

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? [1]	
What is the name of the Vaccine?	
If the Vaccine is a two dose vaccine, did the Patient receive both doses of the Vaccine?	
Did the Patient receive any additional dose(s) and/or booster dose(s) in addition to the original one or two doses of the Vaccine?	

[1] Please see the list of Vaccines listed in Schedule 1 to the Protocol, available on the Program's website at www.covaxclaims.com

Batch or lot number(s) of each of the Vaccine dose(s) (i.e., first, second, additional and booster dose(s), as applicable) administered to the Patient or, in case of birth defects, to the Patient's mother. Such batch or lot number(s) are provided by the immunizer(s) (person or organization) who administered the Vaccine dose(s) in question[2]	
If known, name(s) of immunizer(s) (person or organization) who administered the Vaccine dose(s) to Patient or in the case of birth defects, to the Patient's mother.	
Location(s)/place(s) (for example, health facility) where the Vaccine dose(s) was/were administered to the Patient or in the case of birth defects, to the Patient's mother. If the Vaccine was administered at a mobile vaccination unit, please state "mobile vaccination unit in……." [include name of the town or village].	
Date(s) (Day/Month/Year) when the Vaccine dose(s) was/were administered to the Patient or in the case of birth defects, to the Patient's mother (please specify the date for each Vaccine dose administered)	

[2] **NOTE:** The batch or lot number(s) of the Vaccine dose(s) administered to the Patient, or, in case of birth defects, to the Patient's mother, is critical information that is needed in order to verify whether such Vaccine dose(s) is (are) covered by the Program. This information **must** therefore be provided. In general, you can find this information on the vaccination card or any other paper or electronic document that the Patient may have received when the Vaccine dose(s) was (were) administered to the Patient. If you do not know the batch or lot number(s) of the Vaccine dose(s), please contact the vaccination centre or the immunizer(s) (person or organization) who administered the Vaccine dose(s) to the Patient or in the case of birth defects, to the Patient's mother, in order to obtain this information.

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

(a) Please list any medicines taken by, and/or any other (non-COVID-19) vaccines administered to, the Patient after the Vaccine dose(s) was/were administered to the Patient (Please provide this information separately for each Vaccine dose administered):

(b) Please list any medicines taken by, and/or any other (non-COVID-19) vaccines administered to, the Patient during the period of 6 weeks before the administration of each Vaccine dose to the Patient (Please provide this information separately for each Vaccine dose administered):

(c) In the case of birth defects, please list any medicines taken by, and/or any other (non COVID-19) vaccines administered to, the Patient's mother during the pregnancy:

(d) In the case of birth defects, please list any medicines taken by, and/or any other (non COVID-19) vaccines administered to, the Patient's mother 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 (or in the case of birth defects, the Patient's mother) for a consecutive period of more than 3 weeks, during the 24 months before each of the Vaccine dose(s) was/were administered to the Patient, or in the case of birth defects, the Patient's mother (Please provide this information separately for each Vaccine dose administered):

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 dose(s) was/were administered to the Patient or in the case of birth defects, to the Patient's mother. Please:

(i) describe the injury or illness suffered by the Patient

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

(iii) describe the symptoms of the injury

(iv) indicate what you believe has caused the injury or illness suffered by the Patient

(v) indicate if 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

(vi) indicate if you know of a close family member of the Patient, such as brother, sister, parent, child, aunt, uncle, or 1st 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 Application

The following documents must be submitted by the Applicant together with this Application form, in order for this Application to be considered complete. Please note that failure or delay in submitting any of the following documents may lead to the rejection of, or delays in considering, this Application:

a. The completed and signed Supporting Evidence form attached as Schedule 3 to the Program's Protocol. The Supporting Evidence form must be completed and signed by one or more Registered Healthcare Professional(s)[3].
b. If the Patient (1) has died, or (2) is disabled to the extent that the Patient cannot submit this Application himself, or (3) is a child (minor), or (4) does not have legal capacity for any other reason to submit this Application for himself, then the person submitting this Application for the Patient (as indicated in Section 2 of this Application form) must also submit a power of attorney or statement that has been notarized by a Notary Official within the territory of residence of the Patient or the Applicant, or within the territory of administration of the Vaccine. This notarized power of attorney or statement must confirm that:
    i. the person submitting the Application for the Patient is the legally recognized 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 Application on behalf of the Patient: (A) is the duly-authorized and legally recognized 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.

[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 licensed or legally authorized to practice the profession in the AMC Eligible Economy 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.

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 (address, telephone or mobile number, email address) of any third parties who can be contacted for further information about the injury or illness suffered by the Patient. This includes for example any treating hospitals or medical clinics, any person or organization who administered the Vaccine dose(s) to the Patient or in the case of birth defects, to the Patient's mother, any Registered Healthcare Professionals who treated the Patient, 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 Application, the Applicant :

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 and other relevant records in connection with this Application for the purposes of determining whether a compensation payment under the Program 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 organizations mentioned in this Application and/or in any documents attached to this Application (including the Supporting Evidence form) for any information which is needed to process and evaluate the Application, any subsequent appeals and/or other proceedings relating to this Application; and
c. releases any and all of the aforesaid the persons and organizations from any applicable medical and/or professional secrecy under any applicable law.

11. Personal data process consent

By signing in the space provided under Section 14 of this Application, the Applicant: (i) consents to all necessary processing of Patient's (and in the case of birth defects, the Patient's mother's) personal and medical data for the purposes of the Application and any related matters, as detailed in the ESIS, INC. Privacy Policy for COVAX No-Fault Compensation Program for AMC Eligible Economies; and (ii) agrees that any such data, as well as any other information and documentation provided in connection with this Application (including, without limitation, in the Supporting Evidence form) and/or any subsequent appeals or other proceedings relating to this Application 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 organizations 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 Application or any appeals or other proceedings relating to this Application; or
c. with any other third party anticipated by the ESIS, INC. Privacy Policy for COVAX No-Fault Compensation Program for AMC Eligible Economies or required by applicable laws.

Consent may be withdrawn at any time. Withdrawing consent however means that it may not be possible to continue processing the Application under the Program.

12. Certifications and agreements

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

a. He/she accepts, and agrees that this Application (together with any subsequent appeals or other proceeding relating to this Application) will be subject to and dealt in accordance with, the terms and conditions of the Program's Protocol and its Schedules;
b. For the entire duration of the assessment process of this Application and any subsequent appeals or other proceedings relating to this Application, the Applicant (which includes the Patient and the individual, if any, submitting this Application for the Patient), shall not initiate, or cause or allow to be initiated, any other application, legal proceeding, demand or claim for compensation or damages against any other person or legal entity (including any application or claim before any other vaccine injury compensation program), in relation to the Injury for which this Application is made. In the event that any such other application, legal proceeding, demand or claim comes to the attention of the Administrator, this Application shall automatically be rejected.
c. If any compensation under the Program is approved for payment to the Applicant (which includes the Patient and the individual, if any, submitting this Application for the Patient), then such Payment shall only be made if the Applicant returns to the Administrator the following documents within the applicable deadline described in the Protocol:
    1. a duly signed, dated, and certified Release Agreement, which will be provided by the Administrator; and
    2. 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 Application 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 Applicant or Claimant, as the case may be. If the Applicant or Claimant is dissatisfied with the decision, the Applicant or Claimant has the option to submit the matter to binding arbitration as provided hereinbelow.
e. Any dispute arising out of or relating to this Application 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 Application form and any translations, the English language version shall prevail.

13. Declaration of Truth and Correctness

By signing in the space provided under Section 14 of this Application, the Applicant: (i) certifies that the statements, facts and answers contained in this Application and/or any documents submitted with this Application, 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 Program, whether for himself 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.

14. Signature, Name and Date

The **Applicant** (i.e., the Patient or the individual submitting this Application for the Patient, as applicable), has signed this Application form as of the date set forth below:

Full Name: _____

Signature: _____

Date: _____

Place:_____

Annexes:

Annex 1 – Contact Information for the Program's Regional Centers

[4] For purposes of this Section 13, the term "person" includes, but is not limited to: (i) the Applicant or the individual submitting the Application on behalf of the Applicant; (ii) the author of any evidence in support of this Application, any Supporting Evidence or any notice of appeal under this Application, and/or (iii) any Notary Official as required by the Protocol..

SCHEDULE 2 TO
PROTOCOL FOR COVAX NO-FAULT COMPENSATION PROGRAM FOR AMC ELIGIBLE ECONOMIES

ANNEX 1

CONTACT INFORMATION FOR REGIONAL CENTERS UNDER THE COVAX NO-FAULT COMPENSATION PROGRAM FOR AMC ELIGIBLE ECONOMIES (THE "PROGRAM")

In the table below, you can find the names, addresses, e-mail addresses and direct (at-cost) telephone numbers of the various Program Regional Centers. There is also a Global Telephone Hotline for the Program, which is 1-833-276-8262. The telephone number for the Global Telephone Hotline may be toll-free or at-cost to you, depending on which AMC Eligible Economy you are calling from. You should verify whether or not any calling charges apply before calling the Global Telephone Hotline.

You can contact the Regional Center allocated to your country, if you have any questions about the Program or need help in completing or submitting an Application or any other Program forms. A Regional Center allocated to your country means, either (i) the country where the Patient (or in the case of birth defects, the Patient's mother) has been vaccinated, or (ii) the country of residence of the Applicant or the Patient (or in the case of birth defects, the Patient's mother).

In addition, you can submit any Program forms and other documents that you should submit with these forms to the Program's Administrator, i.e. by sending them via registered mail to the relevant Regional Center.

The Program's Regional Centers are available to assist you in your native language, as well as in English, French or Spanish. If you have any questions or need help, please contact your allocated Regional Center by email, telephone or regular mail, using the contact information provided in the table below, and the Regional Center will do its best to assist you in your native language.

IMPORTANT NOTE: Each Regional Center listed below services only those AMC Eligible Economies that are listed on the right side of that Regional Center. Please ensure that you only contact, and that you only submit Program forms and other documents to, the correct Regional Center—i.e., the Regional Center that services the AMC Eligible Economy in which the Vaccine was administered to you, or to the Patient on whose behalf you are submitting an Application, as applicable, or that services the AMC Eligible Economy of residence of the Applicant or the Patient (or in the case of birth defects, the Patient's mother).

SCHEDULE 2 TO
PROTOCOL FOR COVAX NO-FAULT COMPENSATION PROGRAM FOR AMC ELIGIBLE ECONOMIES

Regional Center Contact Information	AMC Eligible Economies Serviced by the Regional Center				
South Africa Crawford & Company PO Box 782023 Sandton 2146 South Africa **+27 (0)11 463 5900** Covaxclaims.SouthAfrica@crawford.com	1. Angola 2. Benin 3. Burkina Faso 4. Burundi 5. Cabo Verde 6. Cameroon 7. Central African Republic 8. Chad	9. Comoros 10. Congo, Dem Rep. 11. Congo Rep. 12. Côte d'Ivoire 13. Djibouti 14. Eritrea 15. Eswatini 16. Ethiopia 17. Gambia	18. Ghana 19. The Guinea 20. Guinea-Bissau 21. Kenya 22. Lesotho 23. Liberia 24. Madagascar 25. Malawi 26. Maldives	27. Mali 28. Mauritania 29. Mozambique 30. Niger 31. Nigeria 32. Rwanda 33. Sao Tome & Principe 34. Senegal	35. Sierra Leone 36. Somalia 37. South Sudan 38. Sudan 39. Tanzania 40. Togo 41. Uganda 42. Zambia 43. Zimbabwe
Australia Crawford & Company GPO Box 1016, Brisbane QLD 4004 Australia **+61 7 3223 3100** Covaxclaims@crawco.com.au	44. Fiji 45. Kiribati 46. Marshall Islands 47. Micronesia, Federated States 48. Papua New Guinea			49. Samoa 50. Solomon Islands 51. Tonga 52. Tuvalu 53. Vanuatu	
Germany Crawford & Company Werdener Strasse 4, 40227 Düsseldorf Germany **+49 211 95456250** Covaxclaims@crawco.de	54. Kosovo 55. Kyrgyz Republic 56. Moldova 57. Tajikistan 58. Ukraine 59. Uzbekistan				
Mexico Crawford & Company de México, S.A. DE C.V. Miguel Laurent No. 17 Piso, 601. Colonia Del Valle, Alcaldia Benito Juarez Ciudad De México C.P. 03200 Mexico **+52 55 5093 6467** Covaxclaims.Mexico@crawford.com	60. Dominica 61. El Salvador 62. Grenada 63. Guyana 64. Haiti			65. Honduras 66. Nicaragua 67. St. Lucia 68. St. Vincent and the Grenadines	
Brazil Crawford & Company	69. Bolivia				

Geraldo Flausino Gomes, 78 14º Andar Cidade Monções 04575-060 São Paulo Brazil **+55-11-3879-7500** Covaxclaims.Brazil@crawford.com		
Singapore Crawford & Company 8 Shenton Way #03-01, AXA Tower Singapore 068811 Singapore **+65 6632 8639** Covaxclaims.Singapore@crawford.asia	70. Cambodia 71. Indonesia 72. Korea, Dem. People's Rep. 73. Lao PDR	74. Myanmar 75. Timor-Leste 76. Vietnam
Hong Kong Crawford & Company 24/F Sunshine Plaza, 353 Lockhart Rd, Wanchai Hong Kong **+852 2526 5137** Covaxclaims.HongKong@crawford.asia	77. Mongolia 78. Philippines	
United Arab Emirates Crawford & Company P.O. Box 2976 Dubai, United Arab Emirates **+971 4 345 9541** Covaxclaims@crawco.me	79. Egypt, Arab Rep. 80. Syrian Arab Rep. 81. Yemen, Rep.	
India Puri-Crawford Unit No.1, First floor, Windsor Terrace, Above Hotel Samruddhi, Vishrantwadi, Pune, Maharashtra 411015 India **+91 (020) – 26612524** Covaxclaims.India@crawford.com	82. Afghanistan 83. Bangladesh 84. Bhutan 85. India 86. Nepal 87. Pakistan 88. Sri Lanka	
Israel	89. West Bank and Gaza	

Crawford-Tossman No. 2 Choma Umigdal St., Tel Aviv, Israel, 6777102 **+972 35 628 811** Covaxclaims.Israel@crawford.com	
Belgium Crawford & Company Jan Olieslagerslaan 41 1800 Vilvoorde Belgium **+32 2 257 03 52** Covaxclaims@crawco.be	90. Algeria 91. Morocco 92. Tunisia

[END OF THE APPLICATION FORM]