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

APPLICATION FORM
UNDER THE COVAX NO-FAULT COMPENSATION PROGRAM FOR AMC ELIGIBLE ECONOMIES

INSTRUCTIONS / IMPORTANT NOTICES FOR APPLICANTS:

1. When to Use this Form: Use this Application form to file a claim for compensation under the Program in the event that you consider that you (as the Patient), or the Patient which you are duly authorized to represent, has suffered an Injury following the administration of a Vaccine. Before completing and submitting an Application, please carefully read the Program's Protocol and the "How to Submit an Application" instructions, available on the Program's website at www.covaxclaims.com. If you have questions about the Program, this Application Form or any other Program forms, please contact the Program's Administrator by email at covaxclaims@esis.com.
2. Submission with Supporting Evidence required: You should submit this Application form together with the Supporting Evidence required by Schedule 3 of the Program'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 an Application for compensation under the Program can be taken. In this regard, please do not complete and submit an Application 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 Application 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 Application Form must be completed and submitted in English, French or Spanish only. If this Application is completed or submitted in any other languages, it cannot be accepted or considered. However, any documents required under Section 8 of this Application can be submitted in another language, if they are not available in either English, French or Spanish.
5. Applicant to Complete this Application: You should complete all sections/questions under this Application. 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 Application.
7. Failure (i) to complete all sections in this Application form, or (ii) to sign, date and insert your full name in the spaces provided under Section 14 of this Application, will lead to the rejection of this Application or to delays in processing it.
8. Deadline for Submission**:** Please submit this Application (together with all of the documents mentioned in Section 8 of this Application) and all Supporting Evidence required by Schedule 3 to the Protocol to the Program's Administrator, before the end of the applicable Reporting Period (as indicated in Schedule 1 to the Program's Protocol). If this Application is submitted after the end of the applicable Reporting Period, the Application may not be accepted or considered under the Program.
9. How to Submit this Application: Once this Application has been duly completed, signed and dated, you must submit this Application (together with the documents mentioned in Section 8 of this Application) and the Supporting Evidence required by Schedule 3 of the Protocol to the Program's Administrator, by any of the following means:
    - By uploading them to the Program's web portal, available at www.covaxclaims.com;
    - By emailing them to covaxclaims@esis.com; or
    - By sending them by regular mail to one of the Program's Regional Centers, whose addresses

appear on 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.

10. Definitions: Capitalized terms used but not defined in this Application have the meaning given to them in the Program's Protocol, available at www.covaxclaims.com

[Application Form continued on the next page]

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APPLICATION FORM
UNDER THE COVAX NO-FAULT COMPENSATION PROGRAM FOR AMC ELIGIBLE ECONOMIES

1. Details of the Patient. Please provide the following information about the **Patient** (i.e., the individual (i) who is a citizen, resident, or person within the populations of concern to the COVAX Humanitarian Buffer, as defined and updated from time to time by the Inter-Agency Standing Committee (IASC)[1] in an AMC Eligible Economy; (ii) who was administered a Vaccine in an AMC Eligible Economy; and (iii) 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 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	
Date of birth (day/month/year)	
Place of birth	
Sex	
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	

[1] The definition of populations of concern to the COVAX Humanitarian Buffer as at 8 June 2021 can be found at: Frequently Asked Questions- The COVAX Humanitarian Buffer, 08 June.pdf (interagencystandingcommittee.org).

2. Details of the person who has the legal power 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; or (d) does not have legal capacity for any reason to submit an Application himself, then another person who has the legal power 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 power to submit this Application 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 Application 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 or similar identification number), if any	
Home phone number, if any	
Mobile phone number, if any	
Email address, if any	
Relationship with the Patient	
Nature of the person's authority to make this Application for the Patient	
If the Patient has died, state the nature of the person's right to make	

this Application for the deceased Patient and to represent all legal heirs	

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 in the cases outlined in Section 2 of this Application form, as applicable) should please respond to all of the following questions and, if necessary, provide relevant details:

A. Has the Applicant waited at least 30 days after the Vaccine dose that resulted in the Injury was administered, before he completed this Application and obtained the Supporting Evidence referred to in Section 8 of this Application? 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 application for compensation under the Program been made for the Injury to which this Application relates?

Yes _____ No _____ (check only one answer)

If "yes", provide details:

Has any prior payment from any other source, including but not limited to court awards, settlements and insurance payments, been made as compensation for the Injury to which this Application relates?

Yes _____ No _____ (check only one answer)

If "yes", provide details:

C. Is the Applicant eligible to receive compensation from any other source for the Injury to which this Application relates? Yes _____ No _____ (check only one answer) If "yes", provide details of the nature and extent of Applicant's eligibility to receive compensation from another source for the Injury:
D. Are there any pending lawsuits or claims for compensation for the Injury to which this Application 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]	
Was the Vaccine administered to the Patient: (a) as part of a national immunization program, or (b) as part of a humanitarian mechanism under the COVAX Facility?	
What is the name of the Vaccine?	

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

If the Vaccine is a two dose schedule vaccine, did the Patient receive both doses of the Vaccine? If so, please provide below the details for both the first and second doses.	
Batch or lot number(s) of the Vaccine dose(s), as provided by the immunizer(s) (person or entity/organization) who administered the Vaccine dose(s) to the Patient or in the case of birth defects, to the Patient's mother	
Name(s) of immunizer(s) (person or entity/organization) who administered the Vaccine dose(s) to Patient or in the case of birth defects, to the Patient's mother	
In case any Vaccine dose(s) was supplied or administered by a Humanitarian Agency, please provide: - Name of the Humanitarian Agency that supplied or administered the Vaccine dose(s) to the Patient or, in the case of birth defects, to the Patient's mother; and - Name(s) of the focal person(s) in that Humanitarian Agency	
Exact location(s)/place(s) where the Vaccine dose(s) was/were administered to the Patient or in the case of birth defects, to the Patient's mother	
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	

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

(a) Please list any medicines taken by, and/or any other vaccines administered to, the Patient after the Vaccine dose(s) was/were administered to the Patient and/or during the period of 6 weeks before the administration of each 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 each of 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 dose(s) was/were 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 Application 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 Application 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

(vi) whether 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 ALL of the following documents may lead to the rejection of this Application and/or delays in considering this Application:

a. The duly 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. 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 Application is made.
c. 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, 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 pursuant to Section 2 of this Application form must also submit a power of attorney and/or statement that has been notarized by a notary public or other public official legally authorised to provide notarization or legalization 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:
    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.

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 Applicant agrees can be contacted for further information about the injury or illness suffered by the Patient for which this Application 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 dose(s) 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.

[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 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.

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 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 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/or organisations mentioned in this Application and/or in any documents attached to this Application (including, without limitation, in the Supporting Evidence form) for any information which is needed to process and evaluate the Application 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 process consent

By signing in the space provided under Section 14 of this Application, the Applicant hereby: (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, 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 contained or referred to in, or otherwise provided in connection with this Application and/or any documents attached to or relating to this Application and/or any subsequent appeals or other proceedings arising from or in connection with this Application (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 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 arising from or relating to it; or
c. with any other third party anticipated by ESIS, INC. Privacy Policy for COVAX No-Fault Compensation Program for AMC Eligible Economies or required by applicable laws.

The Applicant understands that consent may be withdrawn at any time, but that doing so 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 has fully read and understood, or has had read and explained to him/her, the terms and conditions of the Program's Protocol and its Schedules, available at www.covaxclaims.com. This Application (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 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 arising from or relating to it, the Applicant (which includes the Patient and the individual, if any, submitting this Application 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 against any other person, organisation or legal entity, whether under this Program or any other mechanism, in relation to the injury or illness suffered by the Patient for which this Application is made. In the event that any such other application or claim is commenced or comes to the attention of the Administrator, this Application shall automatically be rejected and the Administrator shall have the right to enforce Section 10 of the Program's Protocol.

c. If any compensation under the Program is agreed to be paid to Applicant (which includes the Patient and the individual, if any, submitting this Application for the Patient), such a payment shall only be made if the Applicant 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 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 control and prevail in all respects.

13. Declaration of Truth and Correctness

By signing in the space provided under Section 14 of this Application, the Applicant, hereby: (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

[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 certifying the Release Agreement, if any.

(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

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 and direct (at-cost) telephone numbers (*) of the various Regional Centers under the Program where you can:

A. contact the Program's Administrator if you have any questions about the Program or need help in completing or submitting an Application Form or other Program Forms; and
B. submit to the Program's Administrator (by sending via registered mail): (1) your application materials (i.e., the Application Form on Schedule 2, the Supporting Evidence Form on Schedule 3, and all other documents required to be submitted under the terms of these forms); (2) the other Program forms; and (3) any other documents that are required or permitted to be submitted under the Program's forms.

(*) 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.

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.

SCHEDULE 2 TO
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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**	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**	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**	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**	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 Geraldo Flausino Gomes, 78 14º Andar Cidade Monções 04575-060 São Paulo Brazil **+55-11-3879-7500**	69. Bolivia	
Singapore Crawford & Company 8 Shenton Way #03-01, AXA Tower Singapore 068811 Singapore **+65 6632 8639**	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**	77. Mongolia 78. Philippines	
United Arab Emirates Crawford & Company P.O. Box 2976 Dubai, United Arab Emirates **+971 4 345 9541**	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**	82. Afghanistan 83. Bangladesh 84. Bhutan 85. India 86. Nepal 87. Pakistan 88. Sri Lanka	

Israel Crawford-Tossman No. 2 Choma Umigdal St., Tel Aviv, Israel, 6777102 **+972 35 628 811**	89. West Bank and Gaza
Belgium Crawford & Company Jan Olieslagerslaan 41 1800 Vilvoorde Belgium **+32 2 257 03 52**	90. Algeria 91. Morocco 92. Tunisia

[END OF THE APPLICATION FORM]