

**SCHEDULE 3 TO  
PROTOCOL FOR COVAX NO-FAULT COMPENSATION PROGRAM FOR AMC ELIGIBLE ECONOMIES**

**SUPPORTING EVIDENCE FORM  
UNDER THE COVAX NO-FAULT COMPENSATION PROGRAM FOR AMC ELIGIBLE ECONOMIES**

**INSTRUCTIONS / IMPORTANT NOTICES FOR APPLICANTS:**

1. When to Use this Form: Please use this Supporting Evidence form to provide the medical evidence that is required pursuant to Section 8(a) of the Application form to file an application for compensation under the Program. You should submit this Supporting Evidence form together with the Application form (Schedule 2 of the Program’s Protocol). Please do not complete this form yourself. As provided below, this form should be completed by one or more Registered Healthcare Professionals.<sup>1</sup>
2. 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 this Program can be taken. In this regard, please do not complete and submit an Application and do not obtain Supporting Evidence, 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.
3. Registered Healthcare Professional (Not Applicant) Must Complete this Form: This Supporting Evidence form should be completed, signed and dated by at least one Registered Healthcare Professional (as defined in footnote 1 below), although it is also possible for several Registered Healthcare Professionals to complete this form. The Registered Healthcare Professional(s) completing this form should answer all sections/questions in this form, and provide as much detail and information as possible. The Applicant should not complete this Supporting Evidence form himself.
4. Attachments to this Form: You may answer questions in this Supporting Evidence form by referring to documents provided with this form. The information contained in the documents provided with this form does not need to be repeated in the answers provided in the form itself.
5. Name, Signature and Date Required: Each of the Registered Healthcare Professional(s) completing this Supporting Evidence form should sign, date and insert his full name in Section 2 of this form.
6. Accepted Languages: This Supporting Evidence form must be completed and submitted in English, French or Spanish only. If this form is completed in any other languages, it will not be accepted or considered. However, any documents required to be provided under this Supporting Evidence form can be submitted in another language, if they are not available in either English, French or Spanish.
7. Failure by the Registered Healthcare Professional(s): (a) to complete all sections/questions in this Supporting Evidence form, or (b) to sign, date and insert his/her/their full name(s) in this form, will lead to the rejection of the Applicant’s Application or to delays in processing it.
8. Deadline for Submission: Once this Supporting Evidence form has been duly completed, signed and dated by Registered Healthcare Professional(s), the Applicant must submit this Supporting Evidence form, together with the Application form and the other documents required by Section 8 of the Application form, to the Program’s Administrator before the end of the applicable Reporting Period (as set forth in Schedule 1 to the Program’s Protocol). If Applicant submits this Supporting Evidence form after the end of the applicable Reporting Period, then this Supporting Evidence Form and the Application to which it relates cannot be accepted or considered.

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<sup>1</sup> 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 or received the Vaccine or in the case of birth defects, where the Patient’s mother resides or received the Vaccine.

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9. How to Submit this Form: Once this form has been duly completed, signed and dated by Registered Healthcare Professional(s), the Applicant must submit this Supporting Evidence form, together with the Application form and the other documents required by Section 8 of the Application form, 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](http://www.covaxclaims.com);
  - By emailing them to [covaxclaims@esis.com](mailto: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 Supporting Evidence form and are also available on the Program's website at [www.covaxclaims.com](http://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](http://www.covaxclaims.com)

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**SUPPORTING EVIDENCE FORM**

**IMPORTANT NOTE FOR COMPLETING THIS FORM:** You may answer questions in this Supporting Evidence form by referring to documents provided with this form. The information contained in the documents provided with this form does not need to be repeated in the answers provided in the form itself.

**1. REPORT OF REGISTERED HEALTHCARE PROFESSIONAL(S)<sup>2</sup>**

<b>A. INFORMATION ABOUT THE PATIENT<sup>3</sup></b>	
Full name of the Patient, including any middle names	
Mailing address of the Patient (including city, zip code and country)	
Date of birth of the Patient (day/month/year)	
Sex of the Patient	
<b>B. INFORMATION ABOUT THE REGISTERED HEALTHCARE PROFESSIONAL(S) COMPLETING THIS FORM</b>	
1. Full name(s), including any middle names, of the Registered Healthcare Professional(s) completing this Supporting Evidence form.	

<sup>2</sup> 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.

<sup>3</sup> The term “Patient” means an 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), 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 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. Injury means a serious bodily injury or illness suffered or sustained by a Patient that:

- (i) requires Hospitalization or prolongs an existing Hospitalization; and
- (ii) results in permanent total or partial Impairment; or
- (iii) is a congenital birth injury or illness in an unborn or new-born child of a woman who received a Vaccine and results in permanent total or partial Impairment; or
- (iv) results in death.

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2. Name of the hospital, clinic or other place of work of Registered Healthcare Professional(s) completing this form, including: (A) Mailing address(es), (B) Email address(es), and (C) Telephone number(s).
  
  
  
  
  
  
  
  
  
  
3. Type of registration held by the Registered Healthcare Professional(s) completing this form, together with the registration number(s) or other means to identify the registration(s). For example, if you are a state registered nurse, please state “nurse” and provide your registration number.

**C. INFORMATION ABOUT THE VACCINE ADMINISTERED TO THE PATIENT**

**IMPORTANT NOTE: IF THE VACCINE IS A TWO DOSE SCHEDULE VACCINE, PLEASE INDICATE BELOW WHETHER THE PATIENT RECEIVED BOTH DOSES OF THE VACCINE, AND IF SO, PROVIDE THE DETAILS FOR BOTH DOSES.**

1. Details of the Vaccine administered to the Patient (or in the case of birth defects, to the Patient’s mother), including the Vaccine’s: (A) name, (B) dose(s), (C) batch or lot number(s), and (D) expiry date(s).
  
  
  
  
  
  
  
  
  
  
2. If known, details of diluent (if any) used with the Vaccine dose(s) administered to the Patient (or in the case of birth defects, to the Patient’s mother), including the diluent’s: (A) name, (B) dose(s), (C) batch or lot number(s), and (D) expiry date(s).

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3. Date(s) and places(s) the Vaccine dose(s) was/were administered to Patient (or in the case of birth defects, to the Patient's mother). Please state the date(s) as day/month/year.
  
4. If applicable, please provide:
  - A. 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
  - B. Name(s) of the focal person(s) in that Humanitarian Agency

**D. INFORMATION ABOUT THE INJURY OR ILLNESS SUSTAINED BY THE PATIENT AFTER THE VACCINE DOSE(S) WAS/WERE ADMINISTERED TO THE PATIENT.**

**IMPORTANT NOTE: IF A PATIENT HAS DIED, PLEASE COMPLETE THIS SECTION D TO THE EXTENT APPLICABLE, IN ADDITION TO COMPLETING SECTION E.**

1. If the Patient received two doses of the Vaccine, please indicate if the injury or illness suffered by the Patient has started after the administration of the first or second dose of the Vaccine.
  
2. Describe the injury or illness suffered by the Patient after the Vaccine dose(s) was/were administered to Patient (or in the case of birth defects, to the Patient's mother). Please include:
  - (A) details of all examinations and tests of the Patient in relation to such injury or illness; and
  - (B) if applicable, details of any congenital birth injury or illness.

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3. Regarding symptoms, please describe the following:
- (A) all symptoms experienced by the Patient after the Vaccine dose(s) was/were administered to the Patient (or in the case of birth defects, to the Patient's mother);
  - (B) the dates (day / month / year) when the symptoms were first recorded; and
  - (C) for each symptom, the extent to which that symptom was serious; and
  - (D) the details of any sequelae.

In particular, please mention:

- any severe local reaction suffered by the Patient after the Vaccine dose(s) administered to him/her (and whether that reaction extended beyond nearest joint); and
- any seizures (febrile or afebrile), abscess, sepsis, encephalopathy, toxic shock syndrome, thrombocytopenia, anaphylaxis, fever (above 38 degrees centigrade).

4. Did the Patient require any treatment for the injury or illness suffered by the Patient after the Vaccine dose(s) was/were administered to him/her (or in the case of birth defects, to the Patient's mother)?
- If yes**, please describe what treatment was provided to the Patient for the injury/illness suffered by the Patient after the Vaccine dose(s) was/were administered to him/her (or in the case of birth defects, to the Patient's mother).

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5. Please describe to what extent the Patient has or has not (as applicable) recovered from the injury or illness suffered by the Patient after the Vaccine dose(s) was/were administered to him/her (or in the case of birth defects, to the Patient's mother).
6. In your opinion, what was the cause of the injury or illness suffered by the Patient?
7. If known, please provide the date (day/month/year) and place when the injury or illness suffered by the Patient was first reported to a Registered Healthcare Professional or to the health system.
8. Describe the extent of any permanent impairment of the Patient and the prognosis for the Patient as a result of such impairment
9. What is the functional impact on the Patient of the injury or illness suffered by the Patient after the Vaccine dose(s) was/were administered to him/her (or in the case of birth defects, to the Patient's mother)?

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10. Details of any hospitalization, or prolongation of existing hospitalization, of the Patient for more than 24 consecutive hours in connection with the injury or illness suffered by the Patient after the Vaccine dose(s) was/were administered to the Patient (or in the case of birth defects, to the Patient's mother), including:

- (A) Date (day/month/year) when the Patient was admitted to the hospital or when the Patient's existing hospitalization was prolonged;
- (B) Date (day/month/year) when the Patient was discharged from the hospital; and
- (C) Type of care/treatment provided to the Patient during the initial hospitalization for the injury or illness suffered by the Patient after the Vaccine dose(s) was/were administered to him/her (or in the case of birth defects, to the Patient's mother); and
- (D) If applicable, type of care/treatment provided to the Patient during the prolongation of the hospitalization, if any, for the injury/illness suffered by the Patient after the Vaccine dose(s) was/were administered to him/her (or in the case of birth defects, to the Patient's mother).



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

(A) Details of 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, including:

- name of each medicine/vaccine;
- dose
- time period taken or /administered (stated as day/month/year)

(B) In the case of birth defects, details of 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, including:

- name of each medicine/vaccine;
- dose;
- time period taken or /administered (stated as day/month/year)

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

- name of each medicine:
- dose
- time period taken (stated as day/month/year)

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13. Details of any known pre-existing medical conditions of the Patient or in the case of birth defects, of the Patient's mother (i.e., medical conditions existing before the period the Vaccine dose(s) was/were administered to the Patient or in the case of birth defects, to the Patient's mother)

14. Has the Patient suffered any similar injury or illness before? If yes, please describe the previous similar injury or illness.

15. In the case of birth defects, did the Patient's mother have another unborn or new-born child with a congenital birth injury or illness? If yes, please provide details.

16. In your opinion, is it possible that the injury or illness suffered by the Patient after the Vaccine dose(s) was/were administered to the Patient (or in the case of birth defects, to the Patient's mother) was caused by, or resulted from, any previous injury or illness of the Patient (or in the case of birth defects, of the Patient's mother)?  
If yes, please provide details.

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17. To the extent known, has a close family member of the Patient, such as brother, sister, parent, child, aunt, uncle, or 1st cousin, suffered any similar injury or illness before?

If yes, please indicate which close family member and describe the similar injury or illness.

18. Have you seen any injury or illness similar to that suffered by the Patient amongst other patients who received (or in the case of birth defects, whose mother received) the same Vaccine?

**E. IF THE PATIENT HAS DIED, INFORMATION ABOUT THE PATIENT'S DEATH:**

1. If the Patient has died after the Vaccine dose(s) was/were administered to Patient, then please:

- a. State date of the Patient's death (day/month/year) and all causes of death stated on the Patient's death certificate; and
- b. Include the details of any autopsy performed on the Patient.

2. In accordance with Section G below, please provide a copy of the Patient's death certificate and any other documentation available regarding the cause and manner of the Patient's death.

3. In your opinion, what is/are the causes(s) of the Patient's death?

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<p><b>4.</b> Have you seen death similar to that suffered by the Patient among other patients who received the same Vaccine as the Patient? If yes, please provide details.</p>
<p><b>F. OTHER INFORMATION:</b></p>
<p>Please set out any further information which you consider may be relevant for the Patient's claim for compensation under the Program</p>
<p><b>G. DOCUMENTATION TO BE PROVIDED WITH THIS FORM</b></p>
<p><b>1.</b> Please provide documentation confirming that the Vaccine dose(s) was/were administered to the Patient (or in the case of birth defects, to the Patient's mother), for example, a copy the immunization card or certificate, a copy of the service point immunization log(s) documenting the administration of the Vaccine dose(s), or a copy of the completed national adverse event following immunization investigation form</p>
<p><b>2.</b> Please attach a copy of all available medical documentation and records related to the injury or illness sustained by the Patient after administration of the Vaccine dose(s), including case sheet, case notes, discharge summary, laboratory reports, autopsy report, as well as prescriptions for concomitant and/or long-term medication, as referred to above, etc.</p>
<p><b>3.</b> If available, please also attach a copy of the AEFI investigation form, AEFI committee causality assessment, and related documentation.<sup>4</sup></p>

In the event of any conflict or inconsistency between the English language version of this Supporting Evidence form and any translations hereof, the English language version shall control and prevail in all respects.

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<sup>4</sup> AEFI investigations and causality assessments may be conducted by a Ministry of Health, its national immunization program, or associated committees, and documents related to such investigations and assessments may be available from such groups.

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**2. DECLARATION AND SIGNATURE OF REGISTERED HEALTHCARE PROFESSIONAL(S)**

By signing below, I/we hereby certify that:

- before this Supporting Evidence form was completed, a waiting period of 30 days has been observed since the Vaccine dose(s) was/were administered to the Patient (or in the case of birth defects, to the Patient's mother); and

- the statements and answers contained in this Supporting Evidence form are true and correct to the best of my/our knowledge and belief.

I/We understand that should these statement or answers not be true, the Administrator shall have the right, where applicable, to refer to the relevant law enforcement authority for further investigation.

Full Name of Registered Healthcare Professional: \_\_\_\_\_

Title: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Full Name of Registered Healthcare Professional: \_\_\_\_\_

Title: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Annexes:**

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

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**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.**

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Regional Center Contact Information	AMC Eligible Economies Serviced by the Regional Center					
<p><b><u>South Africa</u></b> Crawford &amp; Company PO Box 782023 Sandton 2146 South Africa <b>+27 (0)11 463 5900</b></p>	1. Angola	9. Comoros	18. Ghana	27. Mali	35. Sierra Leone	
	2. Benin	10. Congo, Dem Rep.	19. The Guinea	28. Mauritania	36. Somalia	
	3. Burkina Faso	11. Congo Rep.	20. Guinea-Bissau	29. Mozambique	37. South Sudan	
	4. Burundi	12. Côte d'Ivoire	21. Kenya	30. Niger	38. Sudan	
	5. Cabo Verde	13. Djibouti	22. Lesotho	31. Nigeria	39. Tanzania	
	6. Cameroon	14. Eritrea	23. Liberia	32. Rwanda	40. Togo	
	7. Central African Republic	15. Eswatini	24. Madagascar	33. Sao Tome & Principe	41. Uganda	
	8. Chad	16. Ethiopia	25. Malawi	34. Senegal	42. Zambia	
		17. Gambia	26. Maldives		43. Zimbabwe	
<p><b><u>Australia</u></b> Crawford &amp; Company GPO Box 1016, Brisbane QLD 4004 Australia <b>+61 7 3223 3100</b></p>	44. Fiji	49. Samoa				
	45. Kiribati	50. Solomon Islands				
	46. Marshall Islands	51. Tonga				
	47. Micronesia, Federated States	52. Tuvalu				
	48. Papua New Guinea	53. Vanuatu				
<p><b><u>Germany</u></b> Crawford &amp; Company Werdener Strasse 4, 40227 Düsseldorf Germany <b>+49 211 95456250</b></p>	54. Kosovo					
	55. Kyrgyz Republic					
	56. Moldova					
	57. Tajikistan					
	58. Ukraine					
	59. Uzbekistan					
<p><b><u>Mexico</u></b> Crawford &amp; 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 <b>+52 55 5093 6467</b></p>	60. Dominica	65. Honduras				
	61. El Salvador	66. Nicaragua				
	62. Grenada	67. St. Lucia				
	63. Guyana	68. St. Vincent and the Grenadines				
	64. Haiti					

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<p><b><u>Brazil</u></b> Crawford &amp; Company Geraldo Flausino Gomes, 78 14º Andar Cidade Monções 04575-060 São Paulo Brazil <b>+55-11-3879-7500</b></p>	<p>69. Bolivia</p>	
<p><b><u>Singapore</u></b> Crawford &amp; Company 8 Shenton Way #03-01, AXA Tower Singapore 068811 Singapore <b>+65 6632 8639</b></p>	<p>70. Cambodia 71. Indonesia 72. Korea, Dem. People’s Rep. 73. Lao PDR</p>	<p>74. Myanmar 75. Timor-Leste 76. Vietnam</p>
<p><b><u>Hong Kong</u></b> Crawford &amp; Company 24/F Sunshine Plaza, 353 Lockhart Rd, Wanchai Hong Kong <b>+852 2526 5137</b></p>	<p>77. Mongolia 78. Philippines</p>	
<p><b><u>United Arab Emirates</u></b> Crawford &amp; Company P.O. Box 2976 Dubai, United Arab Emirates <b>+971 4 345 9541</b></p>	<p>79. Egypt, Arab Rep. 80. Syrian Arab Rep. 81. Yemen, Rep.</p>	



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<p><u>India</u> Puri-Crawford Unit No.1, First floor, Windsor Terrace, Above Hotel Samruddhi, Vishrantwadi, Pune, Maharashtra 411015 India <b>+91 (020) - 26612524</b></p>	<p>82. Afghanistan 83. Bangladesh 84. Bhutan 85. India 86. Nepal 87. Pakistan 88. Sri Lanka</p>
<p><u>Israel</u> Crawford-Tossmann No. 2 Choma Umigdal St., Tel Aviv, Israel, 6777102 <b>+972 35 628 811</b></p>	<p>89. West Bank and Gaza</p>
<p><u>Belgium</u> Crawford &amp; Company Jan Olieslagerslaan 41 1800 Vilvoorde Belgium <b>+32 2 257 03 52</b></p>	<p>90. Algeria 91. Morocco 92. Tunisia</p>

**[END OF THE SUPPORTING EVIDENCE FORM]**