## SCHEDULE 4

## CLAIM FORM

This form may be updated from time to time to meet the needs of information requirements to properly process and assess claims as they might be identified, and any updated versions of the form will be available on the National Department of Health website, https://www.health.gov.za/covid19/ .

| EPID | S O A - | - | - | - |
|---|---|---|---|---|
| *Or SAHPRA* | Country | - Province - | District - | Year - |
| | Case no | | | |

| *Date received* | *Stage* | *Signature* |
|---|---|---|
| | NISEC | |
| | NDOH Administrator | |
| | Claim (Claimant) | |

**For Office use only:**

**Date vaccine injured party notified, by Administrator regarding NISEC causality assessment outcome:** D D / M M / Y Y Y Y

**NISEC causality outcome and case dossier attached** ☐ **YES** ☐ **NO**

*All fields in this form are mandatory, unless indicated 'if applicable'.*
*Provide the requested information or tick the appropriate box.*

### SECTION A: IDENTIFYING INFORMATION

**Date of Claim submitted:** D D / M M / Y Y Y Y

**Claimant name & surname:**

_____

**Vaccine injured person name & surname**:

_____

**Relationship to the vaccine injured party:** Eligible person / Dependent / Authorized person / Parent or legal guardian in the case of a child or Other please specify

_____

**Where a dependant is the claimant, please attach:**

- Vaccine injured party death certificate: ☐ YES ☐ NO
- For a spouse the marriage certificate: ☐ YES ☐ NO
- For Child dependent, a unabridged birth certificate: ☐ YES ☐ NO
- Other dependants to submit proof as required

**Claimant residential address**:

_____

_____

**Mobile no:** _____ **Telephone no:**

_____

**Email:**

_____

**Sex:** ☐ M ☐ F ☐ Other

**Form of Identification attached of Claimant: ID / Passport / Other – Please specify:**

_____

**ID number:** ☐☐☐☐☐☐☐☐☐☐☐☐☐

***Claimant banking details:***

***Account holder name:*** _____

_____

***Bank:*** _____

***Branch:*** _____

***Account type:*** _____

***Account number:*** _____

***Bank stamp:***

*Validate banking details at your bank, alternatively submit stamped bank statement not older than 3 months confirming these details.*

**Passport number:** _____

**Date of birth:** D D / M M / Y Y Y Y

## SECTION B: VACCINE INFORMATION (Please attach a copy of the Vaccine certificate OR Vaccination Card)

**Health facility / vaccination center name:** _____ ☐ DoH ☐ Private ☐ NGO

**Address / location:**

_____

| Vaccine administered | | | | |
|---|---|---|---|---|
| **Vaccine/s given** (Use trade name) | **Date vaccinated** | **Time vaccinated** | **Dose number** (1st, 2nd) | **Batch/ Lot number** |
| | | | | |
| | | | | |
| | | | | |
| **Vaccination code received from EVDS** | | | | |

## SECTION C: DESCRIBE THE ADVERSE EVENT REPORTED / TYPE OF VACCINE INJURY

**Date & time AEFI started:** D D / M M / Y Y Y Y ☐☐ Hr ☐☐ Min

**Describe vaccine recipient's or caregiver's concern (AEFI signs and symptoms). Use additional sheet if needed**

**Final Diagnoses:**

_____

_____

_____

_____

_____

_____

**AEFI reported through: Health System/Facility** ☐ **MedSafety application** ☐ **COVID-19 Call Centre** ☐

**Not reported, please provide details:**

_____

_____

_____

## SECTION D: TYPE OF VACCINE INJURY

**Is this event a serious AEFI?** ☐ Yes ☐ No

- ☐ Death ☐ Disability

Describe injury:

_____

## SECTION E: THE OUTCOME OF THE ADVERSE EVENT REPORTED

☐ Recovering ☐ Recovered fully (no complications) ☐ Not Recovered ☐ Unknown

☐ Recovered with complications; Specify:

_____

_____

_____

**Treating Clinician name:** _____ **Practice number:**

_____

| |
|---|
| **Telephone number:** _____ **Clinician address:** _____<br>☐ Died ➔ Date of death: D D / M M / Y Y Y Y ➔ Autopsy: ☐ Yes ☐ No ☐ Unknown<br>☐ Hospitalisation ➔ Date of admission: D D / M M / Y Y Y Y<br>➔ Name of hospital: _____ Hospital number: _____ |
| **Claimant Signature:** **Date:** : D D / M M / Y Y Y Y |

| **FOR OFFICE USE ONLY - SECTION F: CLAIM MOVEMENT AND PROCESSING** | |
|---|---|
| Adjudication panel evaluated claim: ☐ Yes ☐ No<br>Date claim evaluated:<br>D D / M M / Y Y Y Y | Adjudication outcome received: ☐ Yes ☐ No<br>Date the outcome received by Administrator:<br>D D / M M / Y Y Y Y<br>Date claimant informed of adjudication panel outcome:<br>D D / M M / Y Y Y Y |

## CONSENT CLAUSE FOR COLLECTION AND PROCESSING OF PERSONAL INFORMATION

By their signature below, the claimant or vaccine recipient or relative (in the event of the vaccine recipient being unresponsive or has demised) or caregiver (in the case of a child) hereby provides consent to the collection and processing of their personal information (as set out in this No Fault Compensation Claim Form) by the National Department of Health and third parties appointed by it (the "Department") for the purposes of No Fault Compensation Claim Administration. The claim process will investigate and asses potential adverse events related to the use of COVID-19 vaccines The claimant, vaccine recipient or relative (in the event of the vaccine recipient being unresponsive or has demised) or caregiver (in the case of a child) acknowledges that this information may be used i) to access all medical and clinical records for the purpose of claim processing or case investigation, when required; ii) in the generation of statistics; and iii) to make policy decisions relating to vaccine safety and efficacy. This consent may be withdrawn at any time, and the claimant, vaccine recipient or relative (in the event of the vaccine recipient being unresponsive or has demised) or caregiver (in the case of a child) may, at any time, object to the collection and processing of their personal information, by contacting the National Department of Health.

The Department undertakes to process the personal information contained in this No Fault Compensation Claim form, and collected during the process of claim processing and case investigation in a manner that adheres to the Protection of Personal Information Act. The information will not be stored (in a manner that identifies the vaccine recipient) for any longer than is necessary to achieve the purpose for which the information was collected, unless the Department has a lawful basis to do so. If the vaccine recipient or relative (in the event of the

vaccine recipient being unresponsive or has demised) or caregiver (in the case of a child) wishes to access and/or rectify their personal information, they may do so by contacting the National Department of Health.

**Claimant: _____ (Name and Surname)**

**Signed by the claimant/ vaccine recipient / relative / caregiver***

| _____ | _____ | _____ |
|---|---|---|
| **Name and Surname** | **Signature** | **Date** |

*Delete what is not applicable

## SCHEDULE 6

## COMPENSATION TABLE

In the event that a Payment is approved either by the Adjudication Panel or the Appeals Panel then, the sum to be paid shall be calculated using a Quantum Assessment using the following methodology:

### a. Death Benefit

A total amount of R150,000 in the event of a death, divided equally between all dependants whom the Adjudication Panel or the Appeals Panel is able to identify within 2 months of the final determination of the claim.

### b. Permanent Disability Benefit

The proportion for permanent disability is calculated as a ratio of the amount payable in the event of death, which is R150 000.

The harm factors resulting from the Vaccine or its administration are:

| | | |
|---|---|---|
| a) | 0 | No compensation will be paid if the impairment is below 5% |
| b) | 0,13 | if the Impairment is equal to or greater than 5% but below 10% |
| c) | 0,26 | if the Impairment is equal to or greater than 10% but below 20% |
| d) | 0,44 | if the Impairment is equal to or greater than 20% but below 30% |
| e) | 0,61 | if the Impairment is equal to or greater than 30% but below 40% |
| f) | 0,79 | if the Impairment is equal to or greater than 40% but below 50% |
| g) | 0,96 | if the Impairment is equal to or greater than 50% but below 60% |
| h) | 1,14 | if the Impairment is equal to or greater than 60% but below 70% |
| i) | 1,31 | if the Impairment is equal to or greater than 70% but below 80% |
| j) | 1,49 | if the Impairment is equal to or greater than 80% but below 90% |
| k) | 1,75 | if the Impairment is equal to or greater than 90% |

### c. Temporary Disability Benefit

For a person with a serious vaccine injury (in excess of 25% impairment), a fixed temporary compensation amount of R5,000 per month of disability, up to a maximum of 6 months, will be paid, provided that the duration of the temporary disability is at least one month and provided that the claimant does not receive a benefit for the same injury under COIDA.

A person may claim for both temporary and permanent disability, where applicable.

Temporary disability payments may be made prior to the finalisation of a claim for permanent disability.