

CSL Data Subject Request Form – For Self

Please answer all of the following questions completely and truthfully.

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| Enter the date you are making this request [Month/Day/Year] | |
| Information about you | |
| Enter your first name | |
| Enter your last name | |
| Please list any former/ alternative names | |
| Enter your phone number | |
| Enter your mailing address, which must include: Street Address City/Town/Locality State/Territory/Province Postal Code Country | |
| Enter your email address. | |
| Can we contact you by email regarding this request? | <input type="checkbox"/> Yes - This is how we will contact you and provide any information regarding your request. <input type="checkbox"/> No - How would you prefer that we contact you and provide any information regarding this request? <input type="checkbox"/> Postal Mail <input type="checkbox"/> Phone <input type="checkbox"/> Other (please specify): |

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| <p>Can you provide proof of your identification?</p> | <p><input type="checkbox"/> Yes - Please attach copy of your identification (e.g., photo ID, passport, or another proof of identification).</p> <p><input type="checkbox"/> No - Please provide an explanation. Be advised, your request may be delayed until verification of your identity is obtained.</p> |
| <p>For which CSL entity are you requesting information? (Select one)</p> | <p><input type="checkbox"/> CSL Behring Pharmaceuticals</p> <p><input type="checkbox"/> CSL Plasma</p> <p><input type="checkbox"/> Seqirus Pharmaceuticals</p> |
| <p>What is the relationship with the CSL entity? (Select one)</p> | <p><input type="checkbox"/> Patient/Donor or Customer</p> <p><input type="checkbox"/> Health Care Providers (HCPs) who are not clinical trial investigators</p> <p><input type="checkbox"/> Clinical Trial Investigator (e.g., nurses, site coordinators, investigators)</p> <p><input type="checkbox"/> Clinical Trial Participant (e.g., patients in a clinical trial)</p> <p><input type="checkbox"/> Family (e.g., HCP spouses, employee dependents, patient caregivers)</p> <p><input type="checkbox"/> Current Employee</p> <p><input type="checkbox"/> Former Employee</p> <p><input type="checkbox"/> Candidates for Employment</p> <p><input type="checkbox"/> Contractor or Contingent worker</p> <p><input type="checkbox"/> Third party vendor/supplier</p> <p><input type="checkbox"/> Other (please enter brief explanation):</p> <p>_____</p> |

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| <p>Provide a unique CSL Identifier to help us locate your data. (Select one)</p> | <p><input type="checkbox"/> Patient/Donor ID (please specify): _____</p> <p><input type="checkbox"/> Health Care Provider (HCPs) Number (please specify): _____</p> <p><input type="checkbox"/> Clinical Trial Investigator ID (please specify): _____</p> <p><input type="checkbox"/> Clinical Trial Subject ID (please specify): _____</p> <p><input type="checkbox"/> Employee ID (please specify): _____</p> <p><input type="checkbox"/> Applicant Number (please specify): _____</p> <p><input type="checkbox"/> Contractor or Contingent worker User ID (please specify): _____</p> <p><input type="checkbox"/> Third party vendor/supplier Number (please specify): _____</p> <p><input type="checkbox"/> Other (please specify): _____ What type of identifier is this? _____</p> <p><input type="checkbox"/> I do not have a unique CSL Identifier</p> |
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| Information about the request | |
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| <p>What type of request are you making? (Select one)</p> | <ul style="list-style-type: none"> <input type="checkbox"/> Access: request for further details regarding how CSL makes use of Personal Data and a copy of Personal Data that CSL holds <input type="checkbox"/> Rectification: request that CSL correct specific Personal Data it is processing if it is inaccurate or incomplete <u>Note:</u> In your response to the following question, please provide detail on how the data is currently recorded/listed as well as how you would like data to be changed <input type="checkbox"/> Erasure: request for CSL to delete or remove specific Personal Data no longer needed for a legal or legitimate purpose <input type="checkbox"/> Portability: request that CSL move, copy, or transfer Personal Data to another organization in a secure and useable manner <input type="checkbox"/> Objection/Restriction of Processing of Personal Data: request that CSL stop processing specific Personal Data, either entirely, for a limited time, or for certain purposes <input type="checkbox"/> Objection to Automated Decision-Making: request for CSL to cease making automated decisions and review any decision made |
| <p>Please provide a description of what action you are seeking</p> | |

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| <p>What type(s) of data is this request regarding? (Select all that apply)</p> | <p><input type="checkbox"/> General Contact Information (e.g., Name & Initials, Personal Directory Information such as email, address, and phone number) (please specify): _____</p> <p><input type="checkbox"/> Personal Information (e.g., Personal characteristics such as racial or ethnic origin, age, place of birth, gender identity, religious or philosophical belief, and sexual orientation, Household information such as estimated income, number of cars owned, dwelling type, Sensitive Personal Data such as criminal records, account usernames) (please specify): _____</p> <p><input type="checkbox"/> Personal Identification Information (e.g., Government Issued Identification such as driver’s license, passport number, national identity card) (please specify): _____</p> <p><input type="checkbox"/> Digital Information (e.g., account login information, Cookie Identifiers)</p> <p><input type="checkbox"/> Health Information (e.g., medical history, genetic information, visit history, insurance, information, adverse reactions to medications) (please specify): _____</p> <p><input type="checkbox"/> Employment Information (e.g., occupation, compensation, performance reviews) (please specify): _____</p> <p><input type="checkbox"/> Education and Professional Qualification Information (e.g., education history, academic record, professional identifiers) (please specify): _____</p> <p><input type="checkbox"/> Family/Caregiver information (e.g., information related to dependents such as the name, age, and/or gender of a child or caregiver) (please specify): _____</p> <p><input type="checkbox"/> Financial Information (e.g., credit card information, financial transactions, credit history) (please specify): _____</p> <p><input type="checkbox"/> Clinical Trial Information (e.g., study information, treatments provided as part of a study, patient outcome, treatment dates) (please specify): _____</p> |
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| | <input type="checkbox"/> Financial Reporting Information (e.g., Financial statements, Customer Pricing) (please specify): _____ <input type="checkbox"/> Other (please enter a brief description): _____ |
| Is there a specific CSL system or application you would like us search to evaluate your request? | <input type="checkbox"/> Yes (please specify): _____ <input type="checkbox"/> No |

I certify that I understand that before complying with this request, CSL may require me to provide:

- a. Proof of my identity;
- b. Such further information as may be reasonably required for CSL to complete the request.

I understand that missing or incomplete information may result in a rejection of the request or a delay in the completion of the request.

Printed Name

Signature

Except with the prescribed consent of the individual concerned, the Personal Data provided in this form will be used only for the purposes of processing this request and other directly related purposes. All information collected as a function of this request will be deleted 120 calendar days after the request has been closed, unless required for continuing legal requirements.