



Cost of Medical Care in respect of an Occupational Accident or Disease

How to complete application form for Cost of Medical Care in respect of an Occupational Accident or Disease.

- Please tear off this page and use as a guide to filling in this form.
- Please use BLACK ball point pen.
- Please use BLOCK LETTERS and place an X in the relevant boxes.
- Please answer all questions that apply to you. If a question does not apply to you, please leave the answer area blank.
- You need a Personal Public Service Number (PPS No.) before you apply.
- Log on to www.welfare.ie for more information.

Fill in all Parts as they apply to you. When form is completed, sign declaration in Part 1.

If you need any help to complete this form, please contact your local Social Welfare Office or Citizens Information Centre.

Important:

The cost of Medical Care should be claimed within 6 weeks of the start of the care. If the claim is received later, a good reason must be shown for the delay in claiming.

How to fill in first page of this form

To help us in processing your claim:

- Print letters and numbers clearly.
- Use one box for each character (letter or number).

Please see example below.

| | | | | | | | | | | | | | | | | | | | | |
|---|-----|--------------------------|------|-------------------------------------|-----|--------------------------|-------|---|---|---|--|--|--|--|--|--|--|--|--|--|
| 1. Your PPS No.: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | T | | | | | | | | | | | | |
| 2. Title: (insert an 'X' or specify) | Mr. | <input type="checkbox"/> | Mrs. | <input checked="" type="checkbox"/> | Ms. | <input type="checkbox"/> | Other | | | | | | | | | | | | | |
| 3. Surname: | M | U | R | P | H | Y | | | | | | | | | | | | | | |
| 4. First name(s): | M | A | U | R | E | E | N | | | | | | | | | | | | | |
| 5. Your first name as it appears on your birth certificate: | M | A | R | Y | | | | | | | | | | | | | | | | |
| 6. Birth surname: | M | C | D | E | R | M | O | T | T | | | | | | | | | | | |
| 7. Your mother's birth surname: | K | E | L | L | Y | | | | | | | | | | | | | | | |
| 8. Your date of birth: | 2 | 8 | | 0 | 2 | | 1 | 9 | 7 | 0 | | | | | | | | | | |
| | D | D | | M | M | | Y | Y | Y | Y | | | | | | | | | | |

Contact Details

| | | | | | | | | | | | | | | | | | | | | | |
|----------------------------|----------|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|--|--|--|
| 9. Your address: | 1 | | N | E | W | | S | T | R | E | E | T | | | | | | | | | |
| | O | L | D | | T | O | W | N | | | | | | | | | | | | | |
| | C | O | | D | O | N | E | G | A | L | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | |
| 10. Your telephone number: | 0 | 1 | 7 | 0 | 4 | 3 | 0 | 0 | 0 | | | | | | | | | | | | |
| | LANDLINE | | | | | | | | | | | | | | | | | | | | |
| | 0 | 8 | 6 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | | | | | | | | | | | |
| | MOBILE | | | | | | | | | | | | | | | | | | | | |
| 11. Your email address: | M | M | U | R | P | H | Y | @ | W | E | L | F | A | R | E | . | I | E | | | |
| | | | | | | | | | | | | | | | | | | | | | |

SAMPLE

Send this completed application form to:

Medical Care Section
Social Welfare Services
Department of Social and Family Affairs
Áras Mhic Dhiarmada
Store Street
Dublin 1

Telephone: (01) 704 3022
(01) 704 3627

Data Protection and Freedom of Information

We, the Department of Social and Family Affairs, will treat all information and personal data you give as confidential. We will only disclose it to other people or bodies according to the law.

Explanations and terms used in this form are intended as a guide only and are not a legal interpretation.

