



Application form for Disablement Benefit and/or Incapacity Supplement under the Occupational Injuries Scheme

How to complete application form for Disablement Benefit and/or Incapacity Supplement under the Occupational Injuries Scheme.

- 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.

If you are applying because of an accident at work, complete **Parts 1, 2, 3, 4, 7** and have your employer fill in **Part 5**. When the form is complete, sign the declaration in **Part 1**.

If you are applying because of a work-related disease, complete **Parts 1, 2, 3, 6, 7** and have your employer fill in **Part 5**. When the form is complete, sign the declaration in **Part 1**.

If you also want to claim Incapacity Supplement, complete **Part 8** too. When the form is complete, sign the declaration in **Part 1**.

If you also want to claim Constant Attendance Allowance, complete **Part 9** too. When the form is complete, sign the declaration in **Part 1**.

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

For more information, log on to www.welfare.ie.

How to fill in first page of this form

To help us in processing your application:

- 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	8	6	1	2	3	4	5	6	7											
	MOBILE																				
	0	1	7	0	4	3	0	0	0												
	LANDLINE																				
11. Your email address:	M	M	U	R	P	H	Y	@	W	E	L	F	A	R	E	.	I	E			

SAMPLE

Disablement Benefit is paid directly to your current or deposit savings account in a financial institution.

Financial Institution

You will get the following details printed on statements from your financial institution.

Name of financial institution:

Sort code:

Account number:

Bank Identifier Code (BIC):

International Bank Account Number (IBAN):

Name(s) of account holder(s):

Name 1:

Name 2 (if any):

If you do not have an account in a financial institution please contact Disablement Benefit Section.



28. Please state:

- Date employment started:
D D M M Y Y Y Y
- What class PRSI contributions were paid?
- Was employment part-time? Yes No
- If 'Yes', please state number hours a week of hours a week:

29. I agree with the date, time and place of accident and injuries received by the applicant:

Yes No

Did the accident happen during normal working hours?

Yes No

Was the applicant doing something permitted for the purpose of their work?

Yes No

If 'No', give details here:

Did they work on any day(s) after the date of the accident?

Yes No

If 'Yes' when did they work, and for how long?

Has the applicant returned to work since the accident?

Yes No

If 'Yes', give date here:

D D M M Y Y Y Y



Please read information booklet SW 33 for full details of diseases covered by Disablement Benefit.

30. Please give name of disease you contracted at work:

31. What type of work do you think caused the disease?

How long have you been doing this type of work?

years months

On what date did you last do this type of work?

D D M M Y Y Y Y

On what date did you develop the disease?

D D M M Y Y Y Y

32. Have you claimed benefit before now for the disease from this Department or from another EU country? Yes No

If 'Yes' please state:

Date you claimed:

D D M M Y Y Y Y

Your Claim or reference number:

Name of country you applied to for benefit:



33. Please give details of your doctor:

Doctor's surname:

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Doctor's first name:

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Doctor's address:

34. Did you receive medical attention for the injury/disease at a hospital or clinic?

Yes No

If 'Yes', please state:

Name of hospital or clinic:

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Address of hospital or clinic:

Name of consultant or specialist:

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Period of treatment:

From:

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To:

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D D M M Y Y Y Y

Did you stay overnight?

Yes No

Did you have an operation?

Yes No



Employer 3

Employer's name:

Employer's address:

Period of work: From:

To:

D D M M Y Y Y Y

Type of work:

Gross weekly earnings: € , . a week

Employer 4

Employer's name:

Employer's address:

Period of work: From:

To:

D D M M Y Y Y Y

Type of work:

Gross weekly earnings: € , . a week

37. Have you had any other earnings since the accident or disease?

Yes No

If 'Yes', please state:

Type of work:

Gross weekly earnings: € , . a week



Part 8 (b)

Details of your qualified child(ren)

44. How many children do you wish to claim for?

under age 18

age 18 - 22 in full-time education

You must attach written confirmation from the school or college for the children aged 18 - 22

Please state child's:

Surname:

First name(s):

PPS No.:

Surname:

First name(s):

PPS No.:

Surname:

First name(s):

PPS No.:

Surname:

First name(s):

PPS No.:

Surname:

First name(s):

PPS No.:

Note: A separate sheet of paper can be used for details of other children you have.



Constant Attendance Allowance cannot be paid if a Carer's Allowance or Carer's Benefit is in payment for the person requiring Care.

60. Do you wish to claim Constant Attendance Allowance?

Yes No

61. What are you unable to do because of your loss of faculty?

[Empty text box for question 61]

62. What does your attendant do for you?

[Empty text box for question 62]

63. Does she/he attend you daily?

Yes No

64. For how long does she/he attend you each day? hours a day

65. For how long have you been in need of Constant Attendance?

years months

Applicant details (details of person providing full-time care)

Surname:

First name:

PPS No.:

Address:





Warning: If you make a false statement or withhold information you may face a fine, a prison term or both.

Send this completed application form to:

Disablement Benefit Section

Social Welfare Services
Government Buildings
Ballinalee Road
Longford

LoCall: 1890 92 77 70 (from the Republic of Ireland only)
Telephone: Dublin (01) 704 3000
+ 353 43 3340000 (from Northern Ireland or overseas)

Important: If you do not apply within 3 months you could lose benefit.

Note

The rates charged for using 1890 (LoCall) numbers may vary among different service providers.

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.

