Social Welfare Services
OB21

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. ☐ Mrs. ☒ Ms. ☐ Other

3. Surname: MURPHY

4. First name(s): MAUREEN

5. Your first name as it appears on your birth certificate: MARY

6. Birth surname: MCDERMOTT

7. Your mother's birth surname: KELLY

8. Your date of birth: 28 02 1970
D D M M Y Y Y Y

Contact Details

9. Your address:
1 NEW STREET
OLD TOWN
CO DONEGAL

10. Your telephone number: 0861234567
MOBILE
01704300 0
LANDLINE

11. Your email address: MMURPHY@WELFARE.IE

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

Social Welfare Services
OB21

Part 1 — Your own details

1. **Your PPS No.:**
2. **Title:** (insert an 'X' or specify) Mr. ☐ Mrs. ☐ Ms. ☐ Other
3. **Surname:**
4. **First name(s):**
5. **Your first name as it appears on your birth certificate:**
6. **Birth surname:**
7. **Your mother's birth surname:**
8. **Your date of birth:** D D M M Y Y Y Y

Contact Details

9. **Your address:**
10. **Your telephone number:** MOBILE / LANDLINE
11. **Your email address:**

Declaration

I declare that all the information I have given on this form is accurate. I will tell the Department when my means or circumstances change.

I give permission to the hospital or clinic named in Part 7 to provide the Department of Social and Family Affairs with any relevant medical information about my treatment.

If you cannot sign your name, make a mark, such as an X, and have a witness sign their name beside it.

Signature (**not** block letters)

Date: D D M M 2 0 Y Y

Warning: If you make a false statement or withhold information, you may be prosecuted leading to a fine, a prison term or both.

Your own details

12. What is your old Social Insurance number, if any?

13. Are you?

☐ Single ☐ Widowed ☐ Remarried ☐ Divorced

☐ Married ☐ Cohabiting ☐ Separated

14. What country were you born in?

15. What was your job when the accident/disease occurred?

16. Are you getting or have you claimed any payments from this Department or from any other EU country?

☐ Yes ☐ No

If 'Yes', please state:

Type of payment:

Your claim or reference number:

Name of country that pays you:

17. Are you applying for this payment within 3 months of the date of the accident?

☐ Yes ☐ No

If 'No', do you wish to have your claim backdated?

☐ Yes ☐ No

If 'Yes', give reason(s) for not applying sooner:

Failure to claim within 3 months of the start of your disablement may result in loss of benefit.

Part 2 Your payment details

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.

Part 3 Details of your disablement

18. Have you suffered a loss of faculty because of...?

- ☐ a work-related accident?
- ☐ a work-related disease?

19. Are you incapable of work because of the accident or disease?

☐ Yes ☐ No

20. Are you fit to travel for a medical exam?

☐ Yes ☐ No

21. Did you receive Injury Benefit for this accident or disease?

☐ Yes ☐ No

22. Who were you working for at the time of the accident or disease?

Employer's name:

Employer's address:

Employer's telephone number:

MOBILE

LANDLINE

Your Employer's Registered Number:

Dates you worked there: From: To:

D D M M Y Y Y Y

If your employment was part-time how many hours a week did you work? hours a week

Part 4 Details of accident at work

23. Please state:

- Date of accident: D D M M Y Y Y Y
- Time: . am/pm
- Place of accident:

24. Have you reported the accident to your employer?

☐ Yes ☐ No

- **If 'No', you should report it immediately.**

25. What were you doing at the time of the accident and how did it happen?

26. What injuries did you receive?

27. Give names and addresses of any witnesses to the accident:

Their surname:

Their first name:

Their Address:

Their surname:

Their first name:

Their Address:

Their surname:

Their first name:

Their Address:

Part 5 Employer's account of accident

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 of hours a week: ☐☐ 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)

Part 5 Employer's account of accident

Employer's name:

Position in company:

Employer's telephone number:

MOBILE

LANDLINE

Employer's email address:

Signature (**not** block letters)

Date: D D M M 2 0 Y Y Y Y

Employer's official stamp

Part 6 Details of work-related disease

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:

Part 7 Your medical details

33. Please give details of your doctor:

Doctor's surname:

Doctor's first name:

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:

Address of hospital or clinic:

Name of consultant or specialist:

Period of treatment:

From: D D M M Y Y Y Y

To: D D M M Y Y Y Y

Did you stay overnight? ☐ Yes ☐ No

Did you have an operation? ☐ Yes ☐ No

If you wish to claim Incapacity Supplement, please complete Parts 8 (a), (b), (c) and (d).

Part 8 Details for Incapacity Supplement

35.Do you wish to claim Incapacity Supplement?

☐ Yes ☐ No

If 'No', please sign and date the Declaration in Part 1

If 'Yes', please answer the following questions.

36.Have you worked since your accident at work or the onset of the disease?

☐ Yes ☐ No

If 'Yes', please give details below:

Employer 1

Employer's name:

Employer's address:

Period of work: From: D D M M Y Y Y Y

To: D D M M Y Y Y Y

Type of work:

Gross weekly earnings: € , . a week

Employer 2

Employer's name:

Employer's address:

Period of work: From: D D M M Y Y Y Y

To: D D M M Y Y Y Y

Type of work:

Gross weekly earnings: € , . a week

Details for Incapacity Supplement

Employer 3

Employer's name:

Employer's address:

Period of work: From: D D M M Y Y Y Y

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: D D M M Y Y Y Y

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 (a) continued — Details for Incapacity Supplement

38. If you are getting any payment from this Department, please state:

Name of payment:

Your claim or reference number:

Amount: € , . a week

39. If you are getting any payment from the Health Service Executive (for example, Supplementary Welfare Allowance), please state:

Name of payment:

Your claim or reference number:

Amount: € , . a week

40. If you are getting a pension or allowance from another country, please state:

Name of payment:

Your claim or reference number:

Amount: € , . a week

41. If you are getting Jobseeker's Benefit or Allowance, give name and address of local Social Welfare Office:

Office name:

Office address:

42. Have you done any training or rehabilitation to prepare you for a different type of work since you became disabled? ☐ Yes ☐ No

If 'Yes', please state:

Type of training:

Place of training:

Length of training: years months

Earnings: € , . a week

43. Do you live alone? ☐ Yes ☐ No

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.

Part 8 (c) Your spouse's or partner's details

45. Their PPS No.:

46. Title: (insert an 'X' or specify) Mr. ☐ Mrs. ☐ Ms. ☐ Other

47. Their surname:

48. Their first name(s):

49. Their birth surname:

50. Their mother's birth surname:

51. Their date of birth:

D D M M Y Y Y Y

52. Their address:

This question only applies if you and your spouse or partner no longer live at the same address.

- **If you are paying maintenance, please attach copy of the Maintenance Order.**

Part 8 (d) Your spouse's or partner's work and claim details

53. If they are employed at present, please state:

Employer's name:

Employer's address:

Employer's telephone number: MOBILE

LANDLINE

Gross weekly earnings: € , . a week

Please attach their most recent payslip

54. If they are self-employed at present, please state:

Type of work they do:

Date they started self-employment:

D D M M Y Y Y Y

Net yearly earnings: € , . a year

This is the money they have made from self-employment after deducting operating expenses.

- **Please enclose a copy of end of year accounts.**

Part 8 (d) Your spouse's or partner's work and claim details

55. If they have any other income please give details in this space provided:

56. If they are getting any payment from this Department, please state:

Name of payment:

Your claim or reference number:

Amount: € , . a week

57. If they are getting any payment from the Health Service Executive (for example, Supplementary Welfare Allowance), please state:

Name of payment:

Your claim or reference number:

Amount: € , . a week

58. If they are getting a pension or allowance from another country, please state:

Name of payment:

Your claim or reference number:

Amount: € , . a week

59. If they are getting Jobseekers Benefit or Allowance, give name and address of local Social Welfare Office:

Office name:

Office address:

Part 9 Details for the Constant Attendance Allowance

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?

62. What does your attendant do for you?

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 Statement

Personal data is required to determine eligibility for payments and services, administered for Ireland's social protection system. It may be shared with other Government Departments/Agencies where provided for by law. Data protection policy available at www.welfare.ie/dataprotection or hard copy.

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

00K 05-18 Edition: May 2018