



Request for a statement of Recoverable Benefits

Please use a **BLACK** ballpoint pen and **BLOCK** capitals when completing this form

Compensator

*Reference no.:

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***Mandatory**

*Name of compensator:

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*Address:

Country:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Post Code:

--	--	--	--	--	--	--	--	--	--	--	--	--

Email:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Telephone:

Landline:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Mobile:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Contact details of Compensator's Case manager (agent/legal representative)

Reference no.:

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*Name of case manager:

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*Address:

Country:

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Post Code:

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*Email:

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*Telephone:

Landline:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Mobile:

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Declaration

In accordance with Part 11B of the Social Welfare Consolidation Act 2005, I/we wish to apply for a statement of recoverable benefits in respect of the injured person named overleaf who has made a personal injury claim for compensation based on the injury & incident date specified overleaf.

*Requestor:

Signature (not block letters)

Date:

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Details of Injured Person

*PPS Number:	<input type="text"/>	*Mandatory
*Surname:	<input type="text"/>	
*First name(s):	<input type="text"/>	
Gender (X)	Male: <input type="checkbox"/>	Female: <input type="checkbox"/>
Birth surname:	<input type="text"/>	
*Date of birth:	<input type="text"/> / <input type="text"/> / <input type="text"/>	Date of death (if applicable) <input type="text"/> / <input type="text"/> / <input type="text"/>
*Injured Person's address:	<input type="text"/>	
Country:	<input type="text"/>	
Post Code:	<input type="text"/>	

***Are details of the Injured Person's agent/personal representative known? Please X: Yes No**
If 'Yes' it is mandatory to enter the details below

Reference No:	<input type="text"/>	
Injured person's agent/personal representative name:	<input type="text"/>	
Correspondence address:	<input type="text"/>	
Country:	<input type="text"/>	
Post Code:	<input type="text"/>	
Email:	<input type="text"/>	
Telephone:	Landline: <input type="text"/>	
	Mobile: <input type="text"/>	

Reason for claim as alleged by the Injured Person

*Date of the incident: <input type="text"/> / <input type="text"/> / <input type="text"/>	Time of the incident: <input type="text"/> : <input type="text"/> hrs
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***Brief description of personal injury (see note below):**

Note: Please specify the injury/illness suffered by the injured person, e.g. broken left leg, arm fracture. Do not describe injuries as soft tissue injury, post op, in RTA, medical negligence, etc.

RBA01 (09-2017)

ICD10 code:	<input type="text"/>	-	<input type="text"/>
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