

Application form for Medical Care scheme

Social Welfare Services

C1

Data Classification R



What is the Medical Care scheme?

The Medical Care scheme is a benefit under the Occupational Injuries Scheme. If you are injured at work, on an unbroken journey to or from work, or you contract a prescribed occupational disease while insured, the Medical Care scheme may refund any costs not covered by the HSE or the Treatment Benefit scheme.

Under the scheme, payment is made for certain medical expenses which have reasonably and necessarily resulted from an occupational accident or the development of a prescribed occupational disease. It is normally a once-off payment, but if the treatment is ongoing payment may be made in a few installments.

How do I qualify?

To qualify, you must:

- have been injured as a result of your work; **or**
- have been on an unbroken journey to or from work; **or**
- have contracted a prescribed occupational disease which developed due to the nature of your employment; **and**
- be employed at PRSI class A, B, D, J, or M for employees under 16 years of age only.

Note: You must notify the department within 6 weeks of starting medical treatment.

How to complete this application form?

There is an example on the back of this page that can be used as a guide to fill in this form. Please:

- write with a **black** ballpoint pen, use capital letters and place an **X** in the relevant boxes;
- fill in **Parts 1 to 5** and answer all questions that apply to you. Leave blank any that do not apply; **and**
- sign the declaration.

How do I apply?

Send this completed application form to:

Medical Care Section
Department of Social Protection
Áras Mhic Dhiarmada
Store Street
Dublin 1
D01 WY03

How can I get help and further information?

If you need any help to complete this form, please contact the Medical Care Section on **0818 928 400** or **(01) 704 3000**, or your local Intreo Centre, Social Welfare Office or any Citizens Information Centre.

You can find the name and address of your local Intreo Centre or Social Welfare Office by visiting www.gov.ie/intreocentres.

For more information visit www.gov.ie/medcarescheme.

How to fill in this form

To help us process this form please write letters and numbers clearly and use one box for each. See examples below.

Part 1

Your details

1. PPS Number:

1	2	3	4	5	6	7	T	
---	---	---	---	---	---	---	---	--

2. Title, insert an **X** or specify:

Mr		Mrs	X	Ms.		Other						
----	--	-----	---	-----	--	-------	--	--	--	--	--	--

3. Surname:

M	U	R	P	H	Y											
---	---	---	---	---	---	--	--	--	--	--	--	--	--	--	--	--

4. First names:

M	A	U	R	E	E	N										
---	---	---	---	---	---	---	--	--	--	--	--	--	--	--	--	--

5. First names as they appear on your birth certificate:

M	A	R	Y													
---	---	---	---	--	--	--	--	--	--	--	--	--	--	--	--	--

6. Birth surname:

M	C	D	E	R	M	O	T	T								
---	---	---	---	---	---	---	---	---	--	--	--	--	--	--	--	--

7. Mother's birth surname:

K	E	L	L	Y												
---	---	---	---	---	--	--	--	--	--	--	--	--	--	--	--	--

8. Date of birth:

2	8	0	2	1	9	7	0
D	D	M	M	Y	Y	Y	Y

9. Address:

1		N	E	W		S	T	R	E	E	T								
O	L	D		T	O	W	N												
County		D	O	N	E	G	A	L			Eircode		C	1	5	A	9	6	V

10. Telephone number:

0	8	8	1	2	3	4	5	6	7
---	---	---	---	---	---	---	---	---	---

11. Email address:

M	M	U	R	P	H	Y	@	W	E	L	F	A	R	E	.	I	E		

SAMPLE

Application form for Medical Care scheme



Part 1

Your details

1. PPS Number:

2. Title, insert an X or specify:

Mr ☐ Mrs ☐ Ms. ☐ Other

3. Surname:

4. First names:

5. First names as they appear
on your birth certificate:

6. Birth surname:

7. Mother's birth surname:

8. Date of birth:

D D

M M

Y Y Y Y

9. Address:

County Eircode

10. Telephone number:

11. Email address:

12. Are you:

☐ Male? ☐ Female?

13. What is your nationality?

14. What country were you born in?

15. Was the Medical Care required
as a result of:

an Occupational Injury?

☐ Yes ☐ No

a Prescribed Disease?

☐ Yes ☐ No

If **yes**, have you claimed Injury Benefit or Disablement Benefit?

☐ Yes ☐ No

Note: An accident while on an unbroken journey to or from work is regarded as an occupational accident.

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16. Over which dates did you receive the medical care?

From:

To:

D

D

M

M

Y

Y

Y

Y

17. Do you have a Medical Card?

☐ Yes

☐ No

If **yes**, please state:

Start date:

End date:

D

D

M

M

Y

Y

Y

Y

If **no**, but you have previously applied for one, please state the result of that application:

18. If your claim is late, please state why you did not claim on time:

19. Please state your:

Employer's name:

Employer's address:

County

Eircode

Employer's telephone number:

Job title:

Staff number, if known:

20. Time and date the accident happened or disease developed:

<input type="text"/>	<input type="text"/>	:	<input type="text"/>	<input type="text"/>	<input type="text"/>	AM	<input type="text"/>	PM
<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D	D		M	M	Y	Y	Y	Y

21. Where did the accident happen?

22. What were you doing at the time?

23. Please give a description of the accident:

24. Please give a description of the injury you received:

25. When did you report it to your employer?

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D	D	M	M	Y	Y	Y	Y

Important: If the accident was not reported to your employer, please do so now.

26. If the accident was reported, please state to whom:

Surname:

First names:

Address:

County

Eircode

27. Please give the name and address of anyone who saw the accident:

Witness 1

Surname:

First name:

Address:

CountyEircode

Witness 2

Surname:

First name:

Address:

CountyEircode

28. If a disease was involved, please state the type of disease and why you believe it was caused by the nature of your work:

29. Please state your doctor's:

Surname:

First names:

Address:

CountyEircode

30. On what dates did you visit your doctor?

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D	D	M	M	Y	Y	Y	Y

31. On what dates did your doctor visit you at home?

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D	D	M	M	Y	Y	Y	Y

32. Cost of doctor's visits:

€ , .

Important: Please attach original receipts. Photocopies cannot be accepted.

33. Please give details of pharmaceutical or other medical or surgical supplies obtained on prescription from a doctor:

34. Please give the cost of pharmaceutical or other medical or surgical supplies:

€ , .

Important: Please attach original receipts. Photocopies cannot be accepted.

35. Please give details of any miscellaneous expenses. For example, travel or hospital charges:

36. Please give the cost of these expenses:

€ , .

Important: Please attach original receipts. Photocopies cannot be accepted.

I wish to claim the cost of medical care that was given as a result of an occupational injury or a prescribed disease. The cost of the medical care provided amounts to:

Total: € , .

If you want to get your payment direct to your current, deposit or savings account in a financial institution, please indicate as such with the relevant check box and give your account details below. Alternatively, if you would like us to make your payment to your employer, please indicate with the relevant check box, fill in your employer's account details and sign the declaration. Payments can only be made to accounts held in the state.

Please state who you wish your payment be issued to:

☐ You

☐ Your employer

Name of financial institution:

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

Bank Identifier Code (BIC):

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

International Bank Account Number (IBAN):

Names of account holders:

Name 1:

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

Name 2, if any:

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

Payment direct to my employer

I authorise the Department of Social Protection to pay my Medical Care payment to my employer's account in a financial institution.

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Date:

--	--

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2	0		
---	---	--	--

D D

M M

Y Y Y Y

Signature, **not** capital letters.

Declaration

I declare that the information given by me on this form is truthful and complete. I understand that if any of the information I provide is untrue or misleading or if I fail to disclose any relevant information, that I will be required to repay any payment I receive from the department and that I may be prosecuted. I undertake to immediately advise the department of any change in my circumstances which may affect my continued entitlement.

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Date:

--	--

--	--

2	0		
---	---	--	--

D D

M M

Y Y Y Y

Signature, **not** capital letters.

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

Data Protection Statement

The Department of Social Protection administers Ireland's social protection system. Customers are required to provide personal data to determine eligibility for relevant payments and benefits. Personal data may be exchanged with other government departments and agencies where provided for by law. Our data protection policy is available at www.gov.ie/dsp/privacystatement or in hard copy.

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