Social Welfare Services
C 1
Data Classification R

Application form for

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

You need a Personal Public Service Number (PPS No.) before you apply.

How to complete this application form.

- **Please tear off this page and use as a guide to filling in this form.**
- **Please answer all questions. Incomplete forms will be returned and this may delay your application.**
- **Please use BLACK ball point pen.**
- **Please use BLOCK LETTERS and place an X in the relevant boxes.**

When form is completed, sign declaration in Part 1.

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

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

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 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
DONEGAL TOWN
County DONEGAL Postcode

10. Your telephone number: ONE NUMBER PER BOX
MOBILE
ONE NUMBER PER BOX
LANDLINE

11. Your email address: ONE CHARACTER PER BOX

SAMPLE

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

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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:

County Postcode

10. Your telephone number: MOBILE LANDLINE
11. Your email address:

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.

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.

Part 1 continued

Your own details

12. Are you? ☐ Male ☐ Female

13. What nationality are you:

14. What country were you born in:

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

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

An Occupational Injury? ☐ Yes ☐ No

or

A Prescribed Disease? ☐ Yes ☐ No

If 'Yes', please state:

Have you claimed Injury Benefit or Disablement Benefit? ☐ Yes ☐ No

16. From what date did you receive the Medical Care?

From: D D M M Y Y Y Y

To: D D M M Y Y Y Y

17. Do you have a Medical Card? ☐ Yes ☐ No

If 'Yes', please state:

Start date: D D M M Y Y Y Y

End date: D D M M Y Y Y Y

If 'No', but you have previously applied for one, please state:

Result of that application.

18. If your claim is late, please state in the space provided why you did not claim on time.

Part 2 Your work and claim details

19. Please state your:

Employer's name:

Employer's address:

Employer's telephone number: MOBILE

LANDLINE

Job title:

Staff number (if known):

Part 3 Details of Occupational Accident or Disease

20. Date of accident or development of disease: Time

D D M M Y Y Y Y : am/pm

21. Where did the accident happen?

22. What were you doing at the time?

23. Give a description of the accident in the space provided.

24. Give a description of the injury you received in the space provided.

25. When did you report it to your employer?

D D M M Y Y Y Y

(If the accident was not reported to your employer, do so now).

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

Surname:

First name(s):

Address:

Part 3 continued

Details of Occupational Accident or Disease

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

Witness 1

Surname:

First name(s):

Address:

Witness 2

Surname:

First name(s):

Address:

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

Part 4 Details of Medical Care for which payment is claimed

29. Please state your doctor's:

Surname:

First name(s):

Address:

30. Dates you visited your doctor:

D D M M Y Y Y Y

D D M M Y Y Y Y

31. Dates your doctor visited you at home:

D D M M Y Y Y Y

D D M M Y Y Y Y

Amount claimed

32. Cost of doctor's visits:

(attach original receipts not photocopies) →

€

33. Give details below of pharmaceutical or other medical or surgical supplies obtained on doctor's prescription:

34. Give cost of pharmaceutical or other medical or surgical supplies:
(attach original receipts not photocopies) →

35. Give details below of any miscellaneous expenses:
(travel, hospital charges etc.)

36. Give cost of these expenses:
(attach original receipts not photocopies) →

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

Total

€

Part 5 Your payment details

Please state clearly who you wish your payment to issue to.

This payment should issue to: You ☐ **OR** Your employer ☐

If you want to get your payment direct to your current, deposit or savings account in a financial institution, please fill in your account details below. Alternatively, if you want us to make your payment to your employer, please fill in your employer's account details and sign the declaration below (payments can only be made to accounts held in the Republic of Ireland).

Financial Institution

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

Name of financial institution:

Bank Identifier Code (BIC):

International Bank Account Number (IBAN):

Name(s) of account holder(s):

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.

Signature (not block letters)

Send this completed application form to:

Medical Care Section
Social Welfare Services
Department of Social Protection
Áras Mhic Dhiarmada
Store Street
Dublin 1

Telephone: (01) 704 3000
LoCall: 1890 928 400

If you are calling from outside the Republic of Ireland please call + 353 1 704 3000.

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.