

Application form for Health and Safety Benefit



Complete this application form as follows:

— You must complete Parts 1 to 3 and 5 to 8.

— Your employer must complete and stamp Part 4.

— Your doctor must complete and stamp Part 9.

- Please use BLOCK LETTERS and place a tick (✓) in the boxes provided.
- Please read information booklet SW 21 before completing this application form.
- Please answer all questions. If some questions do not apply to you, draw a line through the answer box.
- If you fail to answer all questions, it could delay processing your claim.

You must send in all relevant certificates and documents with your claim.

Part 1

Your own details

Please state:

Mrs. Ms. Other _____
Please specify

1. What is your full name?

Last name
First name(s)

2. What is your birth surname (your surname before you married), if different?

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3. Where do you live?

Address

4. What is your telephone number, (if any)?

Code	Local number
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5. What is your date of birth?

<input type="text"/>	Day	<input type="text"/>	Month	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Year
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6. What is your Personal Public Service Number (PPS No.) (same as RSI or tax number)?

Figures							Letter(s)	
<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"/>

7. Are you.....?

'Cohabiting' means you live with a man as husband and wife and you are not married to him.

<input type="checkbox"/> Married	<input type="checkbox"/> Single	<input type="checkbox"/> Separated
<input type="checkbox"/> Widowed	<input type="checkbox"/> Divorced	<input type="checkbox"/> Cohabiting

8. If you are married, when did you get married?

<input type="text"/>	Day	<input type="text"/>	Month	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Year
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9. What was your PPS No. before you married (if different to above)?

Figures							Letter(s)	
<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"/>

10. When do you intend to start Maternity Leave?

<input type="text"/>	Day	<input type="text"/>	Month	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Year
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Part 2

Your payment details

You can get your Health and Safety Benefit:

- by **direct payment** to a bank or building society account*
or
- by **cheque** direct to you at home.

Please state if you want to get your payment (tick (✓) one box):

- by cheque into a bank account
 into a building society account

If you want your benefit by direct payment, give details of your bank or building society:

*The account must be a current or deposit savings account (**not** a mortgage account).

Name

Address

Name on the account:

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Type of account:

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Account number:

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Bank sort code (you can get this from your branch):

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Part 3

Your employment details

11. Are you employed at present?

- Yes No

'Employed' is where you work for another person or company and you get paid for this work.

If 'Yes' who do you work for?

Employer's name

Address

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Telephone number: Code Local number

What is your job?

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Your employer must complete Part 4 across. 

Part 3 continued

Your employment details

12. When do you intend to start health and safety leave?

		Day			Month					Year
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13. If you started work within the last 3 years, when did you start?

		Day			Month					Year
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14. Are you related to your employer?

Yes No

If 'Yes', how are you related to them?

Part 4

To be completed by your employer

15. What is your employee's name?

16. What is your employee's PPS No. (same as RSI or tax number)?

Figures							Letter(s)	

17. Please give details of employee's PRSI record for the 12 month period immediately before her baby is due:

Period of employment						Number of weeks	PRSI class
From			To				
Day	Month	Year	Day	Month	Year		

If more than one Class of PRSI has been paid, please give details

Periods of employment						Number of weeks	PRSI class
From			To				
Day	Month	Year	Day	Month	Year		

18. Is your employee entitled to health and safety leave?

Yes No

My employee has told me that she: (tick (✓) relevant box(es) across)

is pregnant
 has recently given birth
 is breastfeeding

Certification of risk: You can get details relating to employees' safety, health and welfare protection, including working conditions, and agents that may pose a risk to pregnant and breastfeeding employees, from **The Health and Safety Authority, 10 Hogan Place, Dublin 2. Tel: (01) 6147000**

Continued overleaf

19. Complete a) workplace risk or b) nightwork risk for employee as follows:**a) Workplace risk**

The following risks to the above named employee have been identified in a risk assessment carried out in line with Regulations under the Safety, Health and Welfare at Work Act, 1989.

List risk(s):

List reason(s) why you cannot remove risk(s):

b) Nightwork risk

The above named employee is required to perform nightwork (work between the hours of midnight and 7 am where the employee normally works at least three hours in this period and at least half of her yearly working time is in this period). The doctor named below has certified that nightwork poses a risk to the employee's health or safety. I am unable to transfer the employee to day work.

Name of employee's doctor

20. What is the start date of health and safety leave?

Day Month Year

You must continue to pay your employee for 21 calendar days.

21. Payment details to employee on health and safety leave:

Start date of payment by you to employee

Day Month Year

Last date of payment by you to employee

Day Month Year

22. Does your employee expect that health and safety leave will continue until the start of maternity leave?

Yes No

If 'No', what date will health and safety leave end?

Day Month Year

Declaration

The details I have given in Part 4 are true and complete. I understand that I (employer) am obliged and agree to pay the employee for the first 21 calendar days of her health and safety leave. I will tell the Department of Social and Family Affairs immediately when I have told the employee to return to work because:

- the risk to the employee no longer exists
- or
- other work that poses no risk to the health and safety of the employee becomes available.

Signed by or for employer

Signature

(Not block letters)

Position in company
or organisation:Company or
organisation name:

Address:

Telephone Number:

Code

Local number

Employer's Official Stamp

Employer's registered number

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Date

3. Have you ever been employed in an EU country other than Ireland? Yes No
If 'Yes', complete the following:

Country where you worked	Your employer's name and address	Dates you worked there		Your Social Security Number there
		From:	To:	

4. Have you been employed in Ireland since your return? Yes No

If you have received any social welfare payments (other than Child Benefit) in the last 2 years, you may be entitled to credited contributions ('credits') to help you qualify for Health and Safety Benefit.

5. Have you 'signed' for Unemployment Benefit or Assistance or for 'credits' during the last 2 years? Yes No

If 'Yes', please state:

Date you last signed

Day Month Year

Name and address of local Social Welfare Office you attended

Local Social Welfare Office Address

6. Are you getting any other payment(s) from the Department of Social and Family Affairs? Yes No

If 'Yes', please state:

Type of payment:

Claim or reference number:

Amount you get:

€ weekly

7. Are you getting a payment from the Health Service Executive (HSE)? Yes No

Since January 2005, the Health Boards were replaced by the Health Service Executive (HSE). You should contact your local office of the HSE for more information.

If 'Yes', please state:

Type of payment:

Name of health centre that pays you:

Only complete this if you are married or cohabiting.

Your 'partner' is a man who is not married to you but lives with you as your husband.

28. What is your husband's or partner's full name?

Last name
First name(s)

29. What is his PPS No. (same as RSI or tax number)?

Figures							Letter(s)	

30. Is your husband or partner employed or self-employed?

Yes No

If 'Yes', what is your husband's or partner's gross income, if under €220.00 gross per week?

€	a week
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If his gross weekly income is under €220.00 per week, please send in his last six payslips, as you may get a higher rate of benefit.

'Gross income' is his pay before tax, PRSI or union dues.

31. Is your husband or partner getting a weekly payment from

— the Department of Social and Family Affairs?

Yes No

or

— the HSE?

Yes No

If 'Yes', please state

Type of payment

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Amount he gets

€	a week
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Claim or Reference Number

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Name of office that pays him?

Name

Part 7

Child dependant details

If you qualify for Health and Safety Benefit, you will qualify for a rate of payment at least the same as the rate of Disability Benefit that you would get if you were absent from work through illness.

To help us calculate the correct rate of benefit, you must give details of your child dependants (your children under age 18). You should also give details of your newborn child(ren). If you are giving details of your newborn child(ren) please attach the **long version** of their Birth Certificate(s).

32. Do you have a child or children under age 18?

 Yes

 No

If 'Yes' please give details here, starting with your eldest child:

Child's full name	Date of birth						How are they related to you?	Are they living with you?
	Day	Month	Year					

Part 8

Declaration by you

I wish to claim Health and Safety Benefit. The information I have given is true and complete. I will tell the Department of Social and Family Affairs if there is any change in my details.

Your signature or mark

Date

(Not block letters)

If you cannot sign, make a mark and have it witnessed. The witness should sign below.

Signature of witness

Date

(Not block letters)

Address of witness

To I certify that I have examined you and that in
 my opinion you may expect to give birth on Day Month Year

Any other remarks:

Doctor's signature

(Not block letters)

Address

Doctor's Official Stamp

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

Send the completed application form to:

Health and Safety Benefit Section
 Social Welfare Services Office
 St. Oliver Plunkett Road
 Letterkenny
 Co. Donegal

Telephone: LoCall 1890 690 690

If you have any difficulty filling in this form, please phone us at the telephone number above or call to your local **Social Welfare Office**.

Personal Public Service Number (PPS No.) (same as RSI or tax number)

You must supply your own PPS No. and the PPS No. of a spouse, partner or children for whom you are claiming a payment. If you do not know these numbers, please contact your local Social Welfare Office.

If you need to apply for a PPS No., you will need:

- the long form of your Birth Certificate,
- a form of photographic ID, and
- evidence of your address.

Please see information booklet **SW 100** for more information.

Remember you must send in all the certificates or documents with this claim.

Important: If you do not claim within six months of becoming eligible you could lose benefit.

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 bodies in line with law. We are responsible for it under the Data Protection Act and Freedom of Information Act.