Department of Social Security

HM Government of Gibraltar

Claim No.
Stamp and date of receipt

Claim form for Disablement Benefit

1. When claiming in respect of an accident at work you are required to complete Part 3 and omit Part 4.

2. When claiming in respect of an occupational disease, you are required to complete Part 4 and omit Part 3.

3. When claiming for an increase in respect of your spouse or civil partner you are required to produce your marriage certificate or your civil partnership certificate as the case may be.

4. When claiming for an increase in respect of your children, you are required to produce their birth certificates.

5. This form, when completed, must be returned without delay, to the Department of Social Security, 79-80 New Harbours Walk, New Harbours, Gibraltar.

6. If any of the documents are not readily available, please do not delay in submitting your claim as this could result in loss of payment.

7. If any change of circumstances occur which may affect your entitlement to payments, you must notify the Department of Social Security immediately.

Part 1 : Particulars of claimant

Full name	
Maiden name (if applicable)	
Address	

Part 1 : Particulars of claimant (continued)

E-mail address

Daytime phone number

Date of birth / /

Place of birth

Nationality

Tax reference number

ID card number

What is your current marital or civil partnership

- Single ☐ Please go to Part 3
- Married or civil partner ☐
- Divorced or civil partnership dissolved ☐
- Marriage or civil partnership annulled ☐
- Separated ☐
- Widowed or surviving civil partner ☐

Are you in receipt of any state benefit, allowance or pension?

- Yes ☐
- No ☐

If yes, please state what benefit, allowance or pension you are in receipt of and the amount being paid

Part 2 : Particulars of spouse or civil partner

Full name		
Maiden name (if applicable)		
Address		
Date of birth	/ /	
Tax reference number		
ID number		
Date of marriage or civil partnership	/ /	
Is he/she in employment?	Yes	
	No	
Is he/she in receipt of any state benefit, allowance or pension?	Yes	
	No	
If yes, please state what benefit, allowance or pension he/she is in receipt of and the amount being paid		

Part 3 : Details of Disablement as a result of an accident at work

Date of accident	/ /
What is the disablement from which you are suffering?	
When do you claim the disablement began?	/ /

Are you incapable of work as a result of the disablement?	Yes	
	No	
Have you been to a hospital or clinic for treatment because of the disablement?	Yes	
	No	
If 'yes' please state name and address of hospital		
Were you an in-patient?	Yes	
	No	

	From	To
Dates of treatment	/ /	/ /
	From / /	To / /
	From / /	To / /
	From / /	To / /

Are you fit to travel for Medical Examinations?	Yes	
	No	

Part 4 : To be completed in case of Occupational Disease

Which of the prescribed occupational diseases do you claim you are suffering from?	
Date of onset of disease	/ /
What type of work do you think caused your disease	
For how long did you carry out that sort of work?	
Please tell us of any tools used, chemicals you may have come into contact with, dust or fumes you may have breathed	
In what way has the disease affected you?	
Name and address of the employer where you did the work	

	From	To
When did you work there?	/ /	/ /

Part 4 : To be completed in case of Occupational Disease (continued)

Are you incapable of work as a result of the disease?	Yes	☐
	No	☐
Have you been to a hospital or clinic for treatment because of the disease?	Yes	☐
	No	☐

If 'yes' please state name and address of hospital

Were you an in-patient?	Yes	☐
	No	☐

Dates of treatment	From	To
	/ /	/ /
	From	To
	/ /	/ /
	From	To
	/ /	/ /
	From	To
	/ /	/ /

Are you fit to travel for Medical Examinations?	Yes	☐
	No	☐

Part 5 : Claim for children

Please note that only children who are under the age limit should be included in this claim.
(Please produce birth certificates)

A child is under the age limit:

- Up to the age of fifteen and;
- For any further period following the fifteenth birthday but not beyond the nineteenth birthday while he or she is receiving full time instruction at any university, college, school, or other educational establishment.

Surname	Forenames	Date of birth	Relationship of child	Is child residing with you?
		/ /		
		/ /		
		/ /		
		/ /		

Part 6 : Claim for adult dependant

(Other than spouse or civil partner)

Full name	
Maiden name (if applicable)	
Is he/she residing with you?	
What is his/her relationship to you?	
Amount you contribute towards his/her maintenance	£
Amount of his/her income or other household income if any	£

Part 7 : Bank details

1. Bank account or building society account of claimant

Please provide details of the financial institution where you want your benefit payment to be made. You will find the account details on the chequebook, passbook or on the bank statements. If you do not have a bank account or building society account and you wish to have the benefit payment paid into someone else's bank account please go to **section 2** below.

Full name of bank or building society

Name of the account holder (The account must be in your name or held jointly)

Sort Code | | – | | | – | | |

Account number | | | | | | | | |

More information if it is a building society account

If you are using a building society account you may need to tell us a roll or reference number. This may be made up of letter and numbers, and may be up to 18 characters long. If you are not sure if the account has a roll or reference number, ask the building society.

Building society account number | | | | | | | | | | | | | | | | | |

2. Bank details of third party

Please note that your benefit payment can be paid into someone else's account (third party). The account holder should be someone that you trust, usually a relative or close friend.

Please provide details of the third party account holder.

Full name of bank or building society

Name of the account holder

Sort Code | | – | | | – | | |

Account number | | | | | | | | |

Building Society account

Building society account number | | | | | | | | | | | | | | | | | |

Part 8 : Other information

Use this space to tell us anything else you think we might need to know.
You can continue on a separate piece of paper if you need to.
If you continue on a separate piece of paper, make sure you;

- Write your full name, address and ID card number on it and attach it to this claim form; and
- Sign and date it.

Part 9 : Declaration

I declare that to the best of my knowledge and belief all the particulars given on this form are true. I claim Disablement Benefit accordingly.

I understand that if I knowingly give information that is incorrect or incomplete, I may be liable to prosecution or other action.

I understand that it is an offence to fail to notify the Department of Social Security of a change of circumstances promptly, and failure to do so may result in action being taken against me.

I agree that:

- the Department of Social Security
- any Doctor with which the Department has a contract for the provision of medical services

may ask any of the people or organisation mentioned on this form for any information which is needed to deal with

- this claim for benefit
- any request for this claim to be looked at again

and that the information may be given to that doctor or organisation or to the Department.

Signature	
Date	/ /

The Department of Social Security should be informed if the claimant is unable to sign due to illness.

How we collect and use information

The Department of Social Security collects information for the purposes of dealing with social security benefits and other non-contributory benefits. The information we collect about you depends on the reason for your business with us, but we may use the information for any of these purposes.

We may check information about you with other information we have. We may get information about you from other people and certain other organisations. We may give information to certain other organisations, as the law allows, to:

- check the accuracy of information;
- prevent or detect crime;
- protect public funds in other ways; and
- use in research or statistics.

These other organisations include other government departments, local authorities, and private sector bodies such as banks and organisations that may lend you money. We will not give information about you to anyone outside our department unless the law allows us to.

The Department of Social Security is the data controller for the purposes of the Data Protection Act.

Department of Social Security

HM Government of Gibraltar

Consent Form for Release of Medical Records

I *(state name of person giving consent)*	
of *(state address)*	
Date of birth	/ /

hereby authorise the Department of Social Security to request a copy of my medical records held by the Gibraltar Health Authority in connection with my claim to disablement benefit:

Signature *(of person giving consent)*	
Date	/ /

For Office Use Only

The Department of Social Security is requesting the following records:

Hospital	
A & E Card	
Primary Care Centre	
X-Ray	
Physiotherapy	
Psychiatric	