Social Welfare Services
HSB 1

Data Classification R

Application form for

Health and Safety Benefit

How to complete this application form.

- Please use this page as a guide to filling in this form.
- Please use **BLACK** ball point pen.
- Please use BLOCK LETTERS and place an X in the relevant boxes.
- Please answer **all questions** that apply to you.
- You need a Personal Public Service Number (PPS No.) before you apply.

Employee:

If you are an **employee** fill in **Parts 1, 2, 3, 5, 7** and **8** as they apply to you. When form is completed, read **Part 9** and sign declaration in **Part 1**.

Employer:

If you are an **employer** fill in **Part 4**. Please make sure you sign and stamp this part of the form.

Self-employment does not qualify for Health and Safety Benefit.

Doctor:

Please fill in **Part 6** of the form. Please make sure you sign and stamp this part of the form.

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

For more information, log on to **www.welfare.ie.**

Important:

If you do not submit this form within 6 months of becoming eligible you could lose benefit.

How to fill 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
CO DONEGAL

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

11. Your email address: ONE CHARACTER PER BOX

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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:**
10. **Your telephone number:**

MOBILE

LANDLINE

11. **Your email address:**

Declaration

I declare that all the information I have given on this form is accurate.

I will tell the Department when my means or circumstances change.

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?

- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Cohabiting
- ☐ In a Civil Partnership
- ☐ A surviving Civil Partner
- ☐ A former Civil Partner (you were in a Civil Partnership that has since been dissolved)

13. If you are married, in a civil partnership or cohabiting, from what date?

D D M M Y Y Y Y

Part 2 — Your work and claim details

14. What is your current employment status? ☐ Employed only ☐ Self-Employed only ☐ Both

If 'Employed', please state:

Employer's name:

Employer's address:

Employer's telephone number: MOBILE / LANDLINE

Job title:

Gross weekly earnings: € , . a week

'Gross pay' is your pay before tax, PRSI, union dues or other deductions.

Is your employment full-time or part-time? ☐ Full-Time ☐ Part-Time

15. When do you intend to start Health and Safety Leave?

D D M M Y Y Y Y

16. If you started work for the first time within the last 3 years, when did you start?

D D M M Y Y Y Y

17. Are you related to your employer? ☐ Yes ☐ No

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

If you are an employee, your employer(s) must complete Part 4.

Your work and claim details

18. Do you currently have more than one employment?

☐ Yes ☐ No

Please note that if you have more than one employer, each employer must complete **Part 4**. A photocopy of **Part 4** or a letter containing the same information will do.

19. If you are getting or have applied for any payment(s) from this Department or from the Health Service Executive, please state:

Name of payment:

Amount: € , . a week

Name of payment:

Amount: € , . a week

20. If you are getting a pension or allowance from another country, please state:

Name of country:

Your claim or reference number:

Amount: € , . a week

21. Have you lived, been employed or received a social welfare payment in another EU country in the last 4 years?

☐ Yes ☐ No

If 'Yes', please state:

Country:

Employer's name:

Employer's address:

Your social insurance number while there:

Dates you worked there: From:

To:

D D M M Y Y Y Y

Type of work:

Note: A separate sheet of paper can be used for more details if needed.

Remember to send in the relevant certificates and documents with this application.

Part 3 Your payment details

You can get payment direct to your current, deposit or savings account in a financial institution.

Financial Institution

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

Name of financial institution:

Sort code:

Account number:

Bank Identifier Code (BIC):

International Bank Account Number (IBAN):

Name(s) of account holder(s):

Name 1:

Name 2 (if any):

Part 4 Employer's information

TO BE COMPLETED BY EMPLOYERS ONLY

Please make sure you SIGN and STAMP this part of the form. If your employee has been working for you for less than 12 months before the start of her Health and Safety Leave, please forward a copy of P45 from previous employment.

22. What is your employee's full name?

23. Please confirm their PPS No.:

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

Period of employment:

From: D D M M Y Y Y Y Number of weeks: PRSI class:

To: D D M M Y Y Y Y

If your employee has more than one class of PRSI (for example, if their PRSI changed from Class A to Class J), please give details.

Period of employment:

From: D D M M Y Y Y Y Number of weeks: PRSI class:

To: D D M M Y Y Y Y

25. Is your employee entitled to Health and Safety Leave?

☐ Yes ☐ No

If 'Yes', please state if your employee:

☐ is pregnant

☐ has recently given birth

☐ is breastfeeding

26. Is your employee employed under a fixed-term contract?

☐ Yes ☐ No

If 'Yes', give date contract ends: D D M M Y Y Y Y

Employer's information

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, The Metropolitan Building, James Joyce Street, Dublin 1. Tel: 1890 289 389 (from Republic of Ireland only).**

27. Complete a) workplace or b) nightwork risk assessment for your employee as follows:

a) Workplace risk assessment: 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 assessment: The above named employee is required to perform nightwork (work between the hours of 11 pm and 6 am the following day where the employee normally works at least three hours in this period and at least a quarter 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:

28. Will your employee remain on Health and Safety Leave until the start of Maternity Leave?

☐ Yes ☐ No

If 'No', what date will Health and Safety Leave end?

D D M M Y Y Y Y

Part 4 continued — Employer's information

29. Payment details to employee on Health and Safety Leave:

Start date of leave/ payment by you to employee: D D M M Y Y Y Y

Last date of payment by you to employee: D D M M Y Y Y Y

Note
You must continue to pay your employee for **21 calendar days** (3 working weeks) from the date Health and Safety Leave is granted. For example, if the start date of leave/payment is 1st Feb, the last date of payment by you to employee would be 21st Feb. This Department would then begin payment on 22nd Feb.

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 (3 working weeks) of her Health and Safety Leave, for the above dates. I will tell the Department of Social Protection immediately when I have asked this 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 has become available.

Employer's name:

Signed by or for employer

Signature (**not** block letters)

Position in company or organisation

Employer's official stamp

Date: D D M M 2 0 Y Y

Employer's registered number:

Employer's telephone number: MOBILE

LANDLINE

Employer's email address:

If you make any alterations after you complete the form, please initial and date them.

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

Part 5 Details of your child(ren)

30. How many children do you wish to claim for?

☐☐ under age 18

☐☐ age 18 - 22 in full-time education*

*** You must attach written confirmation from the school or college for the children aged 18 - 22**

31. Please state child's:

Surname:

First name(s):

PPS No.:

Surname:

First name(s):

PPS No.:

Surname:

First name(s):

PPS No.:

Surname:

First name(s):

PPS No.:

Surname:

First name(s):

PPS No.:

Note: A separate sheet of paper can be used for more details if needed.

Part 6 To be completed by your doctor

I certify that I have examined

(Name of applicant)

and

that in my opinion she may expect to give birth on:

D D M M Y Y Y Y

Date of examination:

D D M M Y Y Y Y

Any other remarks:

Doctor's name:

DSP panel number:

IMC number:

Address:

Doctor's telephone number: LANDLINE

Doctor's email address:

Doctor's Signature (**not** block letters)

Doctor's official stamp

If you make any alterations after you complete the form, please initial and date them.

Part 7 Your spouse's, civil partner's or cohabitant's details

32. Their PPS No.:

33. Title: (insert an 'X' or specify) Mr. ☐ Mrs. ☐ Ms. ☐ Other

34. Their surname:

35. Their first name(s):

36. Their birth surname:

37. Their mother's birth surname:

38. Their date of birth:

D D M M Y Y Y Y

39. Do they currently live with you? ☐ Yes ☐ No

40. If they do not live with you, please state their address:

Part 8 Your spouse's, civil partner's or cohabitant's work and claim details

You may be entitled to an increase for your spouse, civil partner or cohabitant if they have no income or their gross weekly pay is less than €310 a week.

41. Do you wish to claim an increase for them?

☐ Yes ☐ No

If 'No', please go to Part 9.

If 'Yes', please complete fully the remainder of this section.

42. If they are employed, please include their 6 most recent payslips with your application and state:

Gross income: € , . a week

43. If they are self-employed, please include their most recent Notice of Assessment and state:

Gross income: € , . a week

44. If they have income from any other source, such as an occupational pension, please state:

Gross income: € , . a week

45. If they are getting or have applied for any payment(s) from this Department or from the Health Service Executive, please state:

Name of payment:

Amount: € , . a week

46. If they are getting a pension or allowance from another country, please state:

Name of country:

Their claim or reference number:

Amount (in euros): € , . a week

Part 9 Checklist

Has your employer completed Part 4?

Has your doctor completed Part 6?

Have you enclosed the following?

— Letter from school or college
(if you have child(ren) aged between 18 and 22 who are in full-time education).

— Your P45 (if applicable) - See Part 4.

— A verified copy of your GNIB Card/Work Permit and Passport (including all stamps (endorsements)) - Non-EEA citizens only.

In respect of your spouse, civil partner or cohabitant (if applicable):

— If employed - their 6 most recent payslips (if gross weekly earnings are less than €310).

— If self-employed - their most recent Notice of Assessment of Tax and/or P35.

If you were married or entered into a civil partnership or a civil union outside the Republic of Ireland since you last updated your details with the Department:

— A verified marriage certificate or civil partnership or a civil union registration certificate*.

* To have verified, please bring to any office of the Department of Social Protection. Please note that only verified copies of the original versions of certificates are acceptable.

You should note that your claim for Health and Safety Benefit cannot be processed until we receive the documentation indicated above.

Please remember to sign the declaration in Part 1.

Send this completed application form to:

Health and Safety Benefit Section
FREEPOST
Department of Social Protection
McCarter's Road
Ardarvan
Buncrana
Co. Donegal

LoCall: 1890 690 690 (from the Republic of Ireland only)
Telephone: + 353 1 4715898 (from Northern Ireland or overseas)

Note

The rates charged for using 1890 (LoCall) numbers may vary among different service providers.

Data Protection and Freedom of Information

We, the Department of Social Protection, will treat all information and personal data you give as confidential. We will only disclose it to other people or bodies according to the law.

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

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