

Pension Dependants Application Form – HR107 (b)

This form is to be used when you are making application for payment of Dependants Pension Benefits. It is important that you complete this form correctly and forward all requested documentation to Pensions Management as soon as practicable. One form to be completed in respect of each claimant. Please complete in Block Capitals/Tick appropriate boxes.

Section 1. To Be Completed by Claimant or their representative

Name of Deceased Employee/Pensioner

His / Her Date of Birth

His / Her Date of Death

Section 2. Personal Details of Claimant

Surname

First Name

PPS No

Date of Birth

Section 3. Relationship to Deceased Employee / Pensioner

Spouse

Child/

Dependant

If you are the spouse of the deceased employee/ Pensioner please go to section 6

Section 4. Dependant Child Details

This application is in respect of a child under age 16

Yes

No

This application is in respect of a child aged 16 – 22 who is receiving full time education

Yes

No

If Yes please ensure appendix A is completed.

This application is in respect of a disabled child/Adult dependant

Yes

No

If Yes please attach Medical officers Confirmation

Section 5. Address (for receipt of written communications from the HSE)

Street Address

Town/City

County

Post Code

Country

Phone No:

Mobile Phone No:

Please ensure that you advise Pensions Management of any changes to your address

If Faxing please ensure Employee's Name and Personnel Number are included on each page of the form

Name _____ Personnel No. _____

Section 6. Bank Details (confirm details of account you wish your benefits to be paid to)

Bank Name						Bank Address														
Bank Sort Code						Account Number														
Bank Identifier Code (BIC)																				
International Bank Account No (IBAN)																				
Payee Name																				

Section 7. PRSI Class

	Please (✓) One	Note: if you have answered yes to any of these questions please attach supporting documentation from Dept Social & Family Affairs (Social Welfare) or HSE
Are you a Full Medical Card Holder	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Are you a GP Visit Card Holder	Yes <input type="checkbox"/> No <input type="checkbox"/>	

Section 8. Declaration by Claimant

I Declare that the above information is accurate and correct on the date indicated below

Signature	Date										
Name (print)	Contact Tel No										

Section 9. Declaration by Legal Personal Representative

I Declare that the above information is accurate and correct in respect of the above named on the date indicated below

Relationship to Claimant	Date										
Signature	Contact Tel No										
Name (print)	Office Stamp										
E Mail address											
Registered Number											

Section 10. To be completed by Pensions Management

System updated by	Date										
Personnel Number of Deceased Employee / Pensioner											
Personnel Number Created for this claimant											
Review Date (If applicable)											
Deceased Employee/Pensioner removed form payroll	Yes <input type="checkbox"/> No <input type="checkbox"/>										

To Pensions Payroll Officer
 HR National Shared Services
 Áras Sláinte Chluainín
 Manorhamilton
 Co. Leitrim

Local Government Spouses & Children Pension Scheme										
This is to Certify that:										
Surname					First Name					
Street Address										
Town/City										
County					Post Code			Country		
1 (a) Is expected to continue his/her studies/training at:										
Until					(End of academic year)					
(b) If in receipt of training allowance, please specify amount of weekly allowance										
€										
2 Has ceased full-time studies/training with effect from:										
										Last date of education/training/or examinations, whichever is later
Signed					School /College/training Centre Stamp					
Name (print)										
Tel No:										
Date										