Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

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

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 ◯ No ◯	
Are you a GP Visit Card Holder	Yes ◯ No ◯	

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 ◯ No ◯	

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

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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	