Industrial Injuries Disablement Benefit
Change of circumstances

Part 1 - About yourself

Surname | Mr/Mrs/Miss/Ms | Date of birth

Other names | NI No.

Daytime phone no. | STD Code | No.

Address | Postcode

Name and address of your doctor | Postcode

Part 2 - About the decision you want us to look at again

Date of accident

or

Name or number of prescribed disease

or

When was the decision made?

Part 3 - The reason for your application

1. Please say how your condition has changed and why you want us to look at the decision again

Continue on a separate sheet if necessary

2. Are you sending any medical evidence in support of your application?

Yes ☐ Enclose a copy with this form

No ☐

Do not get a new report specially for this application.
Send the form back to us as soon as possible. If you delay, you could lose money.

please turn over >>

Part 4 - About medical treatment

Have you been to a hospital or clinic because of your disablement since the assessment was made?

No ☐ Go straight to Part 5.

Yes ☐ Please give the following information.

If you need to tell us about more than one hospital or clinic, please use a separate sheet of paper.

Name and address of hospital or clinic

Postcode

Department or ward

Reference number or admission number

Name of specialist if you know it

Dates of treatment From ____ to ____

From ____ to ____

Were you an in-patient or an out-patient? In-patient ☐ Out-patient ☐

Did you have an x-ray? Yes ☐ No ☐

Part 5 - Declaration

I understand that if I give information which is incorrect or incomplete, action may be taken against me.

I declare that the information I have given on this form is correct and complete.

I agree that
- the Department of Social Security,
- any organisation with which the Department has a contract for the provision of medical services, or
- any doctor providing services to that organisation

may ask any of the people or organisations mentioned on this form for any information which is needed to deal with
- my claim for benefit, or
- any request for my claim to be looked at again

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

I also understand
that the Department may use the information which it has now or may get in the future to decide whether I am entitled to
- the benefit I am claiming
- any other benefit I have claimed, or
- any other benefit I may claim in the future.

Signature ____ Date ____

For official use only **Decision to be reconsidered** **** Delete as appropriate***

☐ "No loss of faculty" decision made on ____

☐ ____ % from ____ to ____ / life*. Provisional / final*. Made on ____

☐ ____ % from ____ to ____ / life*. Provisional / final*. Made on ____

☐ Other ____