



Severe Disability Benefit

Section 1 – About you

Please read the guidance notes before filling in the claim form.

Please note:

If you wish to claim, please fill in this form and return it to Social Security at the above address.

It's important that you return this section of the form as soon as you can. This is because, if your claim is accepted, payment can only start from the Monday following the date that the form is received by us.

Section 1 – Personal Details	
Title	<input type="text"/>
Last name	<input type="text"/>
First name(s)	<input type="text"/>
Date of birth	<input type="text" value=""/> / <input type="text" value=""/> / <input type="text" value=""/>
Social Security number (if known)	<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>
Usual address	<input type="text"/>
	<input type="text"/>
	Postcode <input type="text"/> Telephone number <input type="text"/>
	Email address <input type="text"/>
If you are not staying at your usual address, where are you staying? (including a temporary stay in hospital or a regular stay in a respite facility)	
<input type="text"/>	
<input type="text"/>	
<input type="text"/>	
Postcode <input type="text"/> Telephone Number <input type="text"/>	
How often do you stay there? (e.g. one-off or 2 days a week)	
<input type="text"/>	
<input type="text"/>	

Section 1 – Medical condition and care

What medical condition are you suffering from? (brief description)

How did you learn about severe disability benefit? (e.g. doctor, social worker etc.)

Who is your usual doctor?

Which surgery do you attend?

Do you see any other Doctor for your medical condition?

(e.g. someone from the Medical Specialist Group / Adult Mental Health Services / Children and Adolescent Mental Health Service)

Yes No

If yes, what is their name?

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Is a social worker involved in your care?

Yes No

If yes, what is their name?

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In the case of a child,
what school do they
attend?

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Who is the main person who helps to care for you?

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If this is a friend or relative, what are their name and contact details?

Postcode

Telephone number

Email address

If this is a professional carer (like a nurse, community support or paid companion), what is their name and which organisation do they work for?

If there is anyone else who is helping to care for you, what is their name and either their relationship to you or the organisation they work for?

Section 1 - Other benefits, local residence and payment

Are you receiving a disability benefit from any other country?

Yes

No

If yes, what benefit have you been receiving and what is the name and address of the organisation that has been paying you the benefit?

Name of benefit

Name and address of organisation

Date your claim was closed following your move to Guernsey

Date of your last benefit payment

Were you born locally?

Yes

No

Have you lived locally for the whole of the last five years?

Yes

No

Have you lived locally for at least 26 weeks in the last 12 months?

Yes

No

If you were living outside Guernsey, what were your previous address(es), when did you stay there and what were your insurance number(s)?

Previous address

From

Until

National Insurance number

Payment

If your claim is accepted, we will pay benefit straight into your bank account. We will write to tell you when the first payment is going to be made.

Please tell us what account you would like your benefit paid into.

Name of bank

Branch

Account holder

Bank sort code

Account number

Section 1 – Your declaration**Please read the section below and sign in the space provided**

1. To the best of my knowledge and belief the information given on this form is true and complete;
2. I believe that I need frequent attention and/or continual supervision – see guidance notes (SDB3);
3. My income and that of my spouse or any other person with whom I am living (as if married) does not exceed £ a year; income and savings include interest from investments, dividends, gratuities, directors or other fees, occupational pensions and social insurance benefits from any country;
4. I authorise the Director of Revenue Services to disclose my annual income which is being used as the basis of the assessment of income tax for the relevant year of charge;
5. I authorise any medical practitioner, health and social care professional or head teacher (in the case of a child) to provide information relevant to my claim.

Warning – To give false information may result in prosecution.

Sign here

Date

 / / **If you have completed this form for someone else, please provide your details in the space below.**

Your name

Your address

Postcode

Telephone number

Email address

Relationship with the applicant

How we collect and use information

The Committee *for* Employment and Social Security will process any personal data which you provide, via this form, in accordance with the Data Protection (Bailiwick of Guernsey) Law, 2017. Further information about how your personal data is processed can be found at www.gov.gg/dp or alternatively you may call 01481 732500 and request a paper copy.

What happens next?

Once this form is completed, you should send it back to us without delay. If your claim is accepted, payment can only start from the Monday after we receive the completed form.

You should now fill in Section 2 of the claim form (unless any of the circumstances below apply to you).

If any of the circumstances below apply, please tick the relevant box and we will contact your treating doctor/specialist directly. Please read the guidance notes as you may not need to complete section 2.

Special rules (Terminal illness)

Renal dialysis

Profound and/or multiple disability