



☐ 1st Application ☐ Request for review ☐ Occupational Disease diagnosis and characterisation (Civil Service)

Personal details of the applicant

Full name

Please state the social protection system you are covered by:

☐ Social Security

Social Security Identification Number

☐ Civil Servants Pension Fund

Caixa Geral de Aposentações Subscriber Number

Taxpayer no.

Birth date

year

month

day

Nationality

Address

Locality

Postal Code

Municipality

District

Country

Mobile phone/Phone no.

Email

Occupational activity details

(To be completed in the case of 1st application and occupational disease diagnosis and characterisation)

2.1. Current employer

Name

Social Security Identification Number

Country

Address

Locality

Postal Code

Occupation

Work period

from - - to - -

year

month

day

year

month

day

Tasks performed

Job position

Risks to which you are or have been subject/products with which you work or have worked

If the occupational disease was contracted and/or aggravated while you were working for this employer, please go to [table 3](#).

Did you have any other occupations/carry out other activities? ☐ Yes ☐ No

If you answered **yes**, please complete also form [GDP 15 - Statement of Occupational Activity](#).

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Occupational activity details (continuation)

2.2. Employer where the occupational disease was contracted/aggravated

Name

Social Security Identification Number

Country

Address

Locality

Postal Code

Occupation

Work period

from - - to - -
year month day year month day

Tasks performed

Job position

Risks to which you have been subject/products with which you have worked

If the occupational disease was contracted and/or aggravated while you were working for this employer, please go to [table 3](#).

2.3. Employer where the occupational disease was aggravated

Name

Social Security Identification Number

Country

Address

Locality

Postal Code

Occupation

Work period

from - - to - -
year month day year month day

Tasks performed

Job position

Risks to which you have been subject/products with which you have worked

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Details of the health service that provides or has provided you health care

(To be completed in the case of 1st application and occupational disease diagnosis and characterisation)

Name of the health establishment

Have you used hospital services because of an occupational disease? ☐ Yes ☐ No

If you ticked **yes**, please indicate the type of service:

☐

Hospitalisation

☐

Emergency

☐

Medical speciality consultation

☐

Treatment

Hospital name

Periods

from - - to - -
year month day year month day

from - - to - -
year month day year month day

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Change of clinical or professional situation

(To be completed in the case of request for review)

Occupational disease that motivates the request for review:

Situation that motivates the request for review:

- ☐ Worsening of the clinical situation
- ☐ Change of professional situation following a change of:
- ☐ Job position or working environment ☐ Occupation ☐ Company
- ☐ Work risks ☐ Products handled
- ☐ Other relevant changes:

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Other details

(To be completed in the case of 1st application and occupational disease diagnosis and characterisation)

Are you a pensioner under another social protection system? ☐ Yes ☐ No

If you ticked **yes**, please complete the following table:

| Nature of the pension | Entitlement date | Paying authority |
|---|------------------|------------------|
| Accident at work with _____ % devaluation | - - | |
| Occupational disease with _____ % devaluation | - - | |
| Civil service | - - | |
| Another | - - | |

Are there any ongoing legal proceedings due to an accident at work or occupational disease? ☐ Yes ☐ No

If you ticked **yes**, please complete the following table:

| District | Court/Public Prosecution Service | Court/Chamber | Case no. |
|----------|----------------------------------|---------------|----------|
| | | | |
| | | | |

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Statements

I am aware that:

- Social Security can consult my tax information to confirm the declared income (*Decree-Law no. 92/2004 of 20 April*);
- false statements are punished according to the law.

I **undertake** to inform the Social Security services of any changes to the information provided, **within 10 working days** from the date on which they occurred.

I **declare** that the information I have provided is complete and true.

Date

- -
year month day

Signature

Signature of the applicant or of another person on his/her behalf
(signature of another person when the applicant cannot or does not
know to sign) according to a valid identification document.

Information



Documents to submit

- ▶ Form [GDP 13 - Mandatory Participation/Clinical Opinion](#), available at www.seg-social.pt/formularios
- ▶ Copies of the complementary diagnostic medical examinations proving the occupational disease.



Where to submit the documents

The application and the required mandatory documents may be submitted in person or sent by post to a Social Security service.



Bank account

The payment of all your current or future benefits/allowances or pensions will be made by bank transfer to the IBAN (International Bank Account Number) registered in the Social Security Information System.

If you have not registered your IBAN yet or if you want to update it, you can do so:

- ▶ via the Internet, through the Social Security Online Service (*Segurança Social Direta*) at www.seg-social.pt
- ▶ at the Social Security Customer Information Services, by submitting the [Application form MG 14 - IBAN Registration or Change \(Requerimento de Registo ou Alteração de IBAN\)](#) - which is available at www.seg-social.pt

If the IBAN registered is incorrect or if you do not have an IBAN registered in the system, the payment of all your current or future benefits/allowances or pensions will be made using the payment method that is registered in the Social Security information system.

Data protection



The collected data will be processed by the competent Social Security Services (*Instituto da Segurança Social, I.P.*, *Instituto da Segurança Social dos Açores, I.P.R.A.* and *Instituto de Segurança Social da Madeira, I.P.-RAM*) and will be kept for the period necessary to fulfil their intended purpose.

These Social Security services are committed to protecting your personal data and to fulfilling their obligations within the scope of data protection.

For further information on data protection, please consult the Social Security website at www.seg-social.pt

To be completed by the Social Security services

I confirm that the signature of the ☐ **Applicant** ☐ **Person that signed on his/her behalf** is in accordance with the following identification document:

☐ Citizen Card ☐ Identity Card ☐ Passport ☐ Other

Number

Valid until

 - -
year month day

Signature and stamp