SEGURANÇA SOCIAL

Protection in Occupational Disease

Application for Death Benefits - annex

Practical guide

Please complete this application if the beneficiary has not been recognised as having an occupational disease.

1 Personal details of the deceased beneficiary

Full name

Social Security Identification Number

Birth date (year - month - day)

Date of death (year - month - day)

2 Details of the employer

(Information concerning the deceased beneficiary)

Name of the employer

Social Security Identification Number

Country

Address

Locality

Postal Code

Occupation

Work period from (year - month - day) to (year - month - day)

Tasks performed

Job position

Risks to which the beneficiary was subject and/or products with which he/she has worked

Was the occupational disease contracted and/or aggravated while the beneficiary was working for this employer?

◯ Yes ◯ No

If you ticked **yes**, please go to table 5 and following ones.

Did the beneficiary have any other occupations/carry out other activities? ◯ Yes ◯ No

If you ticked **yes**, please complete also form **GDP 15 - Statement of Occupational Activity**.

3 Details of the employer where the occupational disease was contracted

(Information concerning the deceased beneficiary)

Name of the employer

Social Security Identification Number

Country

Address

Locality

Postal Code -

Occupation

Work period from year - month - day to year - month - day

Tasks performed

Job position

Risks to which the beneficiary was subject and/or products with which he/she has worked

Was the occupational disease contracted and/or aggravated while the beneficiary was working for this employer?

◯ Yes ◯ No

If you ticked **yes**, please go to table 5 and following ones.

4 Details of the employer where the occupational disease was aggravated

(Information concerning the deceased beneficiary)

Name of the employer

Social Security Identification Number

Country

Address

Locality

Postal Code -

Occupation

Work period from year - month - day to year - month - day

Tasks performed

Job position

Risks to which the beneficiary was subject and/or products with which he/she has worked

5 Other details concerning the deceased beneficiary

Was he/she 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	- -	
Foreign Social Security System	- -	
Civil service	- -	
Another	- -	

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

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

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

6 Statements

I am aware that false statements are punished according to the law.

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 how to sign) according to a valid identification document.

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 wihin 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