

Statement of Extension of the Allowance for the Care of a Child with a Disability, Chronic Illness or Cancer ¹

1 Personal details of the declarant (person providing care)

Full name

Social Security Identification Number

Birth date

 - -
year month day

2 Personal details of the child/person treated as such

Full name

Social Security Identification Number

Birth date

 - -
year month day

3 Extension of the periods of absence from work

For the purposes of Article 20(1) and (2) and Article 76(3) of Decree-Law no. 91/2009 of 9 April, I hereby inform you that the leave for the Care of a Child with a Disability, Chronic Illness or Cancer, identified in table 2, has been extended for the following period:

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

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

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

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

4 Statements (person providing care)

I am aware that I must inform the Social Security services of any fact that determines the end (cessation) of the allowance payment, **within 5 working days** from the date on which it occurred.

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

Date

 - -
year month day

Signature

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

¹ Application of Article 20(1) and (2) and Article 76(3) of Decree-Law no. 91/2009 of 9 April 2009, updated version.

5

Statements of the employer

☐ I confirm ☐ do not confirm the statements made by the employee regarding the continuation of the leave period for the care of the child identified in table 2.

Date

- -
year month day

Signature and stamp

6

Information

Where to submit the statement and time limits for the submission

This statement must be submitted **within 10 working days** before the end of the previous leave:

- ▶ Through the Social Security Online Service (*Segurança Social Direta*), at www.seg-social.pt, by completing the online application form, if the competent entity for the application examination is the Social Security Institute, P.I. (*Instituto da Segurança Social, I.P.*) or the competent bodies of the Autonomous Regions administrations.
- ▶ In person, at the Social Security Customer Information services or sent by post.

Data protection



The collected personal 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, IP-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 Online Service (*Segurança Social Direta*) at www.seg-social.pt.

To be completed by the Social Security services

I confirm that the signature of the ☐ **declarant** ☐ **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