SEGURANCA SOCIAL

Statement

Incapacity Caused by Third-Party Intervention

◯ Invalidity Pension ◯ Long-term Care Supplement ◯ Supplement - Social Inclusion Benefit

1 Personal details of the beneficiary

Full name

Social Security Identification Number

Taxpayer no.

Birth date
year - month - day

Mobile Phone/Phone no.

Email

2 Incapacity details

2.1. Circumstances of the accident

Cause: ◯ Road accident ◯ Accident at work ◯ Assault ◯ Other type of accident

Date of the accident
year - month - day

Hour of the accident :

Location of the accident

Did the accident occur while you were working for an employer? ◯ Yes ◯ No

If you ticked Yes, please complete paragraph 2.3. of table 2.

Healthcare facility where care was provided:

Brief description of the facts that led to the incapacity

Name of the person responsible for the incapacity for work

Birth date
year - month - day

Address

Locality

Postal Code -

Was the insurance company notified? ◯ Yes ◯ No

If you ticked No, please state why the insurance company was not notified:

If you ticked Yes:

- Indicate the insurance company name:
- Are you receiving compensation?[1] ◯ Yes ◯ No
  If you ticked Yes, please indicate the total amount : €
- Has any amount of compensation been set for loss of earning capacity?[1] ◯ Yes ◯ No
  If you ticked Yes, please indicate the total amount : €

[1] If the beneficiary has received or will receive compensation from the third party responsible for the accident that caused the incapacity that justifies the granting of the Invalidity Pension/Long-term Care Supplement and/or the Social Inclusion Benefit Supplement, the respective benefits will not be paid until the sum of their value (to which the beneficiary would be entitled if there were no such liability) reaches the value of the compensation for the loss of earning capacity. When the value of this compensation is not indicated, it shall be presumed to correspond to two-thirds of the total value of the compensation granted (Article 6 of Decree-Law no. 187/2007 of 10 May, and Decree-Law no. 126-A/2017 of 6 October).

Incapacity details (continuation)

2

2.2. To be completed in the event of incapacity caused by a road accident
(Details of the vehicle/s involved in the accident)

Vehicle no. 1

Vehicle brand | Registration number - -

Owner's name

Owner's address

Insurance company

Policy no. | Insurance company case no.

Vehicle no. 2

Vehicle brand | Registration number - -

Owner's name

Owner's address

Insurance company

Policy no. | Insurance company case no.

Vehicle no. 3

Vehicle brand | Registration number - -

Owner's name

Owner's address

Insurance company

Policy no. | Insurance company case no.

2.3. To be completed in the event of an accident at work or a road accident (if it is also an accident at work)

Employee

Name of the employer

Workplace of the injured employee

Insurance company | Policy no.

Self-employed person

Do you have an insurance policy for accidents at work? ◯ Yes ◯ No

If you ticked Yes, please indicate:

- Name of the insurance company:
- Address of the insurance company:

2 Incapacity details (continuation)

2.4. To be completed in the event of assault or other type of accident

Please describe the type of accident:

Indicate:

- Health facility, if you have received hospital treatment:
- Authority that took charge of the occurrence, if the accident resulted from an assault:

2.5. To be completed if there are witnesses to the events that led to the incapacity

Witness no. 1

Full name

Address

Locality

Postal Code -

Witness no. 2

Full name

Address

Locality

Postal Code -

3 Other details

Authority that took charge of the occurrence (GNR, PSP, another authority)[1]

Court where the case is being heard

Court Section Case number

Name of the lawyer representing you

Address of the lawyer's office

Locality

Postal Code -

Mobile Phone/Phone no.

Email

[1] If you have completed this field, please attach a copy of the accident report prepared by the GNR - *National Republican Guard* or the PSP - *Public Security Police*).

4 Statements

I am aware that:

- If I am entitled to compensation, the entity responsible for its payment shall pay Social Security the amount corresponding to the Invalidity Pension (including the Long-term Care Supplement, if applicable) and/or the Social Inclusion Benefit Supplement that was paid to me, up to the limit of the compensation due. In the event of non-compliance, I am jointly and severally liable for the reimbursement to Social Security of the respective amount.
- False statements are punished according to the law.

I undertake to communicate to the Social Security services any changes to the information I have provided.

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

Date

year - month - day

Signature

Signature of the beneficiary 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 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 ◯ **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