Social Welfare Services
DE 2
Data Classification R

Enquiry form for Dental Benefit Eligibility under the dependent spouse's/civil partner's/cohabitant's scheme

Part 1 Patient's details

1. PPS No.:
2. Surname:
3. First name(s):
4. Your date of birth:
   D D M M Y Y Y Y
5. Your address:
   County
   Postcode
6. Your telephone number:
7. Your email address:
8. Are you?
   (a) currently employed: ☐ Yes ☐ No
   (b) self-employed: ☐ Yes ☐ No
   If 'employed', please state your employer's name:
9. Are you getting any payments from this Department, the HSE or have income from any other source?
   If 'Yes', please state: ☐ Yes ☐ No
   Type of payment:
   Amount: € , . a week

Part 2 Your spouse's, civil partner's or cohabitant's details

10. Their PPS No.:
11. Their surname:
12. Their first name(s):
13. Their date of birth:
    D D M M Y Y Y Y
14. Are they?
    (a) currently employed: ☐ Yes ☐ No
    (b) self-employed: ☐ Yes ☐ No
    If 'employed', please state their employer's name:

Part 2 continued — Your spouse's, civil partner's or cohabitant's details

15. If you are a widow, widower, surviving civil partner or cohabitant, please state:

Date your spouse, civil partner or cohabitant died: D D M M Y Y Y Y

16. Did they ever work in another EU member state or EEA country?

☐ Yes ☐ No

If 'Yes', please state their social insurance number while there:

Declaration - to be signed by your spouse, civil partner or cohabitant

I give permission for my spouse/partner to use my PPSN in order to avail of any treatment under the Treatment Benefit Scheme. I understand that this consent will stand until I inform the Department otherwise.

Signature (not block letters)

Date: D D M M 2 0 Y Y

Part 3 — Dentist's details

If my application is approved, I wish to get my treatment from:

17. Dentist's name:

18. DEASP panel number: D

19. Dental practice address:

Declaration - to be signed by you

I approve the dentist nominated above to contact the Department of Employment Affairs and Social Protection about my application for Treatment Benefit and to share any information which is necessary to process my claim. I understand that this consent will stand until I inform the Department otherwise.

Signature (not block letters)

Date: D D M M 2 0 Y Y

Warning: If you make a false statement or withhold information, you may be prosecuted leading to a fine, a prison term or both.

Send this completed application form to:

Treatment Benefit Section, Department of Employment Affairs and Social Protection, St. Oliver Plunkett Road, Letterkenny, Co. Donegal.

Telephone: (074) 916 4480

LoCall: 1890 400 400 NOTE: The rates charged for using 1890 (LoCall) numbers may vary among different service providers

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Data Protection Statement

The Department of Employment Affairs and Social Protection will treat all information and personal data you give us as confidential. However, it should be noted that information may be exchanged with other Government Departments / Agencies in accordance with the law.

Explanations and terms used in this form are intended as a guide only and are not a legal interpretation.