

## Civil Service Pension Scheme

## Appeal against medical retirement decision APP1

### P1 – Member to complete

You should refer to the '*The Medical Reviews and Appeals Guide*', when filling this in. Your employer should have given you a copy. It is also available from:

<http://www.civilservicepensionscheme.org.uk>

| Your Details                       |             |  |
|------------------------------------|-------------|--|
| Your name                          | Title       |  |
|                                    | Surname     |  |
|                                    | Forename(s) |  |
| Your date of birth                 |             |  |
| Home address (including post code) |             |  |
|                                    |             |  |
|                                    |             |  |
|                                    |             |  |

|                          |  |
|--------------------------|--|
| Daytime telephone number |  |
|--------------------------|--|

|                              |  |
|------------------------------|--|
| Alternative telephone number |  |
|------------------------------|--|

**The Scheme Medical Adviser may need to examine you in order to do their assessment. They will telephone you to arrange an appointment if they want you to attend a medical consultation.**

If the Scheme Medical Adviser wants you to attend a medical consultation and you have any specific mobility, hearing or visual needs that you think they should know about in relation to this please provide details.

**Please note:** If you turn down or fail to attend an appointment on two occasions, the Scheme Medical Adviser will provide an assessment on the basis of the

information available to them.

If after completing Stage 2 of the appeal process, there remains uncertainty whether the criteria for medical retirement are satisfied (see the '*The Medical Reviews and Appeals Guide*' for more information) the Scheme Medical Adviser may refer your appeal to an Independent Medical Appeal Board. In such circumstances you will be invited to attend the Board in person or you can ask the Board to consider your case on a papers basis only.

If you attend the Board in person you can be accompanied by someone else, for example a relative, friend or Trade Union official.

Which of the following Medical Appeal board locations would you prefer to attend?  
(Please put 'X' in the appropriate box below)

|                               |                          |
|-------------------------------|--------------------------|
| Aberuthcen, Scotland          | <input type="checkbox"/> |
| Belfast, Northern Ireland     | <input type="checkbox"/> |
| Birmingham                    | <input type="checkbox"/> |
| Cowbridge, Nr. Cardiff, Wales | <input type="checkbox"/> |
| Holt Mill, Nr Dorchester      | <input type="checkbox"/> |
| London                        | <input type="checkbox"/> |
| Preston, Lancashire           | <input type="checkbox"/> |
| Nottingham                    | <input type="checkbox"/> |

**Please confirm what you are appealing against. Please put 'X' in the relevant box below.**

|  |                          |   |                          |
|--|--------------------------|---|--------------------------|
| A decision on whether to issue a medical retirement or refusal certificate   | <input type="checkbox"/> | A decision to award medical retirement benefits at the lower tier level (applies only to <b>premium, classic plus</b> and <b>nuvos</b> members) | <input type="checkbox"/> |
| A refusal to issue a member a medical retirement certificate retrospectively | <input type="checkbox"/> | A refusal to issue a medical retirement certificate for early payment of a preserved award (EPPA) (applies only to <b>classic</b> members)      | <input type="checkbox"/> |

**Please now explain why you disagree with the decision on your application and want to appeal.**

The grounds for my appeal are:

Please list below details of the further medical evidence you are supplying.

**i** You can use the '*Optional Form and Notes - for your doctor or specialist*' at the end of P1 of this form if you are asking one of your doctors to supply a new report and want to make sure they provide suitable detail.

|  |  |
|--|--|
|  |  |
|  |  |
|  |  |

|                  |  |             |  |
|------------------|--|-------------|--|
| <b>Signature</b> |  | <b>Date</b> |  |
|------------------|--|-------------|--|

**Medical Consent Form****Release of the Scheme Medical Adviser’s medical assessment report**

Once the Scheme Medical Adviser has completed their assessment they will produce a report for your employer. The report will confirm whether or not you have a qualifying medical reason for ill health retirement. It will include any information about your health that the Scheme Medical Adviser, in their absolute discretion, regard as being of material relevance to your application.

**Your employer cannot offer ill health retirement without a report and certificate from the Scheme Medical Adviser confirming that you have a qualifying medical reason for ill health retirement.**

|  |  |
|--|--|
| If you <b>consent</b> to the Scheme Medical Adviser sending their report to your employer, including relevant information about your health please put ‘ <b>X</b> ’ in the box and <b>sign</b> and <b>date</b> below to confirm your decision. | <input type="checkbox"/><br><b>I consent</b> |
| <b>Signature</b>   | <b>Date</b>                                  |

You will automatically be sent a copy of the report at the same time as it is sent to your employer, but you can ask not to be sent a copy if you do not want to see it.

You can also ask to see a copy of the report before it is sent to your employer.

|   |                                      |
|---|--------------------------------------|
| If you do not want to see a copy of the report at all please put ‘ <b>X</b> ’ in the box.                           | <b>NO:</b> <input type="checkbox"/>  |
| If you wish to receive a copy of the report before it is sent to your employer, please put ‘ <b>X</b> ’ in the box. | <b>YES:</b> <input type="checkbox"/> |

If there is no ‘**X**’ in either box above then you will automatically be sent a copy of the report at the same time as it is sent to your employer (if you have consented).

If you ask to see the report before it is released to your employer you will have **5 working days from the date it is issued to you to:**

- ask the Scheme Medical Adviser to correct any factual errors in the report;
- withdraw consent for the report to be sent to your employer.

You will only be given one opportunity to ask for factual errors to be corrected.

If you have asked for the report to be amended, the Scheme Medical Adviser can no longer send any report to your employer without your renewed consent to do so. **You must therefore, contact them within 5 working days of the date on the corrected report (or the letter telling you that the Scheme Medical Adviser will not make changes to the report), to tell them whether you wish them to release the report to your employer or not.** If they do not hear from you within this timescale they will tell your employer that they do not have your

consent to release the report and that they are therefore unable to provide any advice.

**Important Notes:**

**It is unlikely to be in your best interests to refuse or withdraw consent for the Scheme Medical Adviser to send their report to your employer, because without a report and certificate:**

- it will be taken that you have stopped the ill health retirement process;
- your employer cannot offer ill health retirement and can proceed to take other action (e.g. dismissal for inefficiency, if they intended to take such action and have not yet done so), having first considered the appropriateness of ill health retirement;
- you will not be able to apply for retrospective ill health retirement.

Please consult the '*Ill Health Retirement – Guide for Members*' for more advice about the role of the Scheme Medical Adviser's assessment report in the ill health retirement process and '*The Medical Reviews and Appeals Guide*' for further information about the appeals process.

|  |  |  |  |
|--|--|--|--|
| <p>I agree that the Scheme Medical Adviser may retain any information submitted as part of this application and any information collected by them as part of their consideration of this application.</p> <p>I agree that the Scheme Medical Adviser can use such information as part of their consideration of any future referrals. I agree that this consent is enduring and will endure unless I provide written confirmation to the Scheme Medical Adviser that I am withdrawing my consent.</p> <p>If you <b>agree</b> to the Scheme Medical Adviser retaining and using information in this way, please put '<b>X</b>' in the box and <b>sign</b> and <b>date</b> below to confirm your decision.</p> |  | <input type="checkbox"/><br><b>I agree</b> |  |
| <b>Signature</b>   |  | <b>Date</b>                                |  |

**MEDICAL IN CONFIDENCE - when completed**

**Optional Form and Notes - for your doctor or specialist**

**i** Members can use this section if they want to ask their doctor or specialist to provide medical detail to support their application.

| Member's Details                 |             |  |
|----------------------------------|-------------|--|
| Member's name                    | Title       |  |
|                                  | Surname     |  |
|                                  | Forename(s) |  |
| Your date of birth               |             |  |
| Date of most recent consultation |             |  |

| Medical information for the member's doctor or specialist to provide |  |
|--|--|
| <b>i</b> See the notes at the end of the form for further guidance   |  |
| <b>1</b>   | What is the diagnosis of the main medical condition?<br><div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>  |
| <b>2</b>   | Please list any secondary conditions<br><div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>  |
| <b>3</b>   | Please indicate the applicant's current symptoms and clinical findings on examination<br><div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>                                   |
| <b>4</b>   | Please detail current and past treatment and response<br><div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>   |
| <b>5</b>   | What is the long-term outlook?<br><div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>  |
| <b>6</b>   | What is the impact of the illness on the physical and mental functional ability of the applicant?<br><div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>                       |
| <b>7</b>   | Is further treatment envisaged or possible and what is its likely effect?<br><div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>   |
| <b>8</b>   | Has there been referral for specialist assessment and treatment? <span style="float: right; margin-left: 20px;"> <b>YES:</b> <input type="checkbox"/><br/> <b>NO:</b> <input type="checkbox"/> </span> |

**MEDICAL IN CONFIDENCE - when completed**



**MEDICAL IN CONFIDENCE - when completed**

|           |   |             |                          |
|-----------|---|-------------|--------------------------|
| <b>9</b>  | Have you received specialist reports on this patient? | <b>YES:</b> | <input type="checkbox"/> |
|           |   | <b>NO:</b>  | <input type="checkbox"/> |
| <b>10</b> | Copies of specialist correspondence attached?         | <b>YES:</b> | <input type="checkbox"/> |
|           |   | <b>NO:</b>  | <input type="checkbox"/> |
| <b>11</b> | Please list this correspondence                       |             |                          |
|           |   |             |                          |
|           |   |             |                          |

**Please note:** If you need more space for any of the answers, please attach an additional sheet clearly marked with the relevant question number.

|                                    |  |             |  |
|------------------------------------|--|-------------|--|
| <b>Signature</b>                   |  | <b>Date</b> |  |
| <b>Name</b>                        |  |             |  |
| <b>Position and qualifications</b> |  |             |  |

**Notes for the applicant’s doctor or specialist**

Ill health retirement should be a last resort. If a member has health problems, in the first instance they should seek the necessary treatment and, if appropriate, occupational health should look at ways to help them to remain in or to return to work, in line with the Equality Act and equivalent legislation in Northern Ireland. This could be through such measures as redeployment, workplace adjustments, flexible working or specialist support. Adjustments must be considered before concluding that ill-health retirement may be appropriate.

It is necessary to demonstrate that the member not only has a medical condition that renders them incapable of doing their normal duties, but also despite appropriate treatment, that the resulting ill health and incapacity is likely to be present until the scheme or state pension age.

When a medical condition is severe enough to warrant ill health retirement, it is generally expected that the applicant will have had the benefit of a specialist opinion during their illness. It is difficult to conclude that an illness will not resolve or improve until all evidence-based treatments for the specific illness have been completed. It is generally helpful in the consideration of an application if medical information is available from the applicant’s treating specialist.

This form provides an opportunity to provide medical detail that may be helpful to the scheme medical adviser in consideration of your patient’s application for ill health retirement benefits.

It is important that the information provided is legible. The applicant can ask their employer for an electronic version of this form if you would prefer this.

**LEAVE BLANK (double-sided printing)**

## Civil Service Pension Scheme

# Appeal against medical retirement decision APP1

## P2 – Employer to complete

You should refer to the '*The Medical Reviews and Appeals Guide*', when filling this in.

| Your Details     |  |
|------------------|--|
| Name of employer |  |

|                              |  |
|------------------------------|--|
| Name of person placing order |  |
|------------------------------|--|

|                               |  |
|-------------------------------|--|
| Address (including post code) |  |
|-------------------------------|--|

|                  |  |
|------------------|--|
| Telephone number |  |
|------------------|--|

|            |  |
|------------|--|
| Fax number |  |
|------------|--|

|                |  |
|----------------|--|
| e-mail address |  |
|----------------|--|

|                        |  |  |  |  |  |  |  |
|------------------------|--|--|--|--|--|--|--|
| Employer Location Code |  |  |  |  |  |  |  |
|------------------------|--|--|--|--|--|--|--|

It is essential that you enter your employer location code (as allocated by the Scheme Medical Adviser so that they can send your invoice to the right place. If you have not used this service before and require a location code, please contact the Scheme Medical Adviser on 01273 815247

|                       |  |
|-----------------------|--|
| Purchase Order Number |  |
|-----------------------|--|

If you do not operate a purchase order system, please provide a unique identifier (for example your cost centre or referring manager's name).

|            |  |
|------------|--|
| Identifier |  |
|------------|--|

| Your Employee's Details                  |               |  |
|--|---------------|--|
| Name of employee                         | Title         |  |
|  | Surname       |  |
|  | Forename(s)   |  |
| Male / Female<br>(delete as appropriate) | Date of birth |  |

|           |  |       |  |
|-----------|--|-------|--|
| Job title |  | Grade |  |
|-----------|--|-------|--|

|   |  |
|---|--|
| If this employee's employment has been, or will shortly be, terminated please confirm the last day of service |  |
|---|--|

**i** It is important that we know the employee's pension scheme retirement age. Please make sure that the information you provide below is correct.

|   |
|---|
| Which CSPS scheme does this employee belong to?<br>Please put 'X' in one of the following boxes to confirm: |
|---|

|  |                          |
|--|--------------------------|
| <b>classic</b> - with a scheme pension age of 60 | <input type="checkbox"/> |
|--|--------------------------|

|   |                          |
|---|--------------------------|
| <b>classic plus</b> - with a scheme pension age of 60 | <input type="checkbox"/> |
|---|--------------------------|

|  |                          |
|--|--------------------------|
| <b>premium</b> - with a scheme pension age of 60 | <input type="checkbox"/> |
|--|--------------------------|

|  |                          |
|--|--------------------------|
| <b>nuvos</b> - with a scheme pension age of 65 | <input type="checkbox"/> |
|--|--------------------------|

|   |     |                          |
|---|-----|--------------------------|
| <b>None of the above</b> apply as this employee has a pension age of: | AGE | <input type="checkbox"/> |
|---|-----|--------------------------|

There are some civil servants who have a pension age that is different to the scheme pension age, for example prison officers in post before a specific date. The pension age of a partnership member will be the same age that would have applied had they joined the PCSPS.

|  |  |          |  |
|--|--|----------|--|
| The employer requests that the Scheme Medical Adviser shall provide medical advice services in accordance with the terms of this order form. |  |          |  |
| The employer agrees to make payment to the Scheme Medical Adviser for the provision of the medical advice services.                          |  |          |  |
| Signed for and on behalf of the employer   |  |          |  |
| Signature  |  | Date     |  |
| Name   |  | Position |  |

**PROTECT – STAFF**

**You must attach ALL the information listed here and tick the box to show that you have done so.**

|          |                                   |                          |
|----------|-----------------------------------|--------------------------|
| <b>A</b> | APP1 P1 – completed by the member | <input type="checkbox"/> |
|----------|-----------------------------------|--------------------------|

|          |   |  |  |
|----------|---|--|--|
| <b>B</b> | The original application papers including the medical adviser’s decision and supporting documents | <input type="checkbox"/>   |  |
|          |   | Please confirm the date the decision was notified to your employee |  |

|          |  |                          |
|----------|--|--------------------------|
| <b>C</b> | Occupational health records including the sealed envelope marked ‘Medical in Confidence’ | <input type="checkbox"/> |
|----------|--|--------------------------|

|   |   |
|---|---|
| <p><b>When you have collected together all of the information asked for, you should send it to the Scheme Medical Adviser either via the portal or to the address opposite.</b></p> | <p><b>Health Management Ltd<br/>Ash House<br/>The Broyle<br/>Ringmer<br/>East Sussex<br/>BN8 5NN</b></p> <p><b>Email<br/>civilserviceadmin@healthmanltd.com</b></p> |
|---|---|