

## Civil Service Injury Benefit Scheme

### Application for injury benefit assessment

#### Part 1 – Member to complete

The Scheme Medical Adviser to the Civil Service Pension and Injury Benefit Scheme is being asked to give advice on the medical aspects of your injury benefit case. Please complete this form as fully as you can, including signatures where required and return the form to your employer as soon as possible.

| 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 may want 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.

**Medical Consent Form 1**

I consent and understand that information in my occupational health records and any Information obtained in relation to my application for Injury benefit to be used for the purpose of assessment against the Civil Service Injury Benefit Scheme criteria.

I also consent and understand that the Occupational Health provider retained by my employer may see my referral for the purpose of providing the aforementioned occupational health or any such Medical-In-Confidence material that may be relevant to my case.

Signature:

Date:

**Medical Consent Form 2**

**Consent for the Scheme Medical Adviser to approach your doctor or specialist for further information about your medical condition.**

**Please read this section which gives information about your rights in relation to your medical records under the terms of the Access to Medical Reports Act 1988.**

The Scheme Medical Adviser may wish to apply to your doctor or specialist for further medical information. They will need your consent to do this. If you wish to give consent you must confirm this by completing the required fields in the consent box below and then proceed to the next section on this page. You also have the right to refuse consent. If you choose to refuse consent then you can ignore the following information on this page and proceed directly to **Medical Consent form 3** which explains what happens to the report that the Scheme Medical Adviser produce after they have completed their assessment.

If you give your consent you have the right to see information about your medical condition before it is supplied to the Scheme Medical Adviser. You will have 21 days from the date of the Scheme Medical Adviser’s letter telling you that a medical report has been requested, in which to ask your doctor, specialist or consultant to let you see their report. If you do not ask to see their report, you will still have a right to see information about your medical condition for up to six months after it has been sent to the Scheme Medical Adviser.

|  |  |  |   |             |  |
|--|--|--|---|-------------|--|
| If you <b>consent</b> to the Scheme Medical Adviser seeking further information about your medical condition, 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> |  |   |             |  |
| <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; padding: 5px;"><b>Signature</b></td> <td style="width: 75%;"></td> </tr> </table>                                 | <b>Signature</b>                             |  | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; padding: 5px;"><b>Date</b></td> <td style="width: 75%;"></td> </tr> </table> | <b>Date</b> |  |
| <b>Signature</b>   |  |  |   |             |  |
| <b>Date</b>  |  |  |   |             |  |

|   |                                      |
|---|--------------------------------------|
| If you have agreed to give consent above you must now answer this question.   | <b>YES:</b> <input type="checkbox"/> |
| Under the terms of the Access to Medical Reports Act 1988 do you intend to ask your doctor, specialist, or consultant to let you see their report before it is supplied to the Scheme Medical Adviser? Please put ‘ <b>X</b> ’ in the relevant box. | <b>NO:</b> <input type="checkbox"/>  |

If you have given consent for the Scheme Medical Adviser to contact your doctor or specialist you **must complete a separate Medical Information Consent Form** for **each** medical practitioner you would be prepared for the Scheme Medical Adviser to contact. The Medical Information Consent Forms (lettered ‘a’, ‘b’ and ‘c’), can be found at the end of this CSIBS1 – P1 form.

**Medical Consent Form 3**

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

Once the Scheme Medical Adviser has completed their assessment they will produce a report on the medical aspects of your case. It will include any information about your health that the Scheme Medical Adviser, in their absolute discretion, regards as being of material relevance to your application.

**MyCSP is responsible for making decisions about injury benefit applications. However, they will need advice from the Scheme Medical Adviser about the level of earnings impairment and level of apportionment for injuries sustained. See the brief guide on the ‘Injury benefit scheme’ for more information: [www.civilservicepensionscheme.org.uk](http://www.civilservicepensionscheme.org.uk) under Members, Publications.**

**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.**

**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.**

**If you agree to the Scheme Medical Adviser retaining and using information in this way, please put ‘X’ in the box and sign and date below to confirm your decision.**

|   |  |             |             |  |  |
|---|--|-------------|-------------|--|--|
| If you <b>consent</b> to the Scheme Medical Adviser sending their report to your employer or MyCSP, including relevant information about your health please put ‘X’ in the box and <b>sign</b> and <b>date</b> below to confirm your decision.                        | <input type="checkbox"/><br><b>I consent</b> |             |             |  |  |
| <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; padding: 5px;"><b>Signature</b></td> <td style="width: 50%;"></td> <td style="width: 25%; padding: 5px;"><b>Date</b></td> <td style="width: 25%;"></td> </tr> </table> | <b>Signature</b>                             |             | <b>Date</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 or MyCSP, 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 or MyCSP.

|  |                                     |
|--|-------------------------------------|
| If you do not want to see a copy of the report at all please put “X” 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 or MyCSP, please put “X” 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 or MyCSP (if you have consented).

If you ask to see the report before it is released to your employer or MyCSP 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 or MyCSP.

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 or MyCSP 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 MyCSP, or not.** If they do not hear from you within this timescale they will tell your employer or MyCSP 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 or MyCSP, because without a report:**

- MyCSP will not be able to make an informed decision about your injury benefit application.
- you will not be able to appeal against the Scheme Medical Adviser’s assessment.
- you will not be able to request a review (informal appeal) against MyCSP or the employer decision not deeming an injury as a qualifying injury

Please consult the ‘*Medical reviews and appeals guide*’ for more advice about actions you can take if you disagree with the assessment. The guide can be found on the Civil Service website: [www.civilservicepensionscheme.org.uk](http://www.civilservicepensionscheme.org.uk) in the employer section under Scheme Medical Adviser.

**Medical Information Consent Form (a)**

Who are you giving consent for the Scheme Medical Adviser to approach for further information about your medical condition? Please put 'X' in one of the boxes below, as appropriate.

**General Practitioner (GP):**  **Hospital Specialist:**  **Consultant:**

Please give their details below, as required.

|  |  |
|--|--|
| <b>Name</b>  |  |
| <b>Specialism</b><br>(if this is your hospital specialist or consultant)   |  |
| <p><b>ⓘ You do not have to reveal details of your own medical condition here but if the Scheme Medical Adviser contacts a doctor it is helpful for them to have detail of the general area of medical speciality or hospital department.</b></p> |  |

|                                      |  |
|--------------------------------------|--|
| <b>Address</b> (including post code) |  |
|                                      |  |
|                                      |  |
|                                      |  |
| <b>Telephone number</b>              |  |

**Declaration**

By signing below, I agree that the medical practitioner named above may give information about my medical condition(s) to the Scheme Medical Adviser. I also confirm that:

I understand my employer or MyCSP is asking the Scheme Medical Adviser to give advice on the medical aspects of my injury case.

I also understand that should I wish to receive a copy of any information supplied to the Scheme Medical Adviser by my doctor (GP), hospital specialist, or consultant, I may have to pay a reasonable fee for any report that is supplied to me.

I have seen and read the information at the beginning of Medical Consent Form 3 about my rights in relation to my medical records.

I understand that this consent is enduring and will endure until my employer has determined the outcome of this application unless I provide written confirmation to the Scheme Medical Adviser that I am withdrawing my consent. A photocopy or electronic copy of this withdrawal consent will have the same authority as the original.

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

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**Medical Information Consent Form (b)**

Who are you giving consent for the Scheme Medical Adviser to approach for further information about your medical condition? Please put 'X' in one of the boxes below, as appropriate.

**General Practitioner (GP):**  **Hospital Specialist:**  **Consultant:**

Please give their details below, as required.

|  |  |
|--|--|
| <b>Name</b>  |  |
| <b>Specialism</b><br>(if this is your hospital specialist or consultant)   |  |
| <p><b>(i) You do not have to reveal details of your own medical condition here but if the Scheme Medical Adviser contacts a doctor it is helpful for them to have detail of the general area of medical speciality or hospital department.</b></p> |  |

|                                      |  |
|--------------------------------------|--|
| <b>Address</b> (including post code) |  |
|                                      |  |
|                                      |  |
|                                      |  |
| <b>Telephone number</b>              |  |

**Declaration**

By signing below, I agree that the medical practitioner named above may give information about my medical condition(s) to the Scheme Medical Adviser. I also confirm that:

I understand my employer or MyCSP is asking the Scheme Medical Adviser to give advice on the medical aspects of my injury case.

I also understand that should I wish to receive a copy of any information supplied to the Scheme Medical Adviser by my doctor (GP), hospital specialist, or consultant, I may have to pay a reasonable fee for any report that is supplied to me.

I have seen and read the information at the beginning of Medical Consent Form 3 about my rights in relation to my medical records.

I understand that this consent is enduring and will endure until my employer has determined the outcome of this application unless I provide written confirmation to the Scheme Medical Adviser that I am withdrawing my consent. A photocopy or electronic copy of this withdrawal consent will have the same authority as the original.

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



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

**Medical Information Consent Form (c)**

Who are you giving consent for the Scheme Medical Adviser to approach for further information about your medical condition? Please put 'X' in one of the boxes below, as appropriate.

**General Practitioner (GP):**  **Hospital Specialist:**  **Consultant:**

Please give their details below, as required.

|  |  |
|--|--|
| <b>Name</b>  |  |
| <b>Specialism</b><br>(if this is your hospital specialist or consultant)   |  |
| <p><b>(i) You do not have to reveal details of your own medical condition here but if the Scheme Medical Adviser contacts a doctor it is helpful for them to have detail of the general area of medical speciality or hospital department.</b></p> |  |

|                                      |  |
|--------------------------------------|--|
| <b>Address</b> (including post code) |  |
|                                      |  |
|                                      |  |
|                                      |  |
| <b>Telephone number</b>              |  |

**Declaration**

By signing below, I agree that the medical practitioner named above may give information about my medical condition(s) to the Scheme Medical Adviser. I also confirm that:

I understand my employer or MyCSP is asking the Scheme Medical Adviser to give advice on the medical aspects of my injury case.

I also understand that should I wish to receive a copy of any information supplied to the Scheme Medical Adviser by my doctor (GP), hospital specialist, or consultant, I may have to pay a reasonable fee for any report that is supplied to me.

I have seen and read the information at the beginning of Medical Consent Form 3 about my rights in relation to my medical records.

I understand that this consent is enduring and will endure until my employer has determined the outcome of this application unless I provide written confirmation to the Scheme Medical Adviser that I am withdrawing my consent. A photocopy or electronic copy of this withdrawal consent will have the same authority as the original.

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

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

## Civil Service Injury Benefit Scheme

### Notes for the employer or MyCSP

## Application for injury benefit assessment

Injury benefit is a benefit payable to employees who have been injured while on duty. It is paid to bring their income up to a guaranteed level. It may also be paid to any dependents should an employee die as a result of their duties. The Civil Service Injury Benefits Scheme (CSIBS) rules set out who can receive benefits and the level of the guaranteed income. The rules also define what a qualifying injury is.

For further information refer to:

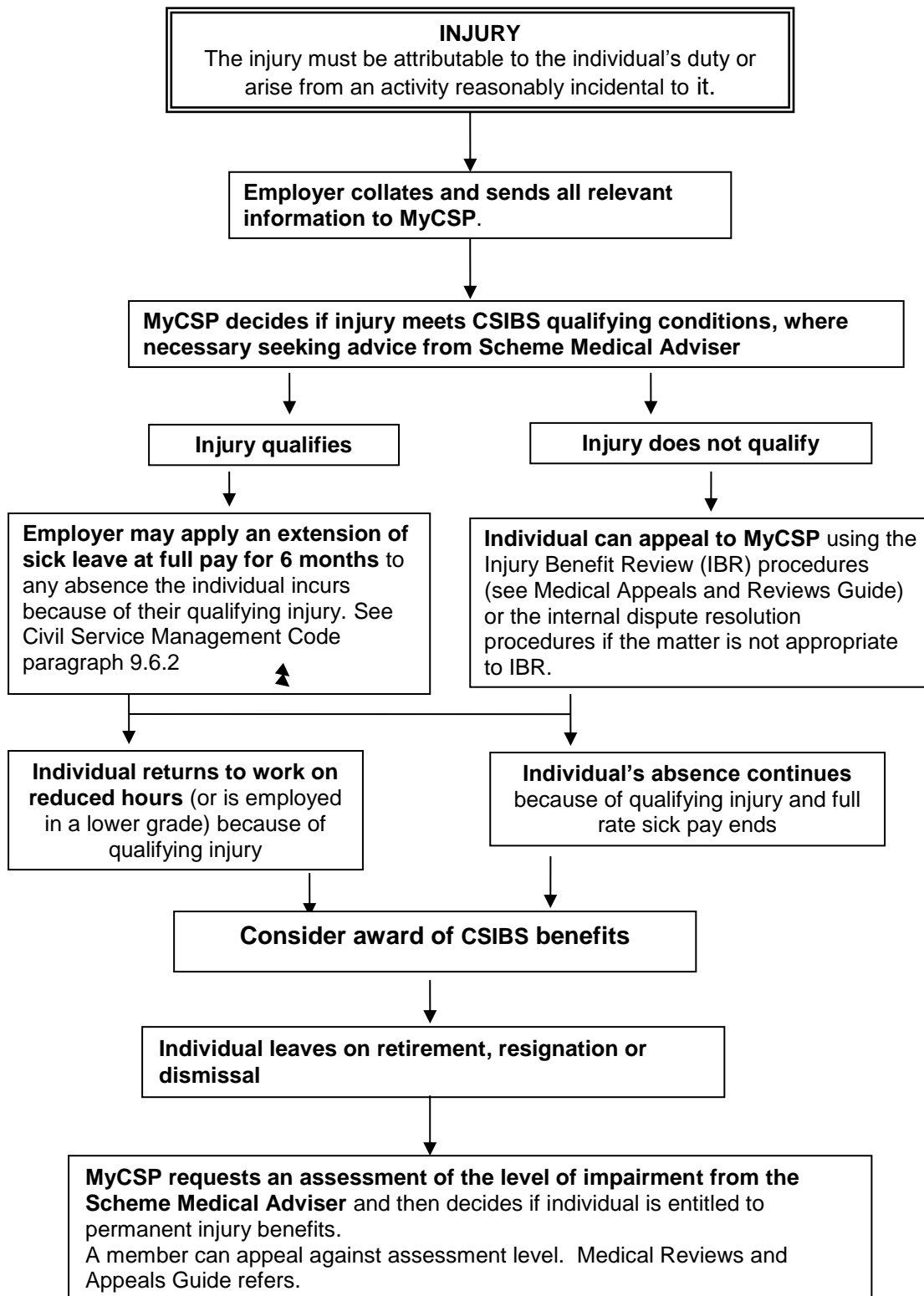
- Scheme rules:
  - Civil Service Injury Benefits Scheme
- Booklet for members:
  - Injury benefit scheme – A brief guide
- Guidance
  - Pensions Manual – Member's benefits section 5
  - Employer's pension guide section 5
  - Civil Service Management Code

These are all available on the Civil Service website:

[www.civilservicepensionscheme.org.uk/](http://www.civilservicepensionscheme.org.uk/)

The following chart outlines the process.

**CIVIL SERVICE INJURY BENEFIT SCHEME (CSIBS)  
PROCESS**



## Civil Service Injury Benefit Scheme

### Application for injury benefit assessment

#### P 2 – Employer to complete

| 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 or email [civilserviceadmin@healthmanltd.com](mailto:civilserviceadmin@healthmanltd.com)

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

PROTECT – STAFF

| Your Employee's Details                        |                                    |       |  |
|--|------------------------------------|-------|--|
| Name of employee                               | Title                              |       |  |
|  | Surname                            |       |  |
|  | Forename(s)                        |       |  |
| Male / Female (delete as appropriate)          | Date of birth                      |       |  |
| Job title                                      |                                    | Grade |  |
| Contracted hours                               | Employee / Staff number (optional) |       |  |
| Home address (including post code)             |                                    |       |  |
| Daytime telephone number                       |                                    |       |  |
| Alternative telephone number                   |                                    |       |  |
| Normal retirement age                          |                                    |       |  |
| For permanent awards only: Last day of service |                                    |       |  |
| Date of injury or date disease contracted      |                                    |       |  |
| Nature of injury or disease                    |                                    |       |  |

| Advice needed  | Please tick at least one box and make sure that you tick all the boxes that apply.  | Please tick<br><input checked="" type="checkbox"/> |          |  |
|--|---|--|----------|--|
| Whether there has been a qualifying injury   |   |  |          |  |
| Whether there is a causal link between the injury and the absence(s) from work between:  | <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;">First day</td> <td style="width: 50%; padding: 5px;">Last day</td> </tr> </table> | First day  | Last day |  |
| First day  | Last day  |  |          |  |
| <b>Please Note:</b> You must include a full list detailing multiple absences (refer to document list page)                         |   |  |          |  |
| Whether there is a casual link between the injury and change of grade or hours   |   |  |          |  |
| <b>Please Note:</b> You must include details of change to terms of employment in the job description (refer to document list page) |   |  |          |  |
| The level of apportionment (permanent awards)  |   |  |          |  |
| The level of impairment (permanent awards)   |   |  |          |  |

**PROTECT – STAFF**

I understand that the Scheme Medical Adviser provides advice to decision makers. They are not the awarding authority for injury benefit awards \*(See note)

I understand that it is for the applicant to make a reasonable case for an injury benefit award.

I understand that the Scheme Medical Adviser may need to examine this officer and/or obtain medical reports and they will charge for this.

I have completed all the sections in this form and enclose the information required.

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 within 10 days of receipt of a valid invoice by the employer.

Signed for and on behalf of the employer

|           |  |          |  |
|-----------|--|----------|--|
| Signature |  | Date     |  |
| Name      |  | Position |  |

**\*Please Note:** For more information please refer to Section 2 of the Employers' Pension Guide which describes the respective roles and responsibilities of employers and MyCSP in dealing with Injury Benefit



**PROTECT – STAFF**

- ① You must supply ALL information listed here. If you supply it in a separate document please label it with the number shown and write ‘see attached’ in the relevant box.  
 Do not send any personal files or other documents to the Scheme Medical Adviser. If we have to return the papers because items are missing or incomplete, we will identify the deficiencies so that you can correct the matter and resubmit the papers. We will make a charge for this each time we return an incomplete referral.

|  |   |  |
|--|---|--|
| Please confirm that you have attached documents 1-11 with this application form. Please put <b>X</b> against those that apply. |   |  |
| <b>1</b>   | Relevant accident reports and/or accident book entries. If no entry exists please say so and ensure that the date of the injury is clearly stated   |  |
| <b>2</b>   | Personal statement from applicant describing reasons for injury   |  |
| <b>3</b>   | Statement from employer accepting or disputing the applicant’s statement. This should explain the reasons for disputing any element of the personal statement and also details of any disciplinary/grievance procedure (and outcome)        |  |
| <b>4</b>   | Any witness statements (obtained by either or applicant)  |  |
| <b>5</b>   | Job description   |  |
| <b>6</b>   | Sickness absence details. Clearly identify the date the absence relevant to the injury started  |  |
| <b>7</b>   | Copies of any Scheme Medical Adviser correspondence relating to the case (or any earlier referral if relevant to the current case)  |  |
| <b>8</b>   | Medical in confidence envelope and any additional original medical evidence relating to injury  |  |
| <b>Permanent awards:</b>   |   |  |
| <b>9</b>   | Annual rate of basic pay on the date of injury including any regular pensionable allowances paid by the PCSPS employer. For those working part time through choice (i.e. <i>not</i> for medical reasons) use the full time equivalent rate. |  |
| <b>10</b>  | Education/past history  |  |
| <b>Medical Consent</b>   |   |  |
| <b>11</b>  | You must also enclose the medical consent form signed by the scheme member within the last 3 months   |  |
| If exceptionally you cannot provide any of the documents please explain why not  |   |  |

|   |  |
|---|--|
| <p><b>When you have collected together all of the information asked for, you should send it to MyCSP.</b></p> | <p><b>MyCSP<br/>                 PO BOX 2017<br/>                 Liverpool<br/>                 L69 2BU</b></p> |
|---|--|