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Application for an ill health retirement assessment

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Part 1 – Member to complete

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You should refer to the *'Ill Health Retirement – Guide for Members'*, when filling this in.

Your details

|                                                                 |                                                                    |                        |
|-----------------------------------------------------------------|--------------------------------------------------------------------|------------------------|
| Title                                                           | <input type="text"/>                                               |                        |
| Surname                                                         | <input type="text"/>                                               |                        |
| First name                                                      | <input type="text"/>                                               |                        |
| Date of birth (DD/MM/YYYY)                                      | <input type="text"/> – <input type="text"/> – <input type="text"/> |                        |
| Home address<br>(including postcode)                            | <input type="text"/><br><input type="text"/>                       |                        |
| Telephone numbers                                               | <input type="text"/><br><input type="text"/>                       | Daytime<br>Alternative |
| Email address (if you agree to<br>receive e-mail communication) | <input type="text"/>                                               |                        |

I am making an application for an ill health retirement assessment and HMRC severe ill-health assessment (see note below).

**If you meet the criteria for severe ill-health you will be exempt from any Annual Allowance tax charge, in relation to your Civil Service pension, in the year that you leave service on ill health grounds.**

**The Scheme Medical Adviser (SMA) may need to carry out a medical consultation as part of their assessment. They will contact you to arrange an appointment if they want you to attend a medical consultation.**

**If the SMA 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 SMA will provide an assessment on the basis of the information available to them.

**Please now provide the following information which will help the Scheme Medical Adviser consider your application:**

**Please describe the health problems preventing you from working in your current role. If you have been diagnosed with a condition please ensure this is also detailed in this section.**

**Please explain any barriers to you working in your usual job.**

**Do you believe that you could you do any other work?**

Yes

☐

No

☐

If you have answered 'yes', please say briefly what work you believe you could do in your current workplace, or any other job with any other employer.

Why do you believe that you will not be able to return to work before your scheme pension age?

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## Your consent

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I consent and understand that Health Management as the Scheme Medical Adviser (SMA) will process my application for ill health retirement and provide advice against the relevant Civil Service pension scheme criteria and, if appropriate, HMRC severe ill health criteria.

I also consent and understand that the Occupational Health Provider retained by my employer may see my referral in the circumstance of providing occupational health records or any such Medical In Confidence material that may be relevant to my case.

Please read the following statements and sign to signify your agreement.

I give my consent for Health Management to:

1. Maintain and process my medical records in compliance with data protection legislation.
2. Contact me to arrange appointments and manage my case.
3. Use the information submitted, including my occupational health records where relevant, and any further information obtained in relation to my application, for the purpose of this assessment and any future review and/or appeal.

Signature

Date

## Medical Consent Form 1

### 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 2 which explains what happens to the report that the Scheme Medical Adviser produces 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 **consent** to the Scheme Medical Adviser seeking further information about your medical condition, please put 'X' in the box and **sign and date** below to confirm your decision.

I Consent

☐

Signature

Date

 –  – 

If you have agreed to give consent above, you must now answer this question.

**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 'X' in the relevant box.**

Yes

☐

No

☐

If you have given the Scheme Medical Adviser consent 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 Form can be found at the end of this IHR1 – P1 form.

## Medical Consent Form 2

### 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 and whether you meet the criteria for severe ill health set by HMRC. 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.

**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 **consent** to the Scheme Medical Adviser seeking further information about your medical condition, please put 'X' in the box and **sign and date** below to confirm your decision.

I Consent

☐

Signature

Date

 –  – 

**We will send you a copy of the report at the same time it is sent to your employer unless you tell us you do not want to see it. Please mark one box only.**

If you do not want to see a copy of the report at all, please put **X** in the box.

☐

If you wish to receive a copy of the report before it is sent to your employer, please put **X** in the box. **Please note that your application may take longer.**

☐

If you want to receive a copy of the report at the same time it is sent to your employer, please put **X** in the box

☐

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 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.

I Consent

☐

Signature

Date

 –  –

**LEAVE BLANK**

(double-sided printing)

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## Medical Consent Form

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You must fill in a separate medical information consent form for each doctor.

**Please photocopy as required.**

You should include your GP and any relevant consultant/specialist currently providing care. You should also consider which consultant/specialist is best placed to write a report on your behalf.

Who are you giving consent for the Scheme Medical Adviser to approach for further information about your medical condition? Please put an **X** in the boxes below, as appropriate. **General Practitioner (GP)**

☐

**Other Hospital Specialist**

☐

**Consultant**

☐

**Due to the sensitive and confidential nature of the information provided,** please provide the name (not just the department) of the specialist to prevent compromising the handling of your personal information.

Please confirm which consultant/specialist is best placed to provide advice.

**Please note that the Scheme Medical Adviser will take this into account when requesting additional medical reports, they will however not be bound by this.**

On the next page, please provide details of the doctors that the Scheme Medical Adviser can approach. A separate form will need to be completed for each one.

|                                                                       |                      |
|-----------------------------------------------------------------------|----------------------|
| <b>Name of doctor/specialist/consultant</b>                           | <input type="text"/> |
| <b>Specialism</b> (if this is your hospital specialist or consultant) | <input type="text"/> |



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>Address</b><br>(including postcode ) | <input type="text"/><br><input type="text"/> |
| <b>Email Address</b>                    | <input type="text"/>                         |
| <b>Telephone number</b>                 | <input type="text"/>                         |

|                                                                       |                      |
|-----------------------------------------------------------------------|----------------------|
| <b>Name of doctor/specialist/consultant</b>                           | <input type="text"/> |
| <b>Specialism</b> (if this is your hospital specialist or consultant) | <input type="text"/> |



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>Address</b><br>(including postcode ) | <input type="text"/><br><input type="text"/> |
| <b>Email Address</b>                    | <input type="text"/>                         |
| <b>Telephone number</b>                 | <input type="text"/>                         |



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## **Declaration**

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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 is asking the Scheme Medical Adviser to consider whether or not I satisfy the criteria for ill health retirement. They will also consider whether or not I satisfy the criteria for HMRC severe ill health, in relation to the Annual Allowance.

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 2 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> | <input type="text"/>                                               |
| <b>Date</b>      | <input type="text"/> - <input type="text"/> - <input type="text"/> |

## Form for your doctor or specialist to complete



Members can use this section if they want to ask their doctor or specialist to provide medical detail to support their application. You do not have to get this section completed but it may speed up your application if you do. Please note that your doctor may charge you a fee for completing this form for which you are responsible. Any supporting documents can be provided in a sealed document marked with your name and date of birth.

### Member details

|                                                  |                                                                                                                                                                             |
|--------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Title                                            | <input type="text"/>                                                                                                                                                        |
| Surname                                          | <input type="text"/>                                                                                                                                                        |
| First name                                       | <input type="text"/>                                                                                                                                                        |
| Date of birth(DD/MM/YYYY)                        | <input type="text"/> <input type="text"/> – <input type="text"/> <input type="text"/> – <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| Date of most recent consultation<br>(DD/MM/YYYY) | <input type="text"/> <input type="text"/> – <input type="text"/> <input type="text"/> – <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |

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### Medical information for the member's doctor or specialist to provide

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See the notes at the end of the form for further guidance.

#### 1. Is the member currently certified as, or regarded as unfit for work?

2. Please outline all active medical problems including diagnosis, treatment received to date, the extent of any disability caused by the condition, the proposed plan of management and the likely prognosis.

3. Is further treatment likely to result in significant functional improvement? If so, please indicate the likely timescale over which such improvement may be seen and the maximum improvement that can reasonably be expected.

4. Is the member's life expectancy likely to be less than 12 months?

Yes ☐ No ☐

- If so, is the member aware of this?

Yes ☐ No ☐

5. Any other relevant information.

6. Please include copies of any relevant correspondence from any specialists who have recently provided care for the member.

Copies of specialist correspondence attached?

Yes ☐ No ☐

7. 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.

|                             |                                                                                 |
|-----------------------------|---------------------------------------------------------------------------------|
| Signature                   | <div></div>                                                                     |
| Date                        | <div><div></div><div>-</div><div></div><div>-</div><div></div><div></div></div> |
| Position and qualifications | <div></div>                                                                     |

Notes for the applicant’s doctor or 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.

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## Part 2 – Employer to complete

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You should refer to the IHR *'notes for the employer'* when filling this in.

### Your details

|                                                  |                                              |
|--------------------------------------------------|----------------------------------------------|
| <b>Name of employer</b>                          | <input type="text"/>                         |
| <b>Employer contacts name</b>                    | <input type="text"/>                         |
| <b>Employers address</b><br>(including postcode) | <input type="text"/><br><input type="text"/> |
| <b>Telephone number</b>                          | <input type="text"/>                         |
| <b>Fax number</b>                                | <input type="text"/>                         |
| <b>Email address</b>                             | <input type="text"/>                         |

If you have not used this service before and require assistance please contact the Scheme Medical Adviser at [pensions.t2@medigold-health.com](mailto:pensions.t2@medigold-health.com)

|                              |                      |
|------------------------------|----------------------|
| <b>Purchase order number</b> | <input type="text"/> |
|------------------------------|----------------------|

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

|                            |                                                                                                                                                                                                                                                                                               |                      |                      |                      |                      |                      |                      |                      |                      |                      |
|----------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| <b>Identifier</b>          | <input type="text"/>                                                                                                                                                                                                                                                                          |                      |                      |                      |                      |                      |                      |                      |                      |                      |
| <b>NI number of member</b> | <table><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr></table> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/>       | <input type="text"/>                                                                                                                                                                                                                                                                          | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |                      |                      |

### Your employee's details

|                                                                            |                                                                                                                                                                         |                                 |                             |
|----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|-----------------------------|
| Has your employee taken partial retirement:                                |                                                                                                                                                                         | Yes <input type="checkbox"/>    | No <input type="checkbox"/> |
| Title                                                                      | <input type="text"/>                                                                                                                                                    |                                 |                             |
| Surname                                                                    | <input type="text"/>                                                                                                                                                    |                                 |                             |
| First name                                                                 | <input type="text"/>                                                                                                                                                    |                                 |                             |
| Gender                                                                     | Male <input type="checkbox"/>                                                                                                                                           | Female <input type="checkbox"/> |                             |
| Job Title                                                                  | <input type="text"/>                                                                                                                                                    |                                 |                             |
| Grade                                                                      | <input type="text"/>                                                                                                                                                    |                                 |                             |
| Employee/Staff number (optional)                                           | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |                                 |                             |
| Contracted hours                                                           | <input type="text"/>                                                                                                                                                    |                                 |                             |
| Is your employee terminally ill with less than 12 months' life expectancy? | Yes <input type="checkbox"/>                                                                                                                                            | No <input type="checkbox"/>     |                             |

In the above circumstances the IHR application will be treated as urgent and the Scheme Medical Adviser should be able to provide an outcome decision quickly subject to the necessary medical.

|                                                                                                                |                              |                             |
|----------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|
| Is this a retrospective IHR application? If yes, please attach Cabinet Office approval                         | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If yes, please provide the last day of service and the scheme they were a member of on the Last day of service |                              |                             |

If your employee has left or been dismissed, you must apply for authorisation from the Scheme Manager, (Cabinet Office) before referring such a case to the Scheme Medical Adviser. You can contact them directly by e-mailing [CSPSEmployerenquiries@cabinetoffice.gov.uk](mailto:CSPSEmployerenquiries@cabinetoffice.gov.uk)

The Scheme Medical Adviser will not be able to consider any application for retrospective IHR without such authorisation.

See the 'Ill Health Retirement – Procedural Guidance for Employers' for more information. If this is a retrospective application, attach the authorisation here. **The application will not be considered unless the approval is attached.**



It is important that we know the employee's pension scheme retirement age and also their state pension age. Please make sure that the information you provide is correct. Please note that the state pension age could differ from the scheme pension age.

You can find the state pension age by visiting the GOV.UK website: [www.gov.uk/state-pension-age](https://www.gov.uk/state-pension-age)

**All members will be assessed under the alpha or partnership scheme- with a scheme pension age the lower of age 65 or State Pension Age- unless the application is retrospective and/or you indicate otherwise and include a covering letter to explain why.**

| Scheme                                                                                        | Retirement Age       | Please select the relevant scheme |
|-----------------------------------------------------------------------------------------------|----------------------|-----------------------------------|
| <b>alpha</b> – with a scheme pension age the later of age 65, or your State Pension age       | <input type="text"/> | <input type="text"/>              |
| <b>Partnership</b> - with a scheme pension age the later of age 65, or your State Pension age | <input type="text"/> | <input type="text"/>              |

Some scheme members have a pension age that is different to the usual scheme pension age, for example, prison officers who are 'pre-fresh start'. If this applies to the member, please include a cover letter to include the pension age and explain why.

There are other qualifying conditions for IHR such as length of service and age. You must check that your employee meets these before applying for IHR. See the IHR1 – P2 'notes for the employer' more information.

Please refer to the Ill Health Retirement Procedural Guide for Employers for further information.



It is important that we know the employee's scheme pension age, which is required for conducting the HMRC severe ill health assessment. Please make sure that the information you provide is correct. Please note that the state pension age could differ from the scheme pension age.

You can find the state pension age by visiting the GOV.UK website: [www.gov.uk/state-pension-age](https://www.gov.uk/state-pension-age)



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.

**1. What consideration has been given to job modification and redeployment?**

Can these adjustments be maintained long term?

Yes

☐

No

☐

**2. What job is this employee expected to do? A full description of the job activities is needed.  
See the IHR1 & IHR2 'notes for the employer' for more information.**

**3. Is the member currently attending work?**

Yes

☐

No

☐

**4. Is the member currently providing regular and efficient service?**

Yes

☐

No

☐



**5. Please list details of sick absences during the last 5 years.**

| From | To | Incapacity |
|------|----|------------|
|      |    |            |
|      |    |            |
|      |    |            |
|      |    |            |
|      |    |            |
|      |    |            |

Please confirm that you have attached documents A & B and, if applicable, C and/or D with this application form. Please put **X** against those that apply.

**A** IHR1 P1 and P2 – completed by the member and employer

☐

**B** Reports to management from your occupational health provider and any reports from the member's doctor that have been obtained by the occupational health provider. In general, all documents less than 12 months old will be sufficient unless the occupational health provider is of the view that older documents contain relevant information and will add to the Scheme Medical Adviser's understanding of the medical condition(s).

☐

**C** Copies of any previous correspondence on this case from the Scheme Medical Adviser, if applicable

☐

**D** Any additional medical evidence that may have been submitted by the member, if applicable

☐

If exceptionally you cannot provide any of the documents please explain why not:

Declaration

I confirm that I have verified the identity of the member as signed, therefore consent is granted for the purposes of processing this application and in requesting, receiving and reviewing third party medical reports as deemed necessary by the Scheme Medical Adviser in undertaking their role. The employer requests that the Scheme Medical Adviser shall provide medical advice services in accordance with the terms of this order form. I can confirm that I have checked that the member satisfies the qualifying conditions of the scheme. 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 | <div></div>                                                                     |
| Date      | <div><div></div><div>-</div><div></div><div>-</div><div></div><div></div></div> |
| Position  | <div></div>                                                                     |

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:

Health Management  
C/O CSPS  
Medigold House  
Queensbridge Northampton  
NN4 7BF

Email [pensions.t2@medigold-health.com](mailto:pensions.t2@medigold-health.com)