

Retirement Form – HR107 (a) v1.3

Purpose: This form is to be used when you are retiring from the HSE and making application for payment of Pension Benefits. It is to be initiated by the employee. It is important that you complete this form correctly and forward it to your line manager.

To Be Completed by Employee

Title	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss <input type="checkbox"/> Prof. <input type="checkbox"/> Dr. <input type="checkbox"/> Rev. <input type="checkbox"/> Fr. <input type="checkbox"/> Sr. Please (✓) Tick one																	
First Name:									Surname:									
Pension Start Date									Personnel Number									
Date Of Birth									PPS No.									
Gender									Male	<input type="checkbox"/>				Female	<input type="checkbox"/>			
Contract									Officer	<input type="checkbox"/>				Non Officer	<input type="checkbox"/>			
Former Health Board/ Area Name																		
Service Area / Hospital Name																		
Employed as / Grade																		

Reason for Retirement

Reached Minimum Retirement Age	<input type="checkbox"/>	Reached Compulsory Retirement Age	<input type="checkbox"/>
Permanent Infirmary	<input type="checkbox"/>	Job Sharing Retirement Initiative	<input type="checkbox"/>
Cost Neutral Early Retirement	<input type="checkbox"/>	Early Retirement Scheme Nurses	<input type="checkbox"/>

Correspondence Address (for receipt of written communications from the HSE & for using HSE Self-Service)

Street Address:		
Town/City		
County	Postcode	Country
Phone No (Landline):	Mobile Phone No:	
Personal Email Address:		

Bank Details (confirm details of account you wish your benefits to be paid to)

Bank Name													Bank Branch												
IBAN No:																									
BIC																									
													Name of Account.												

Please contact bank branch or review bank statements to obtain the above information. Failure to provide completed correct information may delay payment of your benefits.

Name _____ Personnel No. _____

Additional Personal Details

Marital Status ☐ Single ☐ Married ☐ Registered Civil Partnership ☐ Divorced ☐ Separated ☐ Widowed ☐ Other

If Other please Specify:

If you are widowed/divorced please provide death certificate/decre absolute.

Please specify Birth Name (Maiden Name) if applicable:

Spouses Name:	Date of Marriage/Registered Civil Partnership								
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Dependent Children Details

Children (including adopted children) under age 22 and any Incapacitated/Child Dependents over 22 years of age

Children's Names	Date of Birth							

Third Party Payroll Deductions

The following deductions will be facilitated by the HSE National Pensions Payments office and deductions will be arranged by the HSE National Pensions Payments office accordingly. Please tick any deductions you currently have through your salary which you would like to continue from your pension.

VHI	
Hospital Saturday Fund	
New Ireland Assurance	
Irish Life Assurance	

The following deductions can be taken from your pension however you are required to contact the relevant companies directly once you receive your first pension payment quoting your new pension/personnel number from your pension payslip.

AXA insurance	Please call 1890 600 600
Health Service Staff Credit Union	Please call 1890 677 864
Laya Healthcare(New Group Number 24508)	Please call 1890 700 890
Aviva Heathcare	Please call Hennelly Finance 091-586500

The above third party companies are the only deductions which may be facilitated through your pension by HSE National Pensions Management. If you have a deduction currently taken from your payslip, which is not listed and you wish to continue paying after retirement please contact the appropriate organisation/company directly.

Name _____ Personnel No. _____

Employee Declaration

I declare that the above information is accurate and correct on the date indicated below. I undertake to notify the relevant authority of any changes to this information by completing the appropriate form.

Signature	Date								
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To be completed by Line manager

Name (please Print):

Signature:	Date:								
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Grade:	
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Contact Tel No:	E-mail Address:
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Decision Number (If Applicable):

To be completed by General Manager/ Assistant National Director of HR

Name (please Print):

Signature:	Date:								
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Grade:	
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Contact Tel No:	E-mail Address:
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Name _____

Personnel No. _____



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Section 51 Pension Benefits Declaration

**Declaration under Section 51 (Duty to make declarations etc.) of the Public Service Pensions
(Single Scheme and Other Provisions) Act 2012.**

**To be completed by persons applying for a Public Service Pension
Benefit.**

Please note that your retirement benefits cannot be finalised and paid until a completed Declaration Form has been received

Please indicate if any of the following apply (*Specify Yes or No*)

**1) Are you in receipt of any Retirement Benefit(s) or any Preserved Pension / Lump Sum
from any Irish Public Service Pension Scheme?**

☐

**2) Are you entitled to receive any Retirement Benefit(s) or any Preserved Pension / Lump Sum from
any Irish Public Service Pension Scheme?**

☐

If you have answered Yes to either (1) and/or (2) above, please complete details hereunder and furnish a copy of any supporting documentation which you have received from any previous Irish Public Service employers.

Irish Public Service Pension Benefit in Payment / Preserved Irish Public Service Pension Benefit Entitlement other than the HSE benefit to which this HR107 application relates	
Description (Benefit Type) e.g. Current/Preserved Occupational Pension and/or Retirement Lump Sum	
Annual Gross Pension Value	
Annual Preserved Pension Value	
Paying Authority	

3) Are you in receipt of remuneration (earnings) from any other Irish Public Service Body apart from the HSE?

☐

If you have answered Yes to (3) above, please complete details hereunder and furnish a copy of your contract of employment with the relevant Irish Public Service Body.

Remuneration (Earnings)	
Description (Contract Type)	
Annual Gross Pay (Earnings)	
Paying Authority (Per payslip)	

I hereby declare that the information which I have provided above is complete and accurate.

Signed _____

Name _____

PPS No:*

Date _____

*If you have more than one PPS Number, please provide all of your PPS Numbers.

(Block Capitals)

Name _____

Personnel No. _____



Pensions Declaration Ref PD1

AS PROVIDED FOR UNDER SECTION 787R (4) OF THE TAXES CONSOLIDATION ACT 1997 (FOR

THE PURPOSES OF DISCLOSING BENEFIT CRYSTALLISATION EVENTS OCCURRING PRIOR TO THE CIVIL SERVICE OR PUBLIC SERVICE PENSION ENTITLEMENT CURRENTLY BEING CLAIMED)

1. Did you become entitled, on or after 7th December 2005, to any pension, annuity, lump sum or any other pension related benefit, other than your pension entitlements under your Public Service Pension Scheme currently being claimed? (Please Tick as appropriate)	YES	NO
2. Did you direct that a payment or transfer be made to an overseas pension arrangement?	YES	No
3. Prior to, or on the date of your retirement from the Public Health Service or the date of commencement of pension payment, do you expect to become entitled to any pension, lump sum or any other pension related benefit (other than the benefits arising from this Public Health Service Pension Scheme)?	YES	NO
4. Do you intend to direct that a payment or transfer be made to an overseas pension arrangement?	YES	NO
5. If you have answered YES to any of the above questions, please (a) Input in ascending order the sequence in which payment of benefit in respect of each pension arrangement will occur for all Pension Benefit Arrangements AND (b) Complete the attached Form PD 1(a) (noting that a separate PD1(a) form must be completed for each separate Pension Benefit		

Type of Pension Arrangement	Payment Sequence	Type of Pension Arrangement	Payment Sequence
HSE Occupational Pension Scheme			
Defined Benefit			
Defined Contribution			
AVC for purposes of supplementing retirement benefits			

6. Do you have a certificate from the Revenue Commissioners stating the amount of your Personal Fund Threshold (PFT) in accordance with section 787P of the Taxes Consolidation Act 1997? If 'Yes', please enclose a copy of the Certificate issued by the Revenue Commissioners

YES

NO

Employee Declaration

I declare that the information provided by me in this form is complete and correct and hereby personally accept any tax liability that may arise due to my non-declaration/incorrect declaration of any pension benefits on this form.

Full Name (Block Capitals):

PPSN:

Address:

Signature:

Date:

Name _____ Personnel No. _____

Full Name:

(Block Capitals)

PPS No:

Address:

Signature:

Date:

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