Social Security Department
Centre for work, pensions and benefits
P.O. Box 55, La Motte Street
St. Helier, Jersey, JE4 8PE
Tel: +44 (0)1534 445505
Fax: +44 (0)1534 447447

INCOME SUPPORT

APPLICATION FOR PAYMENT TO AN AGENT OR AUTHORITY

Claimant's Social Security Number:

Claim Number:

Claimant's Full name:_____

Claimant's Address: _____

1. APPLICATION FOR PAYMENT TO AN AGENT

Agent's Social Security Number:

Agent's Telephone Number:

Agent's Full name:_____

Agent's Address: _____

If you would like payment to be made to a different bank account, please complete the following:

Sort Code:

Account Number:

Account in the name of: _____

Bank & Branch Name: _____

I authorise the person named above to receive on my behalf any payment of Benefit now due, or which may become due to me during my present claim. My agent who has signed below (*in my presence) is my _____.(State relationship, if any.)

Claimant's Signature (if possible): _____Date: _____

Daytime Telephone No.: _____

Agent's Signature: _____ Date: _____

2. DECLARATION TO BE COMPLETED IF CLAIMANT IS UNABLE TO SIGN AND THE CLAIMANT AND AGENT ARE LIVING AT THE SAME ADDRESS

I declare that the claimant named above is unable to be interviewed or to sign any documents. I undertake to accept and to administer on behalf of the claimant any Social Security benefit payable during the current claim.

Agent's signature: _____Date: _____

3. TO BE COMPLETED BY A DOCTOR IF CLAIMANT IS UNABLE TO SIGN AND CLAIMANT AND AGENT ARE NOT LIVING AT THE SAME ADDRESS

I, being the doctor in attendance, confirm that the above-named claimant is unable to provide a signature.

Doctor's name: _____ Doctor's signature: _____

Date: _____ Telephone No.: _____

4. APPLICATION FOR PAYMENT OF BENEFIT TO BE MADE TO AN AUTHORITY

I authorise the Social Security Department to pay the whole of my Benefit direct to: (name and address of Authority)

_____,
until such time as my Benefit stops or this authority is cancelled by me in writing. I realise that I am under no obligation to give this authority and confirm that it is given of my own free will.

Claimant's Signature: _____Date: _____

Witness to Signature: _____Date: _____

Name of Witness: _____(in block capitals)

Occupation of Witness: _____

Address of Witness: _____

This form must be submitted to the Social Security Department before payment can be made to an appointed agent or Authority. Appointment of an agent may be cancelled at any time by the claimant in writing. Payment to an Authority may be cancelled **by the relevant Authority only**. Unless we are advised otherwise, these details remain valid for the duration of the current claim.

Privacy Statement

The Social Security Department collects information for the purpose of dealing with all matters relating to the benefits and services it administers. We may check information about you with other information we have.

We will not give information about you to anyone outside the Department unless the law allows us to or we have your consent.

The Social Security Department is the Data Controller for the purposes of the Data Protection (Jersey) Law 2005.