



## APPLICATION TO BECOME A PAYEE

If a member of the Scheme is no longer able to manage their own affairs the Trustees may approve the appointment of someone to receive pension payments and communications on the member's behalf.

Please complete Sections 1 and 2 below and provide one of the following items of supporting evidence:

- **Written confirmation from the Department of Work & Pensions (DWP) that the proposed Personal Representative is authorised to receive State Benefits on behalf of the member, or,**
- **A copy of Court of Protection confirmation, or,**
- **A copy of Lasting Power of Attorney documentation.**

If none of the required supporting evidence has been obtained, please ask the member's doctor to complete Section 3. Send the completed form to the Scheme Administrator who will contact the Trustees to consider the application on your behalf.

Please complete Section 1 and Section 2 in BLOCK CAPITALS with the supporting evidence and return to:  
**MPS, Hartshead House, 2 Cutlers Gate, Sheffield, S4 7TL**

### Section 1: Member details & declaration

*(This section must be completed & signed by the Member or Appointed Personal Representative or Power of Attorney)*

**Full name**

**Pension reference number**

**National Insurance number**

**Address**

  
  

**Postcode**

**Telephone/mobile number**

I request the Scheme Administrator to make the changes requested by me, or on my behalf, as set out below.

**Declaration Signed by:**

**Member**

Signature:

**Date**



## Section 2: Details of the person to be appointed

*(This section must be completed & signed by the person to be appointed)*

*Please note that communications will in future be addressed to the member, 'care of' the person and address shown in the box below:*

<b>Full name</b>	
<b>Date of birth</b>	
<b>Relationship to the member</b>	
<b>Address</b>	
<b>Postcode</b>	
<b>Email address</b>	
<b>Telephone/mobile number(s)</b>	

### Reason for the application.

Please explain why the member can no longer manage their own affairs, including brief details of any disability and/or medical condition. If none of the supporting evidence detailed above can be supplied, the member's doctor should complete Section 3 below.

### Important note: please read carefully before completing your bank account details

*Your MPS pension payments will be made using the bank sort code/building society roll number and account number you have provided.*

*The Scheme is unable to verify that you have provided correct bank/building society account details.*

*If you provide incorrect details and as a result your MPS benefits are paid to the wrong account and someone else withdraws your payment, the Scheme will not provide a replacement payment to you to make up for your loss and is not responsible for the recovery of the incorrect payment. Please check that the information you have provided is correct.*

### BANK DETAILS:

Do you want to change the bank account we usually pay the member's pension into?

*Please tick the appropriate box.*

YES

NO

If YES, please provide details of the new bank:

**Names of all account holders**

**Is this a joint account with the member?**

*Please tick the appropriate box.*

YES

NO

**Name of bank**

**Account number**

**Sort code (6 digits)**

*Please note we cannot pay pensions into DWP benefit accounts or National Savings Bank accounts.*



### Declaration

I hereby request that the benefits payable from the Scheme are paid to me and I promise to use the payments in the best interests of the member at all times. I have enclosed the appropriate evidence, or have had Section 3 completed by the member's/pensioner's doctor.

I confirm no other person has been legally appointed to administer the member's affairs.

I will advise the Scheme Administrator if the member's personal circumstances change.

I am responsible for notifying the Scheme Administrator of the member's death and understand that I will be responsible for repayment of any overpayment of pension that may arise through late notification.

**Declaration Signed by:**

**Agent**

Signature:

**Date**

### Section 3: Medical information & declaration

*(This section must be completed and signed by the member's doctor)*

*Only complete this section if none of the supporting evidence referred to in Section 1 is unavailable.*

**Doctor's Name**

**Name of Practice**

**Address**

**Postcode**

I confirm the member is my patient.

I confirm that member/pensioner named in Section 1 is incapable of managing their own affairs.

**Declaration Signed by:**

**Doctor**

Signature:

**Date**

If you call the helpline please have the member's pension reference number or NI number to hand for identification and security purposes.

*This Form will be scanned and held electronically and securely by the Scheme's Administrator under the terms of the Data Protection Act 1998 ("the Act") and will only be made available to persons entitled under the Act to view it.*

**Contact the Scheme Administrator:**

Telephone: **0333 222 0077**

Email: **mps@capita.co.uk**