

Please use **BLOCK CAPITALS** to fill in this form.

For this application to be deemed complete by the Injuries Resolution Board it must include the following:

- All mandatory fields marked with an \* must be completed
- Claimant Declaration as set out in Section 12 must be signed by the claimant
- Please include a copy of the death certificate. If the death certificate is not available, please enclose the interim death certificate.
- Payment of the Injuries Resolution Board processing fee of €45

## Section 1: Claimant Details

Please tick the appropriate box to advise in what capacity you are making the application:

Personal representative     Dependant     Committee     Next friend

\*Name:†

\*Home Address:

  

Eircode:

\*Mobile Number:

Landline Number:

Don't have a contact phone number:

Email Address:

Gender:

Male

Female

\*Date of Birth:

\*PPS Number:\*\*

† This should be consistent with Personal Public Service Number (PPSN) record.

\*\* In cases where a PPSN has never been issued to you, other forms of identification will be accepted. These include a valid Driving Licence, a valid Passport and a valid National Identity Card.

## Section 2: Details of the Deceased person

\*Name:†

\*Home Address:

Eircode:

Gender:

Male

Female

\*Date of Birth:

\*PPS Number:\*\*

Occupation:

Marital Status:

Married

Single

Separated

Divorced

Cohabitant

Number of Children:

Ages of Children:

Other dependents, (please list):

  
  
  
  
  
  

Annual Salary

† This should be consistent with Personal Public Service Number (PPSN) record.

\*\* in cases where a PPSN has never been issued to the deceased, other forms of identification will be accepted. These include a valid Driving Licence, a valid Passport and a valid National Identity Card.

## Section 3: Claimants Solicitor Details (if applicable):

Firm Name:

Contact Name:

Solicitor  
Reference  
Number:

Postal Address:

  

Eircode:

DX Address:

Contact  
Number:

Email Address for  
correspondence:

## Section 4: Accident/Incident Details

\*Please confirm the nature of your claim from the options below:

1. Motor Liability – proceed to Section 5       2. Public Liability – proceed to Section 6       3. Employer Liability – proceed to Section 6

## Section 5: Motor Liability Questions – If claim is not relating to a motor accident/incident, please go to Section 6 of this form.

\*How was the deceased involved in the accident/incident?

- |   |  |
|---|--|
| <input type="checkbox"/> Pedestrian                               | <input type="checkbox"/> Cyclist   |
| <input type="checkbox"/> Driving a car, pick up truck or van      | <input type="checkbox"/> Driving a bus or heavy transport vehicle (lorry)      |
| <input type="checkbox"/> Riding an electric bike or scooter       | <input type="checkbox"/> Driving a motorcycle                                  |
| <input type="checkbox"/> Passenger in a car, pick up truck or van | <input type="checkbox"/> Passenger in a bus or heavy transport vehicle (lorry) |
| <input type="checkbox"/> Passenger on a motorcycle                |  |

Other (please specify)

**\*Please detail how the accident/incident happened:**

Injured in collision with car, pick up truck or van

Injured in collision with heavy transport vehicle or bus

Injured in collision with a motorcycle

Injured in collision with a pedestrian or animal

Injured in collision with fixed or stationary object

Injured in collision with railway train/railway vehicle

Injured in collision with an electric bicycle or scooter

Injured in a non-collision accident (where braking or swerving were involved)

Other (please specify)

  
  

**\*Date of accident/incident:** DD/MM/YYYY

 /  / 

**\*Date of death:** DD/MM/YYYY

 /  / 

**\*Time of accident/incident:**

00:00-06:00

06:00-10:00

10:00-12:00

12:00-16:00

16:00-19:00

19:00-23:59

Was the deceased hospitalised as a result of this accident/incident?

Yes

No

If yes, please provide the hospital name and date the deceased was hospitalised:

 /  /

**What was the purpose of the deceased's journey or activity at the time of accident/incident?**

- |  |  |
|--|--|
| <input type="checkbox"/> Driving to or from work                                 | <input type="checkbox"/> Sport or Exercise                                   |
| <input type="checkbox"/> Recreation/Hobby/Leisure                                | <input type="checkbox"/> Working in Agriculture/Forestry/Fishing             |
| <input type="checkbox"/> Working in Manufacturing                                | <input type="checkbox"/> Working in Construction                             |
| <input type="checkbox"/> Working in Wholesale/Retail                             | <input type="checkbox"/> Working in Transport/Storage                        |
| <input type="checkbox"/> Working in Government administration, or Defence Forces | <input type="checkbox"/> Working in Health Services                          |
| <input type="checkbox"/> Working in finance/insurance/education                  | <input type="checkbox"/> Working in childcare/hospitality/cultural/religious |
| <input type="checkbox"/> Working in property/business/energy supply              |  |

Other (please specify)

**\*Please briefly outline how the accident/incident happened here:**

---

---

---

---

---

**\*Please detail the location type and address of where the accident/incident occurred.**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Road/Motorway                 | <input type="checkbox"/> Footpath                | <input type="checkbox"/> Cycleway                |
| <input type="checkbox"/> Car park                      | <input type="checkbox"/> Garage/Service Station  | <input type="checkbox"/> Driveway to home        |
| <input type="checkbox"/> Industrial/Construction area  | <input type="checkbox"/> Factory/Warehouse       | <input type="checkbox"/> Farm                    |
| <input type="checkbox"/> Public property/premises      | <input type="checkbox"/> Pub/Restaurant/Hotel    | <input type="checkbox"/> Retail premises         |
| <input type="checkbox"/> School/College                | <input type="checkbox"/> Sports/Leisure Facility | <input type="checkbox"/> Residential institution |
| <input type="checkbox"/> Hospital/Health Care Facility |  |  |

Other (please specify)

\*Town/City

\*County

\*Country

**\*Please provide additional details regarding the accident/incident location:**

  
  
  
  

## Section 6: Public Liability or Employer Liability Questions

**\*Please detail the cause of the accident/incident:**

Trip/slip/fall

Accident involving power tools/household machinery

Laceration from a sharp object

Struck by falling object

Fall from a height

Assault

Accident involving agricultural machinery

Electrocution

Crush injury

Food poisoning

Dog bite/attack

Other (please specify)

**\*Date of accident/incident or date range if over a period time:**

/  /  to  /  /

**\*Date of death:**  
DD/MM/YYYY

/  /

**\*Time of Accident:**

00:00-06:00

06:00-10:00

10:00-12:00

In the event there is a date range selected, the time is not applicable.

12:00-16:00

16:00-19:00

19:00-23:59

**What activity was the deceased doing at the time of the accident/incident?**

Sport or Exercise

Recreation/Hobby/Leisure

Resting/Sleeping/Eating

Studying/Voluntary Work/Housework/DIY

Working in Agriculture/Forestry/Fishing

Working in Manufacturing

Working in Construction

Working in Wholesale/Retail

Working in Transport/Storage

Working in Government administration, or Defence Forces

Working in Health Services

Working in finance/insurance/education

Working in childcare/hospitality/cultural/religious

Working in property/business/energy supply

Other (please specify)

**Please briefly outline how the accident/incident happened:**

---

---

---

---

---

---

---

---

---

---

**\*Please detail the location type and address of where the accident/incident occurred.**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Road/Motorway                 | <input type="checkbox"/> Footpath                     | <input type="checkbox"/> Cycleway                 |
| <input type="checkbox"/> Car park                      | <input type="checkbox"/> Garage/Service Station       | <input type="checkbox"/> Driveway to home         |
| <input type="checkbox"/> Home                          | <input type="checkbox"/> Industrial/Construction area | <input type="checkbox"/> Factory/Warehouse        |
| <input type="checkbox"/> Farm                          | <input type="checkbox"/> Office                       | <input type="checkbox"/> Public property/premises |
| <input type="checkbox"/> Pub/Restaurant/Hotel          | <input type="checkbox"/> Retail premises              | <input type="checkbox"/> School/College           |
| <input type="checkbox"/> Sports/Leisure Facility       | <input type="checkbox"/> Sports Ground                | <input type="checkbox"/> Residential institution  |
| <input type="checkbox"/> Hospital/Health Care Facility | <input type="checkbox"/> Airport or transport station |   |

Other (please specify)

\*Town/City

\*County

\*Country

**\*Please provide additional details regarding the accident/incident location:**

## Section 7: Expenses Incurred

Will you be claiming for loss or expenses incurred?

Yes

No

Undecided

Is there a claim for financial dependency?

Yes

No

Undecided

Details of special damages claimed must be provided to PIAB in advance of its assessment. Invoices and receipts should be retained as these will be required in support of the claim.

## Section 8: Respondent Details

We have included fields for two Respondents but if there are more than that, please provide their details on an additional sheet and attach to this application.

### Respondent 1

\*Name:

\*Address:

  
  
  

Respondent  
Eircode

Respondent's  
Insurance  
Company:

Respondent's  
Insurance  
Company  
Address:

  

If this is a motor claim, please provide the following if known:

Respondent Insurance  
Claim/Policy Number:

Respondents Vehicle  
Registration Number:

Vehicle make:

Vehicle model:

## Respondent 2

\*Name:

\*Address:

  
  
  


Respondent Eircode

Respondent's Insurance Company:

Respondent's Insurance Company Address:

  


If this is a motor claim, please provide the following if known:

Respondent Insurance Claim/Policy Number:

Respondents Vehicle Registration Number:

Vehicle make:

Vehicle model:

## Section 9: Additional Details

Please attach to this application any other document(s) or submissions that you consider relevant to your claim.

	Title of Document	Document Description
1		
2		
3		
4		
5		
6		

## \*Section 10: Claimant Declaration

I confirm that the information provided with this application is true and accurate.

I understand that in accordance with section 80A of the Act it is a criminal offence to knowingly or recklessly provide false or inaccurate information to the Board and I confirm that I have reviewed this application and the documents submitted with it in full.

I further acknowledge that I have a continuing obligation to ensure that all information provided to the Board on my behalf is true and accurate.

Print Name:

Claimant  
Signature:

Date:

*The Act referred to in the claimant declaration detailed at Section 10 refers to The Personal Injuries Resolution Board Acts 2003 to 2022.*

*Please note, the Respondent/s named by you, and their insurers where known, will be copied with your application form in order that they may know the nature and extent of your claim. The Respondent and their insurers/legal advisors are required to treat such information confidentially and not to further disclose it. The Injuries Resolution Board respects the privacy rights of all persons in accordance with current Irish Data Protection legislation. PIAB only processes your data in line with the Injuries Resolution Board's statutory duties and in line with data protection obligations. We only retain data for as long as necessary under its data retention policy and Data Protection Policy. For any Data protection queries, please contact enquiries@piab.ie*

**Completed Application and necessary documentation should be returned to:  
Injuries Resolution Board, P.O. Box 8, Clonakilty, Co. Cork. P85 YH98**