Ill health certificate (deaths)

Employer: please complete this section.

Surname of employee ....

First name(s) ....

Mr ☐ Mrs ☐ Miss ☐ Ms ☐

Date of birth ....

National Insurance number ....

Home address ....

....

....

Employer ....

Place of work ....

Occupation or job title ....

Under regulations 23 (4a) and 24 (2A) of the LGPS (benefits, membership and contributions) regulations 2008 where an active member dies in service and where they were in part-time service, wholly or partly as a result of the condition that caused or contributed to a member's death, no account shall be taken of any reduction in pay or membership due to such reduction in service as is attributable to that condition.

Were the employee's contractual hours reduced as a result of their ill health?

☐ **Yes*** ☐ **No**

***If yes, what date were their hours first reduced as a result of their ill health?** ....

Signed ....

Date ....

Doctor: please complete the section over the page >

Continue over the page

Doctor: please complete this section

Under regulations 23 (4a) and 24 (2A) of the LGPS (benefits, membership and contributions) regulations 2008 where an active member dies in service and where they were in part-time service, wholly or partly as a result of the condition that caused or contributed to a member's death, no account shall be taken of any reduction in pay or membership due to such reduction in service as is attributable to that condition.

Was the employee in part-time employment wholly or partly as a result of the condition that caused or contributed to their death?

☐ **Yes*** ☐ **No**

Doctor's stamp

Doctor's name...

Doctor's address ....

....

....

....

Declaration

I, the above-named doctor, hereby certify that:

- I am not acting, nor have at any time acted as the representative of the member, the scheme employer or any other party in relation to this case.
- I hold:
  - a diploma in occupational health medicine (D Occ Med) **or**
  - an equivalent qualification issued by a competent authority in an EEA state (with 'competent authority' having the meaning given by section 55(1) of the medical act 1983) **or**
  - I am an associate, a member or a fellow of the Faculty of Occupational Medicine or of an equivalent institution in an EEA state.

Signed...

Date...

Please return this form to:

West Yorkshire Pension Fund
PO Box 67
Bradford
BD1 1UP