

PERSONAL INDEPENDENCE PAYMENTS (PIP) APPEAL LETTER

NAME:

Name of Appointee:

ADDRESS:

Date of Birth:

National Insurance No:

APPEALS Send to:
HMCTS SSCS Appeals Centre
PO Box 27080
GLASGOW
G2 9HQ

Dear Sir/Madam

Please accept this **appeal** against your decision dated _____.

I do not accept that the decision-maker has taken my full circumstances into consideration against my entitlement to the Personal Independence Payment.

I submit that where appropriate the decision maker has failed to follow the correct review, revision or supersession procedures and the decision maker has not followed the correct test for entitlement as stated by the Upper Tribunal and higher courts.

The following areas are in dispute:

- My entitlement to Personal Independence Payment at the standard rate or enhanced rate of Daily Living
- My entitlement to Personal Independence Payment at the standard rate or enhanced rate of mobility
- I have enclosed my mandatory reconsideration notice

SPECIAL REASONS FOR LATE APPEAL (see over)

If my appeal is out-with the time limit, then please forward my appeal directly to the Tribunal Service. I authorise **Welfare Rights Section, Glasgow City Health and Social Care Partnership, City Chambers East, 40 John Street, Glasgow, G1 1JL**, to act on my behalf. Please ensure they receive copies of all further correspondence.

I do not consent to my appeal being heard without an oral hearing. I do not consent to less than the full advance notice stated in rule 29(2) of the Tribunal Procedure Rules 2008. Should you decide to schedule my appeal in a manner contrary to these instructions then please contact my representatives to ensure that my right to a fair hearing under Article 6 of the ECHR remains protected.

I require an interpreter (Language): _____ Dialect: _____

Signature: _____ Date: _____