

**Revised 2014/2015 - Net Pensionable Earnings Declaration**

**Section 1 - Provider information** *Please enter details*

Provider name (or Company Name) \_\_\_\_\_ Contract Number \_\_\_\_\_

Name of Company shareholders/partners if applicable

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**Declaration of Payments, under your contract agreement, for year ending 31 March 2015**

Seniority Pay (£) \_\_\_\_\_ Maternity Pay (£) \_\_\_\_\_

Long Term Sick Pay (£) \_\_\_\_\_ Paternity Pay (£) \_\_\_\_\_

Adoption Leave Pay (£) \_\_\_\_\_

Annual contract value (£) \_\_\_\_\_

Maximum net pensionable earnings (NPE) \_\_\_\_\_

**(43.9 % of annual contract value above)**

**Section 2 - Pensionable performers**

*Please complete your revised figures below and enter a reason for the change in the box provided. Continue on another sheet if necessary.*

Performer Name	Performer Number	Actual pensionable earnings										Performer signature	
		£											:
		£										:	
		£										:	
		£										:	
		£										:	
		£										:	
		£										:	
		£										:	
<b>Total net pensionable earnings (NPE)</b>		£										:	

**Reason for Change**

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**Section 3 - Non Pensionable performers**

Please complete your revised figures below and enter a reason for the change in the box provided. Continue on another sheet if necessary.

Performer Name	Performer Number	Actual net pensionable earnings equivalent (NPEE)										Performer signature			
		£										:			
		£										:			
		£										:			
		£										:			
		£										:			
		£										:			
		£										:			
		£										:			
<b>Total non pensionable earnings (NPEE)</b>		£										:			

**Reason for Change**

**Summary**

Maximum net pensionable earnings (NPE) <i>Figure from section 1</i>	£										:		
less total NPEE <i>Sum of section 3</i>	£										:		
<b>Total NPE available for pension scheme members. Figure in section 2 must not exceed this</b>	£										:		

**Section 4 - Declaration**

I declare that I am the Provider named on this form.

For the purposes of verification I consent to the disclosure of information provided on this form, and sufficient documentary evidence to; the Secretary of State, Area Teams, Local Health Boards and NHS Dental Services.

I understand that the administration of NHS Dental Services and responsibility for anti-fraud work in the NHS are both responsibilities of the NHS Business Services Authority.

I understand that NHS Dental Services may share the information on this form with NHS Protect, a division of the NHS Business Services Authority, for the purposes of the prevention, detection, investigation and prosecution of fraud or any other unlawful activity affecting the health service.

I declare that the information provided on this form is complete, accurate and has been agreed with any performers associated with the contract. I understand and accept that if I provide NHS Dental Services with false or misleading information, I may be liable to prosecution and/or civil

**Print Name**.....

**Signature**..... **Date**.....

**PLEASE RETURN BY POST TO: Administration, 1 St Anne's Road, Eastbourne, BN21 9UN**

*You may wish to take a copy for your records*