

## Revised 20\_\_ / 20\_\_ - 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

_____	_____	_____
_____	_____	_____
_____	_____	_____

### 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**

**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**

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

**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 proceedings.

**Print Name**.....

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

**PLEASE RETURN BY POST TO: Administration, 1 St Anne's Road, Eastbourne, BN21 3UN**

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