DWP BENEFIT OVERPAYMENT 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 as an **appeal** against your benefit overpayment decision for

Name of Benefit: _____ **on Date of Decision:** _____
including any civil penalty that has been applied.

Grounds of Appeal - I do not accept that the decision maker has shown that:

- I have been overpaid benefit
- any alleged overpayment is recoverable from me
- the amount of the alleged overpayment is accurate
- Due regard has been given to the issue of offset.
- I have been properly notified of the decision
- Without reasonable excuse, I have failed to provide information, failed to notify a change of circumstance in time or negligently made an incorrect statement, resulting in an overpayment.

☐ **I enclose a copy of my mandatory reconsideration notice**

In addition I submit that the decision maker has failed to follow the correct revision/supersession procedures and has not followed the correct test in law as stated by the Upper Tribunal and higher Courts.

SPECIAL REASONS FOR LATENESS (see over)

My representatives are **Welfare Rights Section, Glasgow City Health and Social Care Partnership, City Chambers East, 40 John Street, Glasgow, G1 1JL**, I authorise them 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.

Yours faithfully

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

Signature: _____ Date: _____