THE NATIONAL INSURANCE BOARD
OF TRINIDAD AND TOBAGO

GUIDELINES AND CHECKLIST

Application / Benefit:	**Application**
Form Name:	**Disablement Benefit**
Form Number:	**NI 119**

Section A

Description	**To be completed by Applicant**		
Question #	**No.**	**Questions on form**	**What should be inserted**
	1	Name	Surname followed by First name and middle name (if applicable)
	2	Home Address	Where you live currently
	3	Postal Address	Where your mail is delivered go to, if different from home address
	4	National Insurance No.	The National Insurance number of the applicant
	5	Date of Birth	Date of birth of applicant (Year/Month/Day)
	6	Gender	Tick the relevant box - Male or Female
	7	Telephone Numbers	Telephone contact - home, work or cellular
	8	Occupation	The job position the applicant holds
	9	Date of Accident	Insert date of the accident
	10	Time of Accident	Insert time of the accident
	11	Place of accident	Where the accident took place
	12	Last Date worked	Insert the date last worked (year/month/date)
	13	Employer's Name at time of accident	The name of the employer at the time of accident
	14	Telephone Number	Telephone contact - home, work or cellular
	15	Employer's Address of Actual Place of work: (e.g. School/Department/Division)	The address of the actual place of work
	16	Exact Place/ Location where accident occurred	State the exact place /location where the accident occurred. You may use additional page to complete this part

	17	Have you ever applied for Injury Benefit as a result of the same Accident/Prescribed diseases	Tick the relevant box Yes or No
	18	Did the accident occur while travelling in employment?	Did the accident occur while travelling in employer's transport? Tick the relevant box Yes or No (if "Yes" give details)
	18(a)	Place of embarkation	The place where the applicant boarded the transport/left from
	18(b)	Destination	Where was the applicant is going or being sent
	18(c)	Purpose of presence on vehicle	Why were you on the transport
	19	Name of any Witness to Accident	Insert Surname followed by First name of witness
	20	Address of Witness to Accident	Address of witness – street/city/district/country
	21	What injuries were observed as a result of the accident	What were the injuries when the accident occurred
	22	State clearly the nature of disability as a result of the Accident/Prescribed Disease	The nature of your incapacity
	23	Are you at present incapable of work as a result of accident?	Tick the relevant box Yes or No
	24	Are you fit to travel for Medical Examination?	Tick the relevant box Yes or No
	25	Were/are hospitalized because of the accident?	Tick the relevant box Yes or No
	26	Please indicate the method of payment of Benefit	Tick the relevant box to state if you would be collecting via the Service centre or Postal Address
Description	**Applicant's Declaration**		
	Information needed		**What should be inserted**
	Signature or Mark		Sign name or affix thumb print
	Date		Date when the form was completed by applicant
Description	**Particulars of witness to Mark (where applicant cannot sign)**		
	Information needed		**What should be inserted**
	Name		The witness surname and other name
	Address		The address of the witness
	Valid Identification		Tick the box which ID used - Identification should be a valid form of one of the following: Passport, Driver's Permit or Electoral Identification Card.

	Number	Place number from the ID
	Occupation	What position does witness hold
	Signature of Witness to mark	The signture of the witness
	Date	Date the form was completed by the witness

Section B

Section B - Description	For Official Use		
	No.	**Questions on form**	**What should be inserted**
	The Customer Service Representative completes the section of the form		

Section C

Description	To be completed by Medical Practitioner		
	Information needed		**What should be inserted**
	1	Name of claimant	Surname followed by First name and middle name (if applicable)
	2	Date of accident	Date of accident
	3	Is this a Final Assessment of Disability	Tick the relevant box Yes or No. If "No" complete 3(a) and 3(b)
	3a	State reason	Give reasons why a final assessment of disability cannot be given at this time. You may use additional page to complete this part
	3b	Are you able to give a provisional assessment of disability	Tick the relevant box Yes or No. If "No" state reason. You may use additional page to complete this part
	3c	If answer to 3 or 3b is "Yes" then kindly state the full clinical description of the claimant's present condition	Description of the present medical condition as a result of the injury. You may use additional page to complete this part
	4	Is claimant fit for work	Tick the relevant box Yes or No. If "No" state reason. You may use additional page to complete this part
	5a	Has this claimant suffered a loss of faculty as a result of Employment Injury/ Prescribed Disease?	Tick the relevant box Yes or No
	5b	Is this claimant in a position to travel on his/her own?	Tick the relevant box Yes or No
	5c	The extent of disability is assessed at	A percentage of the disability is required, duration of the disability. Tick the relevant box - days/weeks/month and give effective date
	6	Additional Remarks by Medical Practitioner	Additional remarks from doctor. You may use additional page to complete this part
	Particulars of Medical Practitioner		

	Name of Medical Practitioner	Surname of the doctor followed by First name and middle name (if applicable)
	Office Address	The address from which the doctor operates out from
	Registration Number of Medical Practitioner	Registration number of the doctor
	Telephone Number	telephone contact - home, work or cellular
	Signature of Medical Practitioner	Sign name or affix thumb print
	Medical Practitioner's Stamp	Stamp from the Medical Practitioner
	Date	Date when the form was completed by doctor

Section D

Section D - Description	To be completed by Employer (To complete only if an injury claim was not submitted to the NIBTT)		
	No.	**Questions on form**	**What should be inserted**
	1	Name of Employer	The name of the employer for which you work/company name
	2	Employer No	The employer 's registration number
	3	Type of Business	What type of business is it
	4	Telephone Number	Telephone contact - work or cellular
	5	Describe the work the injured person does	Job function of the applicant/ description of the applicant. You may use additional page to complete this part
	6	Was the insured an apprentice	Tick the relevant Yes or No.
	7i	State below the wages paid or payable in Week prior to the week of the accident	The wages earned the week in which the accident occurred
	7ii	Week in which the accident occurred	The wages earned the week in which the accident occurred
	8	Are the particulars stated is Section A accurate	Tick the relevant Yes or No. If "No" state reason. You may use additional page to complete this part
	9	Did accident occur during the working hours?	Tick the relevant Yes or No. If "No" state reason. You may use additional page to complete this part
	10	Has the accident been recorded during working hours?	Tick the relevant Yes or No.

Description	Employer's Declaration	
	Information needed	**What should be inserted**
	Name	Surname and other name of the person who completed the form on behalf of the employer
	Position	The position/ job title of the employer/employer's representative

	Signature of Employer	The signature of the employer/ employer's representative
	Company Stamp	Stamp of the employer
	Date	Date the form was completed by the employer

Section E

Section C - Description	For Official Use
	The Customer Service Representative completes the section of the form

What you should know about this claim

1. Time frame for the submission of claim - 3 months from the date of last injury benefit
2. Where the claim is submitted by a third party, valid ID and letter of authorization to conduct business
3. Any official accident reports relating to this injury can be submitted.
4. Who can sign as witness -

(a) (For a resident of Trinidad and Tobago)
any Magistrate, Justice of the Peace, Clergyman, Warden, Councilor/Assemblyman, Bank Manager, Medical Practitioner, Attorney- at-Law, Principal/Vice Principal of any Government/approved School, Head of any Government Institution or any Police/Military officer of the rank of Sargeant and above or Local Office Staff or Supervisory Officer of the National Insurance Board. A member of the Trinidad and Tobago Mission in the Country in which the Beneficiary is a resident OR an Attorney-at-Law, OR a Notary Public, OR a Justice of the Peace OR a Medical practitioner.

(b) (For a non-resident of Trinidad and Tobago)
a member of the Trinidad and Tobago Mission in the Country in which the Beneficiary is a resident OR an Attorney-at-Law, OR a Notary Public, OR a Justice of the Peace OR a Medical practitioner.

Supporting Documents

List of Errors	No.	Questions on form	Possible Errors
	1		
	2		
	3		

CHECKLIST

- Claim Form – **N.I. 119**. This form is completed upon the loss of physical or mental faculty and includes disfigurement due to a job related incident.

- **ALL** fields must be completed. **ALL** changes **MUST** be initialed and / or stamped.

a. **Section "A"** The form **MUST** be signed and dated by the applicant.
   - If the insured is unable to sign, the thumbprint will be certified at the NIBTT.
   - If the claim is being submitted by a third party, at the "Particulars of Witness to Mark" the thumbprint should be certified by an approved authority.

- The insured **MUST** state clear details of the accident.

b. **Section "C"** to be completed by a Registered Medical Practitioner.
   - The insured's name **MUST** be correctly stated.
   - The date the insured was examined **MUST** be clearly stated.
   - The effective date, period of the incapacity and percentage **MUST** be clearly stated. The form **MUST** be signed, dated and stamped by the Registered Medical Practitioner.
   - The Registered Medical Practitioner's registration number **MUST** be correctly stated

c. **Section "D"** to be completed by the Employer. (This section should **ONLY** be completed if an injury application was not previously submitted).
   - The original or certified copy of an accident report may be submitted.

- Identification Card of the Insured.

- Original & Copy of the Birth Certificate / Affidavit / Deed Poll / Divorce Decree Absolute where there is a change to the insured's name.

- If the method of payment is **Financial**, the bank statement reflecting the name of the bank, the account number and the branch should be submitted. If the method of payment is **Postal** a utility bill, no older than three (3) months should be submitted.

- If the claim is being submitted by a third party, the Identification Card of the third party **MUST** be presented.

- The claim **MUST** be submitted within fifty-two (52) weeks from the start date of the incapacity, if not a letter **MUST** be written with an explanation for the late submission.