THE NATIONAL INSURANCE BOARD OF TRINIDAD AND TOBAGO

GUIDELINES AND CHECKLIST

Application / Benefit:	**Application**
Form Name:	**INJURY BENEFIT**
Form Number:	**NI 19**
	To be completed by the Customer Service Representative
	For Offical Use *(top right hand corner)*

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	Marital Status	Tick the relevant box Single/Married/Window/Divorced
	9	Occupation	The job position the applicant holds
	10	Employer's Name	The name of the current employer
	11	Employer's Address	The address of the employer
	12	Name of Actual Place of Work	e.g School/ Department/ Division
	13	Address of Actual Place of Work	The address of the actual place of work
	14	Are you currently employed elsewhere?	Tick Yes or No. If "yes" insert Business name and address of other employer
	15	Date and time accident occurred	Insert date and time of the accident
	16	Last date worked	Insert the date last worked (year/month/date)
	17	Date resumed work	Insert the date returned to work (year/month/date)
	18	Exact place/location where accident occurred	State the exact place /location where the accident occurred.You may use additional page to complete this part
	19	Did accident occur while travelling in employer's transport	Tick Yes or No. If "yes" give details in (i)(ii)(iii)(iv)below
	19(i)	Place of embarkation	The place where the applicant boarded the transport/left from
	19ii	Destination	Where was the applicant is going or being sent
	19iii	Purpose of presence on transport	Why were you on the transport
	19iv	Was vehicle owned/rented by employer?	Tick yes or no. If "No" was there an arrangement with the employer to use another means of transport? (Describe)
	20	State clear details of the cause of accident	State exactly how the accident occurred. You may use additional page to complete this part
	21	State details of injury sustained	Give clear details of the injury. You may use additional page to complete this part
	22	Give name and address of any witness to the accident	Insert Surname followed by First name and middle name of witness,street,city/district/country
	23	Was accident reported to your employer?	Tick the relevant box Yes or No .If "yes" state the date the accident was reported
	24	Date of first visit to medical practitioner	Insert the date of your first visit to the doctor
	25	Name of medical practitioner	Surname followed by First name
	26	Address of medical practitioner	Location of the doctor's office
	27	Did you meet the cost of medical expenses?	Tick yes or no. If "yes" complete a form NI 114(medical expenses)
	28	Relapse - is this application in support of a relapse	Tick the relevant box Yes or No

	28 i	If "yes" describe the actitives in which you were engages when the relapse occurred. You may use additional page to complete this part	State what were you doing when the injury reoccurred
	28 ii	State the exact place/location where the relapse occurred .You may use additional page to complete this part	Place where the injury reoccured. You may use additional page to complete this part
	29	Please indicate the method of payment of Benefit	Tick the relevant box - to mail to postal address or deposit to financial institution
Financial Information			
	Information needed		**What should be inserted**
	Name of Financial Institution		The name of the bank you require your payment to be deposited to
	Address		The address of the bank you require the payment to be deposited to
	Account Number		Your bank account number
Declaration			
	Information needed		**What should be inserted**
	Signature or mark of applicant		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	**To be completed by Medical Practitioner**		
	Information needed		**What should be inserted**
	I hereby certify that Mr/Mrs/Ms"		Doctor insert his/her surname and other name
	Examined date		Date applicant was examined
	The date the Accident was sustained/disease		The accident occurred sustained/disease
	I found the following injuries/industrial diseases		Nature of the injuries/industrial diseases
	Line on form for the recommend leave and box for the effective date		Doctor inserts the recommend leave for the patient in words and figures and the effective date
	Name of Medical Practitioner		Surname followed by first name of the doctor
	Address of Medical Practitioner		Location of the doctor's office
	Registration Number of Medical Practitioner		The registration number of the Medical Practitioner
	Telephone No.		Telephone contact - home, work or cellular
	Signature of Medical Practitioner		The doctor affixes signature
	Medical Practitioner's Stamp		The doctor stamp is place
	Date		Date the form was completed by the doctor
Section C			
Description C	**To be completed by Employer**		
	No.	**Questions on form**	**What should be inserted**
	1	Employer's name	The name of the employer for which you work
	2	Employer's registration No.	The employer 's registration number
	3	Telephone No	Telephone contact - work or cellular
	4	Type of business	What type of business is it
	5	Describe the work the injured person does	Job function of the applicant/ description of the injury person. You may use additional page to complete this part
	6	Is he/she an apprentice?	Tick the relevant box

	7i	State below the wages/salary paid or payable in	The wages earned the week or month before the week of the accident
	7ii	Week/ Month prior to the week of accident	The wages earned the week or month in which the accident occurred
	8	Are the particulars stated at Nos.15 to 27 of section "A" accurate?	The information given at #15 to #27, if "No" please give details. You may use additional page to complete this part.
	9i	Did accident occur during working hours?	Tick the relevant box Yes or No
	9ii	Was employee engaged in his/her duties at the time of the accident?	Tick the relevant box Yes or No. If 'No" to either (i) or (ii) give details of what occurred at the time of the accident. You may use additional page to complete this part
	10i	Did the injured person work during the injury period?	Tick the relevant box Yes or No. If "yes "please state period.
	11	Did the employee die at the time of the accident or after?	Tick the relevant box Yes or No. If "yes" please state date of death. (Year/Month/Day)
	12	Has the accident been entered in the employer's accident book?	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 D

Description D	For Official Use
	The Customer Service Representative completes the section of the form

What you should know about this claim

Injury benefit application must be submitted within 14 days of the date of the accident/development of the prescribed industrial disease

1 A claim submitted outside of the stipulated time is considered "late". All late claims should be accompanied by a late letter stating the reason for late submission for the determination of acceptance by the NIBTT

2 A copy of bank statement should be attached to verify account number

3 Employment injury is payable to an insured person who (i) suffers personal injury (ii)by accident arising out of and in the course of employment

4 The Employment injury benefit may be paid for a maximum of 52 calendar weeks.

5 An employer is required to furnish the board with information relating to any accident arising out of and in the course of employment whereby personal injury is caused to any person employed by him

6 Who can sign as witness -

(For a resident of Trinidad and Tobago)

7 (a) 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.

(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

Job description

A detail report of the accident from applicant/ witness and employer

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

CHECKLIST

INJURY

- Claim Form – **N.I. 19**. This form is completed when the insured has suffered a personal injury due to a job-related incident.

- Claim Form – **N.I. 19A**. This form is completed once the incapacity continues for more than fourteen (14) days.

- **ALL** fields must be completed. **ALL** changes **MUST** be initialed and / or stamped.
  a. **Section "A"** to be completed by the insured.
     - The form **MUST** be signed and dated by the Insured.
     - 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** provide clear and concise details of the incident. An original or certified copy of an accident report may be provided.
  b. **Section "B"** to be completed by a Registered Medical Practitioner.
     - 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 "C"** to be completed by the Employer.
     - The form **MUST** be signed, dated and stamped by the Employer.
     - The Employer's Registration number and contact information **MUST** be correctly stated.
     - If the insured is employed by more than one employer **EACH** employer **MUST** complete Section "C".

- Identification Card of Insured.

- Original & Copy of the Birth Certificate / Affidavit / Deed Poll 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 fourteen (14) days from the start date of the incapacity, if not a letter **MUST** be written with an explanation for the late submission.