THE NATIONAL INSURANCE BOARD
OF TRINIDAD AND TOBAGO

GUIDELINES AND CHECKLIST

Application/ Benefit:	**Application**
Form Name:	**INVALIDITY BENEFIT**
Form Number:	**NI 38**

Section A

Description	**To be completed by Applicant - (This is the insured person who the doctor has said is unable to work because of the ailment suffered)**		
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, if different from home address
	4	National Insurance No.	National Insurance number of the applicant (this is a 9-digit number)
	5	Date of Birth	Date of birth of applicant (Year/Month/Day)
	6	Gender	Is the applicant male or female? The applicant ticks the relevant box
	7	Telephone Numbers	Input a working telephone contact - home, work or cellular
	8	Marital status	Tick the relevant box
	9	State Maiden Name	For females - in put the surname you used from childhood until marriage (if you are married)
	10	Last occupation	What was the last job you were doing when you became ill (e.g Road overseer, Supervisor, Teacher etc)
	11	Name of Last employer	Give the name of the last business place you worked at.
	12	Last Employer Registration number	If you know the National Insurance registration number of your employer write it here. If you do not know it then you can leave it blank.
	13	Employment record from 10 April, 1972	Record all the employers you worked with throughout your working life from when the National Insurance system started on 10 April 1972. If you did not start to work on 10 April 1972 use the first row and write that. If your date of birth is after 1957 you need not respond to 10 April 1972. As far as possible provide the dates you started and ended with each employer. If you cannot recall the dates, the month and year will be sufficient. All periods when you did not work must be noted also.
		Type of Employment	For each employment period you provide say whether your employment was Casual, Temporary or Permanent. (in respect of temporary employment - were you temporary but worked for the whole year or just parts of the year)
	14	Did you work or live in Canada or worked in any of the CARICOM Countries	The CARICOM countries are St Lucia, Barbados, Guyana, St Vincent, etc. If you worked in any of these countries, tick the relevant box. If you lived or worked in Canada, tick the relevant box. If lived and worked both in Canada and CARICOM use another sheet of paper to provide the Social Security numbers and the name of the country in which you worked and or lived.
	15	Last date of employment	This means the last date on which your salary or wage was paid by your employer.
	16	Have you ever applied for an Invalidity benefit?	Is this the first time you are applying to the NIBTT for an Invalidity Benefit? If yes, then tick "No". If yes, then input the name of the NIBTT office at which you previously applied and tick "Yes".
	17	I am able or unable to travel	Are you able to travel to a medical institution to be examined? Tick the relevant box
	18	Is Invalidity the result of an injury on the job	Is the ailment you are suffering from a result of a job-related injury. Tick the relevant box

	19	Please indicate the method of payment of Benefit	Tell us where you want us to send your payment. If you want it to go to your financial institution (Bank, Credit Union, Unit Trust) then complete the boxes below. Please ensure you put in the correct details so that your money will go to only your account. Bring with you a current statement so that we can verify that you have provided the correct account number. If you choose to have it mailed to you please provide evidence of your current address (utility bill, bank statement etc)

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 for the 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 signature of the witness
	Date	Date the form was completed by the witness

Section B

Section B - Description	**To be completed by a Registered Medical Practitioner**	
	Information needed	**What should be inserted**
	I certify that I examined	The name of the applicant, putting the surname first then the other name
	Examination date	Insert the date the applicant was examined
	Incapacity for work	Insert the period, in words and figures, that the applicant will not be able to work based on the diagnosis. Select either number of months or years that the applicant is expected to be incapacitated.
	Description of the findings causing the applicant's incapacity for work	Provide a clinical description of the incapacity suffered by the applicant that renders him incapable of working
	Name of Medical Practitioner	Input name - Surname first then other name
	Office address	Input office address
	Registration number of Medical Practitioner	Provide your registration number with whichever Medical Board you are associated
	Telephone Number	Provide a telephone number/s that you can be easily contacted at
	Signature of Medical Practitioner	Medical practitioner signs
	Medical Practitioner's stamp	Affix your stamp in the space provided
	Date	Input the date on which the form was completed.

Description	**Declaration**
	Take note of the declaration before form is signed and given to applicant

Section C

Section - C Description	**For Official Use**
	The Customer Service Representative completes this 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 incapacity as declared by the doctor.
2. Where the claim is submitted by a third party , valid ID and letter of authorization to conduct business
3. The benefit is payable to the applicant
4. The Invalidity Benefit may be paid for the duration the Medical Practitioner states on the form but not after the applicant's 60th birthday.
5. Receipt of this benefit means that you are unable to work at any job, including self-employment.

6. If you return to active employment you MUST inform the NIBTT immediately.
7. If you reside outside of Trinidad and Tobago and are in receipt of the Invalidity benefit you MUST submit a Life Certificate to the NIBTT every December and June of each year.
8. 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
(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
Electronic Birth certificate and affidavit (where applicable), OR
Deed Poll (if applicable)
Marriage Certificate (female applicants only)
Decree Absolute of divorce (female applicants only) where applicable
Valid identification document (ID card, Passport, Driver's permit)

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

CHECKLIST

- Claim Form – **N.I. 38**. This form is completed upon medical certification from a Registered Medical Practitioner of an incapacity which renders the insured unable to engage in **ANY** kind of gainful employment or is **UNABLE** to perform **ANY** work for wage or profit for a period of **NOT LESS THAN** twelve months as a result of mental or bodily disease or injury.
  - Below the age of 60 years.
- **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.
  - **Question #13** should be completed in full detail. For the period 1972 – the period of retirement, each period of employment or unemployment should be stated. Additional paper should be utilized where necessary.
  - **Question #14** If the answer is yes, the Social Security number **MUST** be provided.
  - **Question #15** The insured's last date of employment **MUST** be accurately stated.

b. **Section "B"** 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 and period of the incapacity **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.

- Identification Card of the Insured.
- Original & Copy of the Birth Certificate / Affidavit / Deed Poll / Divorce Decree Absolute / Death Certificate of Spouse.
- All relevant documentation to support employment, if available, e.g. original & copy of certified pay slips, TD4s, Job letters etc. should be submitted.
- 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 three (3) months from the date of certification of the incapacity, if not a letter **MUST** be written with an explanation for the late submission.