THE NATIONAL INSURANCE BOARD
OF TRINIDAD AND TOBAGO

GUIDELINES AND CHECKLIST

Application / Benefit:	**Application**
Form Name:	**Maternity Benefit**
Form Number:	**NI 12A**

Section A

Description	**To be completed by Applicant - (This is person who is making the application)**		
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.	What is your National Insurance Number
	5	Date of Birth	What is your Date of Birth (Year/Month/Day)
	6	Telephone Numbers	Telephone contact - home, office/work or cellular
	7	Was Evidence of Date of Birth Previously Submitted	Did you ever submit a copy of your Birth Certificate for update? If "No" submit Birth Certificate or Passport with application.
	7(a)	If "No", Did the pregnancy result in the birth of a living child/children	Tick "Yes" or "No".
	8	How many children were delivered	You are required to insert in words and figures the number of children delivered
	9(a)	Did you complete and submit - NI 12 - Maternity Benefit Application	Tick "Yes" or "No". If "No" please complete and attach
	9(b)	Did you complete and submit - NI13 - Special Maternity Grant Application	Tick "Yes" or "No". If "No" please complete and attach
	10	Please indicate the method of payment of Benefit	Tick the box to state if you would like to have payments posted to your current address or sent to an active financial institution (attach a copy of your financial information for verification): Insert: - Name of Financial Institution: - Address: - Account Number:

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 Claimant cannot sign)**	
	Information needed	**What should be inserted**
	Name	The witness surname and other name
	Address	The address of the witness
	Occupation	What position does witness hold
	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
	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 or Midwife Certificate of Actual Delivery Resulting in Multiple Births	
	Information needed	**What should be inserted**
	I hereby certify that Miss/Mrs	Surname followed by First name and middle name (if applicable) of the applicant
	Delivered	Medical Practitioner/Midwife to insert the number of children delivered in words and figures
	Date of Delivery (on)	Medical Practitioner/Midwife to insert the exact date of delivery
	Name of Institution/Place of Delivery	Medical Practitioner/Midwife to insert the Name of the institution/place the delivery occurred
	Name of Medical Practitioner/Midwife	Surname followed by First name and middle name (if applicable)
	Address of Medical Practitioner/ Midwife	Address of Medical Practitioner/Midwife
	Registration Number	Registration Number of Medical Practitioner/Midwife as issued by the Medical Board of Trinidad and Tobago or an associated Midwife Association
	Telephone Numbers	Medical Practitioner telephone contact - office/work or cellular
	Signature of Medical Practitioner/Midwife	Medical Practitioner/Midwife to sign
	Stamp	Medical Practitioner to affix stamp

What you should know about this claim
1. Time frame for the submission of claim - 3 months from the date of delivery
2. Application submitted outside of three-month time frame a written letter is require giving valid reason for lateness.
3. A copy and the original of the children's birth certificate
4. Who can sign as witness - (a) (For a resident of Trinidad and Tobago)
Supporting Documents
Children Birth Certificates
Claimant to submit a late letter (if applicable)

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

CHECKLIST

MATERNITY

- Claim Form – **N.I. 12**. This form is completed where the insured is certified as pregnant.

- Claim Form – **N.I. 12A**. This form is completed in instances of multiple births from a single pregnancy.

- **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.

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.
- This section **MUST NOT** be completed earlier than the 11th week prior to the expected / actual date of delivery.
- The pregnancy **MUST** be at least twenty-six (26) weeks old at the date of examination.
- In instances where the pregnancy is less than twenty-six (26) weeks the delivery **MUST** have resulted in a live birth.

c. **Section "C"** to be completed by the Employer.
   - The form **MUST** be signed, dated and stamped by the Employer.
   - The Employer's Registration no. 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.

- Original & Copy of the child's Birth Certificate where Section "B" was completed by a MIDWIFE.

- Original & Copy of payslip (older than three (3) months prior to the date of delivery) / Job letter (**not** older than three (3) months prior to the date of delivery) / TD4 (year prior to the year of delivery).

- 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 date of delivery, if not a letter **MUST** be written with an explanation for the late submission.