THE NATIONAL INSURANCE BOARD
OF TRINIDAD AND TOBAGO

GUIDELINES AND CHECKLIST

Application / Benefit:	**Application**
Form Name:	**Sickness Benefit**
Form Number:	**NI 15**

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	Birth Certificate Pin no: (if Known)	Insert the birth certificate pin. This is found on the top right corner of the birth certificate
	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.
	8	Gender	Are you Male or Female? Tick the box provided
	9	Marital Status	Are you Single, Married, Widowed or Divorced? Tick the box provided
	10	Telephone Numbers	Telephone contact - home, office/work or cellular
	11	Occupation	What position do you hold in your organization
	12	Employer's Name	The name of your employer
	13	Employer's Address	The address of your employer
	14	Name of Actual Place of Work	The exact name of the place where you report for work
	15	Address of Actual Place of Work	The exact address where you report for work
	16	Are you Currently Employed Elsewhere?	Do you have a second job? If "Yes" state the Business Name and Address. - Insert second Employer's Name - Insert second Employer's Address

	17	Is the Sickness as a Result of Injury on the Job?	Were you on the job performing your normal duties when the injury occurred
	18	Last Date Worked	Insert the last date you attended work.
	19	Date Loss of Earnings Started	What was the date you started losing earnings (salary)
	20	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:

Section A: Description	**Declaration**	
	Information needed	**What should be inserted**
	Signature or Mark of Claimant	Sign name or affix thumb print
	Date	Date when the form was completed by applicant

Section A - 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.
	Occupation	What position does witness hold
	Number	Place number from valid Identification
	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 Medical Practitioner**		
	No.	**Information needed**	**What should be inserted**
		I hereby certify that Mr/Mrs/Ms	Surname followed by First name and middle name (if applicable)
		Was examined by me on	Date you were seen by Medical Practitioner
		In my opinion was at the time suffering from	Medical Practitioner to insert name and/or type of illness

Question		The patient will remain incapable of work for a period of	Medical Practitioner to insert in words and figures number of days incapable of work
		Start date of illness	Medical Practitioner to insert the first date of the illness period
		Confidential information has been sent to Board's Medical Practitioner	Medical Practitioner to Tick Yes or No
		Name of Medical Practitioner	Surname followed by First name and middle name (if applicable)
		Office Address	Address of Medical Practitioner
		Registration Number of Medical Practitioner	Registration Number as issued by the Medical Board of Trinidad and Tobago
		Telephone Numbers	Telephone contact - office/work or cellular
Description	**Medical Doctor Declaration**		
	Information needed		**What should be inserted**
	Signature of Medical Practitioner		Medical Practitioner to sign
	Medical Practitioner Stamp		Medical Practitioner to affix stamp
	Date		Date form was completed by Medical Practitioner
Section C			
Section C - Description	**To be Completed by Employer**		
Question #	**No.**	**Questions on form**	**What should be inserted**
	1	Employer's name Registration No Telephone No	What is the employer's name, National Insurance Registration number and Telephone Number
	2	This is to certify that Mr/Mrs/Ms	Surname followed by First name and middle name (if applicable) of employee
	2	Has been absent from work continuously	Employer must state the date from which the employee was first absent from work
	3	Is Sickness as a result of an accident on the job	Tick Yes or No
	4	Is the Applicant still employed?	Tick Yes or No. If "No" the employer must stated the reason why you are no longer employed and the Date of Separation
	5	Weekly Rate of Pay	Using Mondays only, the Employer must state the employee's weekly earnings for the thirteen (13) weeks period before the week in which the employee's incapacity/sickness started.

	6	Daily Earnings During Sickness	(a) Number order to insert information. (b) Employer must insert the period for which the employee would have been absent from work. (c) Total number of days employee was absent from work including Saturday, Sunday and Public Holidays. (d) Employer must state what the employee's daily earnings would have been if they were paid or insert "Nil" if the employee was not paid during their period of sickness.
	7	Was loss of Earnings Caused by Sickness	Tick Yes or No. If "No" the employer must state the reason for the loss of earning

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

Section D - Description	**For Official Use**
Part I	**The Customer Service Representative completes the section of the form**
PART II	**The Supervisor/Clerical Officer II completes this section of the form**
Part III	**Determination of the Application to be completed by Processing Officer**

What you should know about this claim
1. Applicant must lose earnings as a result of illness
2. Claim for sickness benefit shall not be entertained before the fourth day of the insured person's incapacity
3. Application must be submitted within three months of the loss of earnings
4. Application must be completed by a Certified Medical Practitioner
5. Sickness Benefit is a periodical payment to an employed person who is rendered incapable of work
6. Applicant must be in insurable employment for a least 10 in 13 weeks prior to start of incapacity
7. If the incapacity extends beyond 52 weeks the applicant may be eligible for an invalidity benefit
8. If a Sickness is submitted with a Maternity Claim the sickness should be completed prior to processing the maternity claim

9. 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
Medical Certificate from a certified medical practitioner
Applicant Birth Certificate (if none was ever provided)

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

CHECKLIST

SICKNESS

- Claim Form – **N.I. 15**. This form is completed where the insured has been ill for **NOT** less than four (4) days **AND** has suffered loss of earnings due to the illness.

- Claim Form – **N.I. 15A**. This form is completed once the illness 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.

  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.

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

- 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 start date of the illness, if not a letter **MUST** be written with an explanation for the late