THE NATIONAL INSURANCE BOARD
OF TRINIDAD AND TOBAGO

GUIDELINES AND CHECKLIST

Application / Benefit:	**Application**
Form Name:	**CONTINUATION CLAIM TO SICKNESS BENEFIT**
Form Number:	**NI 15A**

Section A

Description	**Particulars of 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)
		National Insurance No.	What is your National Insurance 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	**Subsequent Medical Certificate to be Completed by Medical Practitioner**		
Question #	**No.**	**Information needed**	**What should be inserted**
		I herey 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
		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 continuation 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 - home, office/work or cellular
Description	**Medical Doctor Declaration**		
	Information needed		**What should be inserted**
	Signature of Medical		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 the 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 during the period recorded at Section B of this form Mr/Mrs/Ms	Surname followed by First name and middle name (if applicable) of employee
	2	Is Sickness as a result of an accident on the job	Tick Is or Is Not
	3	Is the Applicant still employed?	Tick Yes or No. If "No" the employer must state the reason why you are no longer employed and the Date of Separation

	4	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.
	5	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 names 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 this section of the form**

What you should know about this claim

1. Where illness persists after the initial claim, a continuation or subsequent medical may be submitted

2. Application must be submitted within three months of the loss of earnings

Supporting Documents

Medical Certificate from a certified medical practitioner

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