THE NATIONAL INSURANCE BOARD OF TRINIDAD AND TOBAGO

Application / Benefit:	**Application**
Form Name:	**Continuation Claim To Injury Benefit**
Form Number:	**NI 19A**

For Official Use (top right-hand corner)

To be completed by the Customer Service Representative

Section A

Description	To be completed by Applicant	
	Information needed	**What should be inserted**
	Box provided for Surname and Other names	Surname followed by First name in the box provided, giving permission to the follow-up Medical Certificate at Section 'B' being submitted to the National Insurance Board.
	Box provided for National Insurance No.	Insert National Insurance number in the box provided
	Box provided for Name of Employer	Insert Name of Employer for which you are employed
	Signature or Mark of Claimant	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 first name
	Address	The address of the witness
	Valid Identification	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 witness affixes signature
	Date	Date the form was completed by the witness

Section B - Subsequent Medical Certificate

Section B - Description	To be completed by Medical Practitioner	
	Information needed	**What should be inserted**
	Boxes provided on form for the doctor "I hereby certify that Mr/Mrs/Ms"	Doctor insert applicant's surname and first name
	Box provided on form for the doctor examined date	Doctor insert the day examined
	Line provided on the form for the following injuries/industrial disease, which is/is not consistent with an accident sustained	Doctor to state type of injuries/industrial diseases
	Box provided on the form for date the following injuries/industrial disease, which is/is not consistent with an accident sustained at work	Doctor insert the date of the injuries/industrial disease

Line on form for an examination date	Doctor insert examination date of applicant (Year/Month/Date)
Line on form for the recommended leave. Box provided for the effective date	Doctor inserts the recommend leave for the patient in words and figures and the effective date
Name of Medical Practitioner	Name of the doctor the applicant visited
Address of Medical Practitioner	The address of the doctor's office visited
Registration Number of Medical Practitioner	The registration number of the Medical Practitioner
Telephone No.	Doctor's telephone contact - home, work or cellular
Signature of Medical Practitioner	The doctor affixes signature
Medical Practitioner's Stamp	The doctor stamp is placed in the box
Date	Date the form was completed by the doctor

Section C

Description C	To be completed by Employer. (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)

No.	Questions on form	What should be inserted
1	Employer's name	The name of the employer at the time of accident
	Employer's registration No.	The employer registration number
	Telephone No	Telephone contact - work or cellular
2	Boxes provided on form for the employer "I hereby certify that Mr/Mrs/Ms"	Employer insert applicant's surname and first name
	Boxes provided on form Mr/Mrs/Ms has been absent from work as a result of an accident/industrial disease	Employer inserts date the applicant has been absent from work as a result of an accident/industrial disease
	If the injured person worked during this period, please state the period worked in the box provided	Employer inserts the period worked (Year/Month/ Date) to (Year/Month/Date)
3	Have you paid any of the related medical expenses?	Tick the relevant box Yes or No. If 'Yes' please state the details of the services paid for. You may use additional page to complete this part

Description	Employer's Declaration

Information needed	What should be inserted
Name	Surname and first name of employer's representative
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**
	The Customer Service Representative completes the section of the form

What you should know about this claim
1. The injury benefit must be submitted within 14 days of the date of the accident/development of the prescribed industrial disease
2. Subsequent medical certificates must be submitted no later than fourteen (14) days from the last date of incapacity on the pervious medical certificate
3. 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
4. A copy of bank statement should be attached to verify account number
5. The Employment injury benefit may be paid for a maximum of 52 calendar weeks.
6.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
7 . 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

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

CLAIM 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.