THE NATIONAL INSURANCE BOARD
INVALIDITY BENEFIT APPLICATION

NI 38

(PLEASE USE BLOCK CAPITALS)

NOTE: (1) This application must be submitted within three (3) months of the first day of being certified an invalid.

(2) Birth Certificate and Affidavit (if necessary) must be submitted with claim form.

(FOR OFFICIAL USE)

CLAIM NO:

SERVICE CENTRE CODE:

SECTION - "A" TO BE COMPLETED BY APPLICANT

I hereby apply for Invalidity Benefit and furnish herewith a Medical Report.

1. NAME: SURNAME OTHER NAME(S)

2. HOME ADDRESS: (STREET)

(CITY/DISTRICT/COUNTY)

3. *POSTAL ADDRESS (if different from above): (STREET)

(CITY/DISTRICT/COUNTY)

4. NATIONAL INSURANCE NO:

5. DATE OF BIRTH: Y Y Y Y M M D D

6. GENDER: MALE ☐ FEMALE ☐

7. TELEPHONE NUMBER: -- (HOME) -- (CELLULAR)

8. MARITAL STATUS: SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. STATE MAIDEN NAME (Where applicable): SURNAME

10. LAST OCCUPATION:

11. NAME OF LAST EMPLOYER:

12. LAST EMPLOYER REGISTRATION NO: (If known)

13. EMPLOYMENT RECORD FROM 10 APRIL, 1972. (Please use an additional sheet of paper if more space is required.)

NAME OF EMPLOYER	ADDRESS OF EMPLOYER	TYPE OF EMPLOYMENT TEMPORARY/CASUAL/ PERMANENT	PERIOD OF EMPLOYMENT

14. DID YOU WORK OR LIVE IN CANADA OR WORKED IN ANY OF THE CARICOM COUNTRIES? ☐ YES ☐ NO

If "YES", please provide:

(i) SOCIAL SECURITY NO.

(ii) COUNTRY

* Please give mailing address.

EXAMPLE: Light Pole No. 8, Southern Main Road, Couva OR Near Bertie's Parlour, Industry Lane, Belmont.

SECTION - "A" TO BE COMPLETED BY APPLICANT (CONT'D)

15. LAST DATE OF EMPLOYMENT: Y Y Y Y M M D D

16. HAVE YOU EVER APPLIED FOR AN INVALIDITY BENEFIT? ☐ YES ☐ NO

17. I AM ABLE ☐ UNABLE ☐ TO TRAVEL TO A MEDICAL CENTRE FOR MEDICAL RE-EXAMINATION.

18. IS INVALIDITY THE RESULT OF AN INJURY ON THE JOB? ☐ YES ☐ NO

19. PLEASE INDICATE THE METHOD OF PAYMENT OF BENEFIT:

MAIL TO: ☐ POSTAL ADDRESS DEPOSIT TO: ☐ FINANCIAL INSTITUTION

FINANCIAL INFORMATION

(If method of payment is "FINANCIAL INSTITUTION", complete below).

The NIBTT considers the foregoing information as instructions from you regarding the deposit of your benefit payment to the financial institution of your choice.

The NIBTT is not liable for any payment issued to an inaccurate financial institution or account based on these instructions.

NAME OF FINANCIAL INSTITUTION

ADDRESS:

(STREET)

(CITY/DISTRICT/COUNTY)

ACCOUNT NUMBER:

NOTE: A recipient of Invalidity Benefit must inform the NIB when he/she resumes work at any job, including self employment. A person entitled to or in receipt of Invalidity Benefit may be required to be medically examined in Trinidad and Tobago.

DECLARATION

I declare that to the best of my knowledge and belief the information given by me is true and correct and I am aware that if there is any statement in this declaration which is false in fact or which I know or believe to be false or do not believe to be true, I am liable on summary conviction to a fine of three thousand dollars ($3,000.00) and to imprisonment for two years in accordance with Sect 33, NI Act Chap 32:01.

I hereby give permission for the NIBTT to update information from this form.

SIGNATURE OR MARK OF CLAIMANT

DATE: Y Y Y Y M M D D

PARTICULARS OF WITNESS TO MARK (Where Claimant Cannot Sign)

NAME: SURNAME OTHER NAME(S)

ADDRESS: (STREET)

(CITY/DISTRICT/COUNTRY)

VALID IDENTIFICATION: (Tick appropriate box) ☐ PASSPORT ☐ DRIVER'S PERMIT ☐ ELECTORAL I.D.

OCCUPATION:

NUMBER:

SIGNATURE OF WITNESS

DATE: Y Y Y Y M M D D

SECTION - "B" TO BE COMPLETED BY A REGISTERED MEDICAL PRACTITIONER

(MEDICAL PRACTITIONER'S REPORT)

NOTE: **National Insurance Legislation provides for the payment of Invalidity Benefit to an insured person who is unable to engage in any kind of gainful occupation 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.**

1. I certify that I examined Mr/Mrs/Miss. _____ (SURNAME)

_____ (OTHER NAME(S)) **on** _____ (Y Y Y Y M M D D). **In my opinion this patient is incapable of work* for a period of** _____ (words and figures) **months/years starting** _____ (Y Y Y Y M M D D).

***The term "incapable of work" means incapacity to do any kind of work, not necessarily the work which the person performed before his incapacity.**

2. Please describe specific findings that contribute to Insured Person's incapacity for work.

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NAME OF MEDICAL PRACTITIONER: _____ (SURNAME) _____ (OTHER NAME(S))

OFFICE ADDRESS: _____ (STREET)

_____ (CITY/DISTRICT/COUNTY)

REGISTRATION NUMBER OF MEDICAL PRACTITIONER: _____ **TELEPHONE NUMBER:** _____

I declare that to the best of my knowledge and belief the information given by me is true and correct and I am aware that if there is any statement in this declaration which is false in fact or which I know or believe to be false or do not believe to be true, I am liable on summary conviction to a fine of three thousand dollars ($3,000.00) and to imprisonment for two years in accordance with Sect 33, NI Act Chap 32:01.

MEDICAL PRACTITIONER'S STAMP

_____
SIGNATURE OF MEDICAL PRACTITIONER

DATE: _____ (YYYY MM DD)

SECTION "C" - FOR OFFICIAL USE

APPLICATION RECEIVED BY:

NAME: ______________________ ______________________
SURNAME OTHER NAME(S)

SERVICE CENTRE STAMP

SIGNATURE OF SERVICE CENTRE STAFF

DATE: YYYY MM DD

PART "I" - SERVICE CENTRE

1. Name, National Insurance Number and Date of Birth confirmed and updated, if necessary on IA System. ☐ Yes ☐ No
2. Registration Record Complete? (If No, complete NI 14, NI 165 & NI 182 application form) ☐ Yes ☐ No
3. Check for duplicate registration (SIRF file included). (Record results on minute sheet) ☐ Yes ☐ No
4. Claim history viewed? (Record results on Minute Sheet) ☐ Yes ☐ No
5. (a) Contribution Record Generated? ☐ Yes ☐ No
   (b) Outstanding contribution Records captured? ☐ Yes ☐ No
6. Application Recorded? (Print and attach claim Profile) ☐ Yes ☐ No

CUSTOMER SERVICE REPRESENTATIVE

SIGNATURE

DATE: Y Y Y Y MM DD