THE NATIONAL INSURANCE BOARD - TRINIDAD AND TOBAGO

CAN/TT 1.2

APPLICATION FOR INVALIDITY BENEFIT
UNDER THE AGREEMENT ON SOCIAL SECURITY BETWEEN TRINIDAD AND TOBAGO/CANADA

Please NOTE the Documentary Evidence Requirements at the back of this form. Please complete all sections in capitals.

SECTION "A" - PARTICULARS OF CONTRIBUTOR

1. NAME: _____ *SURNAME* _____ *OTHER NAME(S)*

1.1 NATIONAL INSURANCE NUMBER

2. NAME AT BIRTH IF DIFFERENT: _____ *SURNAME* _____ *OTHER NAME(S)*

2.1 CANADIAN SOCIAL INSURANCE NUMBER

3. ADDRESS: _____

3.1 TELEPHONE NUMBER: _____

4. DATE OF BIRTH: YYYY MM DD

5. SEX: ☐ MALE ☐ FEMALE

6. FATHER'S NAME: _____ *SURNAME* _____ *OTHER NAME(S)*

7. MOTHER'S MAIDEN NAME: _____ *SURNAME* _____ *OTHER NAME(S)*

8. MARITAL STATUS: *(Tick (✓) Appropriate Box)*

8.1 ☐ SINGLE 8.2 ☐ MARRIED 8.3 ☐ WIDOWED 8.4 ☐ DIVORCED 8.5 ☐ SEPARATED 8.6 ☐ COMMON-LAW

SECTION "B" - PARTICULARS OF ILLNESS

1. WHEN DID YOUR INCAPACITY TO WORK COMMENCE? YYYY MM DD

2. ARE YOU IN RECEIPT OF ANY BENEFIT NOW? ☐ YES ☐ NO

If yes, state the type of benefit. _____

SECTION "C" - PARTICULARS OF EMPLOYMENT

1. NAME AND ADDRESS OF LAST EMPLOYER IN TRINIDAD AND TOBAGO:

_____

_____

2. LAST DATE WORKED IN TRINIDAD AND TOBAGO: YYYY MM DD

3. EMPLOYMENT RECORD IN TRINIDAD AND TOBAGO FROM 1972 APRIL 10.
Use additional sheets if necessary.

3.1 NAME OF EMPLOYER	3.2 ADDRESS	3.3 REGISTRATION NUMBER (If known)	3.4 PERIOD OFEMPLOYMENT FROM YYYY MM DD	TO YYYY MM DD

SECTION "C" - PARTICULARS OF EMPLOYMENT (CONT'D)

4. PERIOD OF EMPLOYMENT IN OTHER COUNTRIES.

4.1 COUNTRY	4.2 NAME OF EMPLOYER	4.3 ADDRESS	4.4 REGISTRATION NUMBER (If known)	4.5 PERIOD OF EMPLOYMENT FROM YYYY MM DD	TO YYYY MM DD

SECTION "D" - PAYMENT ARRANGEMENTS

1. Please forward payment to:

NAME OF FINANCIAL INSTITUTION: _____

ADDRESS OF FINANCIAL INSTITUTION: _____

_____

ACCOUNT NUMBER: | | | | | | | | | | | | | | | |

BANK BRANCH NUMBER OR CODE (if any): | | | | | | | | |

CURRENCY OF THE COUNTRY IN WHICH YOU RESIDE: _____

2. Is the Account a Joint Account? ☐ YES ☐ NO

If yes, please state name and address of the Joint Account holder. _____

_____

_____

SECTION "E" - MEDICAL PRACTITIONER'S REPORT (TO BE COMPLETED BY A REGISTERED MEDICAL PRACTITIONER)

NOTE: **National Insurance Legislation of Trinidad and Tobago (1999) provides for the payment of an Invalidity benefit to any contributor between the ages of 16 and 60 who is an invalid. An invalid is a person likely to remain incapable of work for a period of not less than twelve months as a result of a specific disease or bodily or mental disablement.**

1. Kindly give a full clinical description of the contributor's condition that has caused him/her to be an invalid: .

_____

_____

_____

_____

2. State the date that the condition referred to in 1 above rendered the contributor an invalid: | | | | | | | | | YYYY | | MM | DD |

3. Is this condition likely to be permanent?: ☐ YES ☐ NO

4. If "No" how long is this condition expected to last: (Specify in terms of weeks, months or years) | | | | | | | | | YYYY | | MM | DD |

5. Can the contributor perform any kind of work now? ☐ YES ☐ NO

If "Yes" please describe

_____

_____

SECTION "E" - MEDICAL PRACTITIONER'S REPORT (TO BE COMPLETED BY A REGISTERED MEDICAL PRACTITIONER) (CONT'D)

6. How long have you been treating this contributor?. ______________________

7. ADDITIONAL REMARKS (if any) ______________________

____

____

8. DOCTOR'S ADDRESS ______________________

____

____

8.1 TELEPHONE NUMBER: ______________________

9. ______________________
NAME OF DOCTOR (in Block Capitals) OR STAMP WITH NAME

10. ______________________
SIGNATURE OF DOCTOR

11. DATE: YYYY MM DD

IT IS AN OFFENCE UNDER THE LAWS OF TRINIDAD AND TOBAGO TO MAKE A FALSE OR MISLEADING STATEMENT IN THIS

SECTION "F" -AUTHORIZATION

AUTHORIZATION TO TRANSMIT PERSONAL INFORMATION

For the purpose of this application made under the legislation of Trinidad and Tobago, I authorize Human Resources Development Canada to furnish to the National Insurance Board of Trinidad and Tobago any information in its possession which relates or could relate to this application.

SECTION "G" -DECLARATION AND SIGNATURE OF APPLICANT

1. **DECLARATION OF APPLICANT**

I hereby declare that to the best of my knowledge and belief the information given is true and correct, and I undertake to notify the National Insurance Board of Trinidad and Tobago of any change that might affect my entitlement to this Benefit.

1.1 SIGNATURE OF CLAIMANT:

____

DATE: YYYY MM DD

2. **DECLARATION OF WITNESS**

(Where Contributor Cannot Sign)

I have read this application to the applicant, who appears to understand the contents and has affixed his/her mark.

2.1 NAME OF WITNESS:

____
SURNAME *OTHER NAME(S)*

2.2 ADDRESS OF WITNESS:

____

____

2.3 SIGNATURE OF WITNESS:

____

DATE: YYYY MM DD

(FOR OFFICIAL USE)

Documentary Evidence Required to Support Claim.

Boxes are to be Ticked ( ) by the liaison agency in Canada upon receipt of documentary evidence.

1. PROOF OF AGE

- ☐ (a) Birth Certificate AND Affidavit if applicant's name does not appear on the Birth Certificate
- ☐ (b) Valid Passport; or
- ☐ (c) Electoral Identification Card (Trinidad and Tobago)

2. CHANGE OF NAME

- ☐ (a) Marriage Certificate (Females Only)
- ☐ (b) Deed Poll

NIB,
TRINIDAD AND TOBAGO
1999 JUNE 22