NI 119

THE NATIONAL INSURANCE BOARD
APPLICATION FOR DISABLEMENT BENEFIT

(PLEASE USE BLOCK/CAPITALS)

NOTE: The claim must be submitted within three (3) months of the date on which the injury benefit was last received or date the accident occurred.

(FOR OFFICIAL USE)
CLAIM NO:
SERVICE CENTRE CODE:

SECTION "A" - TO BE COMPLETED BY APPLICANT

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: YYYY MM DD

6. GENDER: ☐ MALE ☐ FEMALE

7. TELEPHONE NUMBERS: (HOME) -- / (OFFICE/WORK) -- / (CELLULAR) --

8. OCCUPATION:

9. DATE OF ACCIDENT: YYYY MM DD

10. TIME OF ACCIDENT: ______ A.M/P.M

11. PLACE OF ACCIDENT: (STREET) / (CITY/DISTRICT/COUNTY)

12. LAST DATE WORKED: YYYY MM DD

13. EMPLOYER'S NAME AT TIME OF ACCIDENT:

14. TELEPHONE NUMBER: --

15. EMPLOYER'S ADDRESS OF ACTUAL PLACE OF WORK:(e.g. School/ Department/Division) (STREET) / (CITY/DISTRICT/COUNTY)

16. EXACT PLACE/LOCATION WHERE ACCIDENT OCCURED: (STREET) / (CITY/DISTRICT/COUNTY)

17. Have you ever applied for Injury Benefit as a result of the same Accident/Prescribed Disease? ☐ Yes ☐ No

    If "Yes", please state the name of the Service Centre and complete questions 21 to 25.

    If "No", complete questions 18 to 25.

18. Did accident occur while travelling in employment? ☐ Yes ☐ No
    If "Yes", give details:-

    (a) Place of embarkation: (STREET) / (CITY/DISTRICT/COUNTY)

    (b) Destination: (STREET) / (CITY/DISTRICT/COUNTY)

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

(c) Purpose of presence on vehicle: ______________________________

____

If "NO", was the vehicle used by an arrangement with the employer: ______________________________

____

19. NAME OF ANY WITNESS TO ACCIDENT: [ ] SURNAME [ ] OTHER NAME(S)

20. ADDRESS OF WITNESS TO ACCIDENT: [ ] (STREET) [ ] (CITY/DISTRICT/COUNTY)

21. What injuries were observed as a result of the accident? ______________________________

____

____

____

22. State clearly the nature of disability as a result of the Accident/Prescribed Disease? ______________________________

____

____

____

23. Are you at present incapable of work as a result of the accident? ☐ YES ☐ NO

24. Are you fit to travel for Medical Examination? ☐ YES ☐ NO

25. Were/are you hospitalised because of the accident? ☐ YES ☐ NO

If "YES",please state the Name and Address of the Hospital/Nursing Home.

____

____

HOSPITALIZATION: [ ] YYYY MM DD TO [ ] YYYY MM DD

26. **PLEASE INDICATE 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: [ ]

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

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.

SIGNATURE OF CLAIMANT

DATE: YYYY MM DD

PARTICULARS OF WITNESS TO MARK (Where Claimant Cannot Sign)

NAME: SURNAME OTHER NAME(S)

ADDRESS: (STREET)

(CITY/DISTRICT/COUNTY)

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

OCCUPATION:

NUMBER:

SIGNATURE OF WITNESS TO MARK

DATE: YYYY MM DD

SECTION "B"- DETAILS OF INCAPACITY AND MEDICAL CERTIFICATION (FOR OFFICIAL USE)

Mr./Mrs./Miss SURNAME OTHER NAME(S) was certified

incapable of work from YYYY MM DD to YYYY MM DD and has had (Words and Figures)

provisional assessment(s) for the period YYYY MM DD to YYYY MM DD by the following Doctor(s)

because of Employment Injury/Prescribed Disease.

NAME OF DOCTOR	NATURE OF INCAPACITY	DURATION					
		FROM			TO		
		YYYY	MM	DD	YYYY	MM	DD
1.							
2.							
3.							
4.							

SECTION "C" - MEDICAL REPORT TO BE COMPLETED BY MEDICAL PRACTITIONER

1. NAME OF CLAINANT ☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐☐☐☐☐
   SURNAME OTHER NAME(S)

2. DATE OF ACCIDENT: ☐☐☐☐ ☐☐ ☐☐
   YYYY MM DD

3. IS THIS A FINAL ASSESSMENT OF DISABILITIY? ☐ Yes ☐ No

   If "No", complete 3(a) and 3(b)

   (a) State reason: ____________________

   (b) Are you able to give a provisional assessment of disability? ☐ Yes ☐ No

   If "No", state reason: ____________________

   (c) If answer to 3 or 3 (b) is "Yes" then kindly state the full clinical description of the claimant's present condition:

   ____

4. Is claimant fit for work? ☐ Yes ☐ No

   If "No", give reason: ____________________

5.
   (a) Has this claimant suffered a loss of faculty as a result of Employment Injury/Prescribed Disease? ☐ Yes ☐ No

   (b) Is this claimant in a position to travel on his/her own? ☐ Yes ☐ No

   I am of the opinion that:

   (c) The extent of disability is assessed at. ____ % ____
   (Words and Figures)

   The disability will persist for a period of ____________________
   (Words and Figures)

   ☐ Days ☐ Weeks ☐ Months ☐ Permanently with effect from ☐☐☐☐ ☐☐ ☐☐ .
   YYYY MM DD

6. Additional remarks by Medical Practitioner: ____________________

SECTION "C" - MEDICAL REPORT TO BE COMPLETED BY MEDICAL PRACTITIONER (CONT'D)

NAME OF MEDICAL PRACTITIONER:

SURNAME

OTHER NAME(S)

OFFICE ADDRESS OF MEDICAL PRACTITIONER:

(STREET)

(CITY/DISTRICT/COUNTY)

REGISTRATION NUMBER OF MEDICAL PRACTITIONER:

TELEPHONE NO.

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.

SIGNATURE OF MEDICAL PRACTITIONER

MEDICAL PRACTITIONER'S STAMP

DATE: YYYY MM DD

NOTE: A provisional assessment of permanent partial disability (p.p.d.) is an interim asessment given where in the opinon of the medical practitioner, a final assessment of p.p.d. cannot be made at the requested time. A medical practitioner who gives a provisional assessment must give detailed reasons for opting to give a provisional asessment instead of a final asessment.

SECTION "D" - PARTICULARS OF EMPLOYER - 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.

1. NAME OF EMPLOYER:

   SURNAME

   OTHER NAME(S)

2. EMPLOYER NO:
3. TYPE OF BUSINESS:
4. TELEPHONE NUMBER: --
5. Descibe the work the injured person does:
6. Was the insured an apprentice? ☐ Yes ☐ No
7. State below the wages paid or payable in

   (i) Week prior to the week of the accident $

   (ii) Week in which the accident occurred $

SECTION "D" - PARTICULARS OF EMPLOYER - TO BE COMPLETED BY EMPLOYER (CONT'D)

8. Are the particulars stated in Section "A" accurate? ☐ Yes ☐ No
   If "NO", please give details:

9. Did accident occur during working hours? ☐ Yes ☐ No
   If "NO"to either (a) or (b), give details:

10. Has the accident been recorded in the employer's accident boook? ☐ Yes ☐ No

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.

NAME: SURNAME OTHER NAME(S)

POSITION:

COMPANY'S STAMP

SIGNATURE OF EMPLOYER

DATE: YYYY MM DD

SECTION "E" - 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" - CUSTOMER SERVICE REPRESENTATIVE

1. NAME, N.I. NO. AND DATE OF BIRTH CONFIRMED AND UPDATED (IF NECESSARY) ON I.A. SYSTEM — YES ☐ NO ☐
2. REGISTRATION RECORD COMPLETE? (If "NO" complete forms NI 4/NI 165/NI 182 as applicable) — YES ☐ NO ☐
3. CHECK FOR DUPLICATE REGISTRATION (SIRF file included)? (Record Results on Minute Sheet) — YES ☐ NO ☐
4. CLAIM HISTORY VIEWED? — YES ☐ NO ☐
   (If yes, record findings here.)
   (Use minute sheet if this space is inadequate.)
5. APPLICATION COMPLETED AND ACCEPTED FOR PROCESSING? — YES ☐ NO ☐
6. APPLICATION RECORDED? (Print and attach Claim Profile) — YES ☐ NO ☐

SIGNATURE OF CUSTOMER SERVICE REPRESENTATIVE

DATE: YYYY MM DD