NI 12A

THE NATIONAL INSURANCE BOARD
MEDICAL REPORT CERTIFYING MULTIPLE BIRTHS

(PLEASE USE BLOCK/CAPITALS)

(FOR OFFICIAL USE)
CLAIM NO:
MB/SM NO.:
SERVICE CENTRE CODE:

NOTE: **This form is to be completed only when the pregnancy results in the birth of more than one child. It is to be completed and lodged at the National Insurance Board within three (3) months of the Date of Delivery.**

SECTION "A" - TO BE COMPLETED BY APPLICANT

1. NAME: SURNAME OTHER NAME

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

7. DID PREGNANCY LAST AT LEAST 26 WEEKS? ☐ YES ☐ NO

If "NO"

(a) DID THE PREGNANCY RESULT IN THE BIRTH OF A LIVING CHILD/CHILDREN? ☐ YES ☐ NO

8. HOW MANY CHILDREN WERE DELIVERED? _____ (words and figures)

9. DID YOU COMPLETE AND SUBMIT: (a) NI 12 - Maternity Benefit Application ☐ YES ☐ NO

(b) NI 13 - Special Maternity Grant Application ☐ YES ☐ NO

If "NO" to both questions 9(a) and 9(b), Please complete and attach NI 12 or NI 13

10. PLEASE INDICATE THE METHOD OF PAYMENT OF BENEFIT:

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

*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)

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 OF FINANCIAL INSTITUTION:

(STREET)

(CITY/DISTRICT/COUNTY)

ACCOUNT NUMBER:

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 OR MARK OF APPLICANT

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 One Box)

- PASSPORT
- DRIVER'S PERMIT
- ELECTORAL I.D.

OCCUPATION:

NUMBER:

SIGNATURE OF WITNESS TO MARK

DATE: Y Y Y Y M M D D

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

CERTIFICATE OF ACTUAL DELIVERY RESULTING IN MULTIPLE BIRTHS

I hereby certify that Miss/Mrs. _____ _____

SURNAME OTHER NAME(S)

Delivered ..... on _____ at .....

(number of children) (words and figures) Y Y Y Y M M D D (Name of Institution/Place of Delivery)

NAME OF MEDICAL PRACTITIONER /MIDWIFE: _____ _____

SURNAME OTHER NAME(S)

REGISTRATION NUMBER: _____

ADDRESS OF MEDICAL _____

(STREET)

PRACTITIONER/ MIDWIFE: _____

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/MIDWIFE