

The National Insurance Board of Trinidad and Tobago

Maternity Benefit Application

F-IOP-NI12

INSTRUCTIONS

1. Please complete in CAPITAL letters.

- 2. Please complete in black or blue ink. The use of correction fluid is prohibited
- 3. The Application must be submitted within three (3) months of the date of Delivery.

FOR OFFICIAL USE						
Loca	al Off	ice N	lo.			
L						
Claim No.						

SECTION "A" - TO BE COMPLETED BY APPLICANT							
1. Name: Surname Other Name(s)							
2. Home Address:							
Street City/District/County							
3. *Postal							
Address (if Street Street							
above): City/District/County							
4. Valid Identification Document: (Tick appropriate box) (Present original and copy of ID)							
☐ Electoral Identification Card ☐ Passport ☐ Driver's Permit Number:							
5. National Insurance No: 6. Date of Birth :							
y y y m m d d							
7. Email address:							
8. Was Evidence of Date of Birth Previously Submitted? If "No", submit Birth Certificate, Passport or Affidavit with this application.							
9. Telephone No.:							
(Home) (Office/Work) (Cellular)							
10. Have You Changed Your Name or Marital Status Since Registration?: YES NO If "Yes", submit Marriage Certificate or Deed Poll.							
11. Occupation:							
12. Business Name of Employer:							
13. *Employer's Address:							
Street							
City/District/County							
14. Name of Actual Place of Work: (e.g. School/Department/Division)							
15. Address of Actual Place of Work:							
Street							
City/District/County							
16. Are You Currently Employed Elsewhere?: YES NO							
If "YES", state Business Name and Address of other employer. Business Name of Employer:							
Employer's Address:							
Street							

SECTION "A" - TO BE COMPLETED BY APPLICANT (Cont'd)							
17. Last Date Worked:	y m m d d	Period of	Absence:	y y y	m m d	TO y	y y y m m d d
18. Please Indicate The Method o		efit:	,	, , ,		,	, , ,
Mail To: Postal Addres	is	ı	Deposit To:	Finar	ncial Institu	ution	
	FIN	NANCIAL	INFORM	<u>ATION</u>			
(If method of payment is "Fina	ıncial Institution",	complete be	elow.)				
The NIBTT considers the foregoing institution of your choice.	information as in	structions fr	om you regar	ding the o	deposit of	your benefit	payment to the financial
,						1 4	
The NIBTT is not liable for any pay	ment issued to an	i inaccurate i	inancial insti	tution or	account b	ased on these	e instructions.
Name of Financial Institution:							
Address of Financial							
Institution:			Street				
Account Number:		City	/District/Cou	nty			
] 	. 1:6: . 1 6		4
National Insurance (Benefits) R if during the period when such	benefit is payable	es an insured e she engages	person snaii in any work	for which	alified from n remunera	n receiving mation is or wo	ould ordinarily
be payable.		DECL	A D A TION				
I declare that to the best of my	knowledge and b		ARATION given	by me is	s true and	correct and I	am aware that if
there is any statement in this de	eclaration which is	s false in fact	or which I k	now or be	elieve to b	e false or do	not believe to be
true, I am liable on summary co in accordance with Sect 33, NI		ot three tho	usand dollars	(\$3,000.	.00) and to	imprisonme	nt tor two years
I hereby give permission to The	National Insuran	so Board of	Frinidad & To	hago to i	undata my	rogistration	information from
this form.	National insuran	ce board or	iiiiidad & id	bago to t	upuate my	registration	miormation from
							
Signature of Claiman	t	_			Date:		m m d d
ADDLICATI	ON SUBMITTI	FD DV TIII	DD DADTV	/Dawaa	41 41.		
APPLICATI	ON SUBMITTI	וחו זם טב	KD PAKII	(Person	i otner tr	ian Ciaima	int)
1							hereby authorize
Claimant's Sur	name		Claim	ant's Oth	ner Name(s)]
							to submit this claim
Surname on my behalf.	!			Other Na	ame(s)		
Third Party must present a valid form of National Identification and provide contact information in order to submit claim (Present original and copy of ID)							
Valid Identification Document: (Tick appropriate box)							
Electoral Identification Card	Passport	Driv	er's Permit	Numbe	er:		
Telephone No.:							
(Ho	me)		(Office/Worl	()		(Cell	ular)
Relationship to Claimant:							
Signature of Claiman	t	_			Date:		
						уууу	m m d d
Signature of Third Part	ty	_			Date:	V V V V	

3/F-IOP-NI12 PARTICULARS OF WITNESS TO MARK (Where Claimant/Third Party Cannot Sign) Name: Other Name(s) Surname **Address:** Street City/District/County **Occupation:** Valid Identification Document: (Tick appropriate box) **Electoral Identification Card** Passport **Driver's Permit Number:** Date: Signature of Witness to Mark y y y m m d d SECTION "B" - TO BE COMPLETED BY A REGISTERED MEDICAL PRACTITIONER OR MIDWIFE CERTIFICATE OF EXPECTED/ACTUAL DELIVERY To be completed not earlier than the 11th week prior to the expected date of delivery. I hereby certify that Miss/Mrs. Other Name(s) Surname Expected/Actual date of delivery is/was was examined by me on y y y y m m d d y y y m m d d Is Pregnancy at least 26 weeks old at the Date of Examination? Yes No Did Delivery result in the birth of a living child or children Yes No If "Yes" (i) State number of children **Words and Figures** Name of Medical **Practitioner/Midwife:** Surname Other Name(s) Office Address of Medical **Practitioner/Midwife:** Street City/District/County **Registration 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.

Signature of Medical Practitioner/Midwife



Telephone No.:

	<u>y</u>	у ,	у	у	m	m	d	d
Date :								

of Medical Practitioner/

Midwife:

<u>INS</u>	TRUCTIONS FOR COMPLETION OF QUESTIONS 4(a) TO 6								
(i)	(i) (a) In completing Question 4(a) refer to expected/actual date of delivery in SECTION "B".								
	(b) Check 6 weeks before the expected/actual week of delivery and enter date at 4 (b).								
	(c) Complete item 5, Table IA, colums (a), (b), (c) for the 13 weeks period prior to the week established at 4 (b).								
(ii)	In completing Table IA determine weekly earnings as follows:								
	(a) Where pay frequency is monthly: Monthly Earnings x 3 e.g. \$800 x 3 13	= \$184.62 (weekly) <u>OR;</u>							
	(b) Where pay frequency is fortnightly: Fortnightly Earnings e.g. \$200 2 2	= \$100.00 (weekly)							
SEC	TION "C" - TO BE COMPLETED BY EMPLOYER								
1. E	Employer's Name:								
R	egistration No.: Telephone	No.: -							
'2. T	This is to certify that Miss/Mrs Surname	Other Name(s)							
h	as been absent from work effective	on maternity leave.							
*1	y y y m m d d y y y m	m d d							
	*Please refer to Table of Absence, IB, at question (6). 3. Applicant is still employed no longer employed y y y y m m d d								
If	f "No Longer Employed" state reason(s).								
4. (a) Expected Week of delivery begins Monday:	TABLE IA							
	5								
	y y y m m d d	State Weekly Rates of Pay for the 13 week period BEFORE the week as							
(b) Sixth week before expected date of delivery begins Monday:	calculated at 4(b) in section C. (a) (b) (c)							
	y y y m m d d	(a) (b) (c) WK Date Actual Earnings NO.							
c	TABLE IB	1							
6.	TABLE ID	2							
	PERIOD OF ABSENCE	3							
	TYPE OF LEAVE FROM TO	5							
	yyyy mm dd yyyy mm dd	6							
		7							
		8 9							
		10							
		11							
		12 13							

Total

SECTION "C" - TO BE COMPLETED BY EMPLOYER (Cont'd)						
EMPLOYER'S 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.						
Name: Surname Other Name(s)						
Position:						
Signature COMPANY STAMP (If any) Date: y y y y m m d d						
SECTION "D" - FOR OFFICIAL USE						
APPLICATION RECEIVED BY:						
Name: Surname Other Name(s)						
Signature of Service Centre Staff SERVICE CENTRE STAMP Date: y y y y m m d d						
PART I - CUSTOMER SERVICE REPRESENTATIVE						
1. Name, N.I. No. and Date of Birth Confirmed and Updated (If Necessary) On I.A. System?						
2. Registration Record Complete? (If "No" complete forms NI 165/NI 182 as applicable) Yes No						
3. Check for Duplicate Registration (SIRF file included)? (Record Result on Minute Sheet						
4. Claim History Viewed? (If yes, record findings here.) (Use minute sheet if this space is inadequate.)						
5. Application Completed and Accepted for Processing?						
6. Application Recorded? (Print and attach Claim Profile)						
7. Contribution Recorded and Transferred? (Print and attach Audit Report)						
8. Application Processed?						
Customer Service Representative Date: y y y y m m d d						