NI 15A

THE NATIONAL INSURANCE BOARD
CONTINUATION CLAIM TO SICKNESS BENEFIT

(PLEASE USE CAPITAL LETTERS)

NOTE: Subsequent medical certificates must be submitted no later than three (3) months from the last date of incapacity on the previous medical certificate.

(FOR OFFICIAL USE)
CLAIM NO:

SERVICE CENTRE CODE:

SECTION "A" - PARTICULARS OF APPLICANT

I. _____ _____ hereby consent to the
SURNAME OTHER NAME(S)

follow-up Medical Certificate at Section "B" being submitted to the National Insurance Board.

NATIONAL INSURANCE 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.

_____ DATE: _____
SIGNATURE OR MARK OF CLAIMANT 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/COUNTY)

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

OCCUPATION: _____ NUMBER: _____

_____ DATE: _____
SIGNATURE OF WITNESS TO MARK YYYY MM DD

SUBSEQUENT MEDICAL CERTIFICATE

SECTION "B" - TO BE COMPLETED BY MEDICAL PRACTITIONER

I hereby certify that Mr/Mrs/Miss _____ _____
SURNAME OTHER NAME(S)

was examined by me on _____ and in my opinion was at the time suffering from
Y Y Y Y M M D D

_____

_____

In my opinion this patient will remain incapable of work for a period of _____ days starting from
words and figures

_____
Y Y Y Y M M D D

Information has been sent to the Board's Medical Adviser? ☐ YES ☐ NO

07/2009

SECTION "B" - TO BE COMPLETED BY MEDICAL PRACTITIONER (Cont'd)

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

NOTE: In the case of a FIRST or SECOND CERTIFICATE the period of certified incapacity must not exceed 14 DAYS including Sundays and Public Holidays. In the case of a THIRD OR SUBSEQUENT CERTIFICATE THE PERIOD entered must not exceed 28 DAYS including Sundays and Public Holidays.

SECTION "C" - TO BE COMPLETED BY EMPLOYER

INSTRUCTIONS FOR COMPLETION

(i) This Section must be completed by the Employer before the Application is submitted to the Board.

(ii) In completing Column 4(d) below proceed as follows:

(a) Earnings mean wages or salary and include overtime payments, long service payments, commissions, payment for standby duty, all allowances, etc.

(b) Weekly Earnings $= \frac{\text{Monthly Earnings x 3}}{13}$ (e.g. $\$\frac{800.00 \times 3}{13} = \$184.62$) OR

(c) Weekly Earnings $= \frac{\text{Fortnightly Earnings}}{2}$ (e.g. $\$\frac{240.00}{2} = \$120.00$)

(d) Daily Earnings $= \frac{\text{Weekly Earnings}}{7}$ (e.g. $\$\frac{120.00}{7} = \$17.14$)

1. EMPLOYER'S NAME:

REGISTRATION NO: TELEPHONE NO: -

2. This is to certify that during the period recorded at Section "B" of this form Mr/Mrs/Ms SURNAME

OTHER NAME(S) has been absent from work.

Sickness ☐ is/ ☐ is not as a result of an accident on the job.

3. Applicant ☐ is still employed ☐ no longer employed.

If "NO LONGER EMPLOYED", state reason(s):

DATE OF SEPARATION: YYYY MM DD

SECTION "C" - TO BE COMPLETED BY EMPLOYER (Cont'd)

4. **DAILY EARNINGS DURING SICKNESS**

(a) NO.	(b) PERIOD OF ABSENCE FROM YYYY	MM	DD	TO YYYY	MM	DD	(c) TOTAL NO. OF DAYS	(d) DAILY EARNINGS DURING SICKNESS $	c
1									
2									
3									
4									
5									

5. Was Loss of Earnings caused by sickness?

(a) ☐ Yes (b) ☐ No

If "No", please state reason for Loss of Earnings:

_____

_____

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:

COMPANY STAMP (If any)

SIGNATURE OF EMPLOYER

DATE: YYYY MM DD

SECTION "D" - FOR OFFICIAL USE

RECEIVED BY:

NAME: SURNAME OTHER NAME(S)

SERVICE CENTRE RECEIVED STAMP

SIGNATURE OF CUSTOMER SERVICE REPRESENTATIVE

DATE: YYYY MM DD