## THE NATIONAL INSURANCE BOARD SICKNESS BENEFIT APPLICATION

## (PLEASE USE CAPITAL LETTERS)

NOTE: This Application must be submitted within 3 months of onset of Illness or Loss of Earnings which ever is later.

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SERVICE CENTRE CODE:										
	CLAI	CLAIM NO	CLAIM NO:	CLAIM NO:	CLAIM NO:					

2039 Of Edithings which ever is later.	
SECTION "A" - TO BE COMPLETED BY APPLICANT	
1. NAME: CLIPNAME  OTHER NAME(S)	
SURNAME OTHER NAME(S)	
2. HOME ADDRESS:	
(STREET)	
L	
3. *POSTAL	
ADDRESS (if (STREET)	
above):	
(CITY/DISTRICT/COUNTY)  4. NATIONAL INSURANCE NO:	
	7
5. DATE OF BIRTH: YYYY MM DD 6. BIRTH CERTIFICATE PIN NO:	_
7. WAS EVIDENCE OF DATE OF BIRTH PREVIOUSLY SUBMITTED? YES NO	
If "NO" submit Birth Certificate or Passport with this application.	
8. GENDER: MALE FEMALE 9. MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCE	ĒD
10. TELEPHONE NUMBERS:	$\neg$
(HOME) (OFFICE/WORK) (CELLULAR)	
11. OCCUPATION:	
The second and the se	
12. EMPLOYER'S NAME:	
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)	
(CITY/DISTRICT/COUNTY)	

SECTION "A" - TO BE COMPLETED BY APPLICANT (CONT'D)
17. IS SICKNESS AS A RESULT OF INJURY ON THE JOB?
18. LAST DATE WORKED:
19. DATE LOSS OF EARNINGS STARTED:  YYYY M M D D
20. PLEASE INDICATE THE METHOD OF PAYMENT OF BENEFIT:
MAIL TO: 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 th 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:
Sickness Benefit will be paid for a period of 52 WEEKS, if there is a loss of earnings. At the end of this
period, if the recipient is still ill, he may be eligible for Invalidity Benefit.
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.
I declare that I am losing earnings and have not worked for the period claimed as a result of my illness.
I hereby give consent for the Medical Certificate at Section "B" to be sent to the National Insurance Board of Trinidad and Tobago.
I hereby give permission for NIBTT to update information from this form.
SIGNATURE OR MARK OF CLAIMANT  DATE:
PARTICULARS OF WITNESS TO MARK (Where Claimant Cannot Sign)
NAME: SURNAME OTHER NAME(S)
ADDRESS: PASSPORT (STREET)
VALID IDENTIFICATION: DRIVER'S PERMIT (Tick appropriate box)
(CITY/DISTRICT/COUNTY) ELECTORAL I.D.
OCCUPATION: NUMBER: NUMBER:
<del></del>
DATE:

SECTION "B" -	TO BE	COI	/IPLE	TED	BY	ME	DIC	AL F	PRAC	TIT	ΊΟ	NE	R											
I hereby certify that	Mr/Mrs/Ms				SUF	RNAN	IE				] [				0	THER	NAI	ME(S	S)					
was examined by me	e on	   Y Y Y	I Y	M	M	D D	an	d in m	y opin	ion w	as a	t the	e tim	ie si	uffer	ing fr	om							
This patient will remain	ain incapab	le of w	ork for	a per	iod of				(w	ords a	and 1	figur	es)							− day	's st	artin	g fro	ım
YYYY	M M	D D	].	Confi	dential	infor	matio	n has I	oeen s	ent to	the	Boa	ırd's	Me	dical	Advi	ser.			YES			] N	0
NAME OF MEDICAL PRACTITIONER:										] [														
OFFICE ADDRESS:		П		SURI	NAME			Т	П		1		Ι		7	01	HER	NA	ME(	(S)				
		<del></del>	<u> </u>	$\frac{\perp}{\Box}$		(ST	REET				<u> </u>				J T									
				Ш	(CITY/I	DISTE	RICT/C	TNUO	Y)						_									
REGISTRATION NUM	_	Γ		Τ	П	T	Π	T			TEL	.EPH	ONE	NU	IMBE	R:	Τ	Т	T			T		$\neg$
I declare that to the is any statement in liable on summary with Sect 33, NI A	n this decl convictio	laration on to a	n which	ch is	false i	in fac	et or v	which	I kno	w or	beli	ieve	to	be '	false	or o	do n	ot b	oelie	eve t	o b	e tru	ıe. I	am
								PR	ACT	DIC. ITIO TAN	NE	R'S	ò											
SIGNATURE OF ME	EDICAL PRA	ACTITIO	ONER				- (							J		DAT	E: [		 YYY			 MM	$\perp$	
NOTE: In the case	of a FIRST	or SEC	OND C	FRTIF	:ICATE	the r	period	of cer	tified i	ncana	ocity	mus	et no	ut av	, caa,	N 14	DAV							
Public Holida In the case Holidays.	ays.																							С
Holidays.																								

## SECTION "C" - TO BE COMPLETED BY EMPLOYER

## INSTRUCTIONS FOR COMPLETION

- This Section must be completed by the Employer before the Application is submitted to the Board.
- (ii) In completing Column 5 (c) and 6 (d) below calculate weekly earnings as follows:
  - (a) Earnings mean wages or salary and include overtime payments, long service payments, commissions, payment for standby duty, all allowances, etc.
  - (e.g.  $$1800 \times 3 = $184.62$ ) OR; (b) Weekly Earnings =  $\underline{\text{Monthly Earnings}}$  x 3
  - (c) Weekly Earnings = Fortnightly Earnings (e.g. \$\_240 = \$ 120.00)
  - (d) Daily Earnings = Weekly Earnings e.g. \$ 120

1.	EMPLOYER'S NAME:													
														_

REGISTRATION NO:				TELEPHONE NO:		-		

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2.	This is to certify that Mr/Mrs/Ms																	

has been absent from work continuously since	VV	V V	M	M	_	_	ı
has been absent from work continuously since	1					ı	1

- 3. Is Sickness as a result of an accident on the job?
- Is Applicant still employed? NO

If "NO", state reason (s):	

if NO , state reason (s):	DAT	E OF	SEP	ARAT	TION:	:
		YY	$\overline{YY}$		M	

**WEEKLY RATE OF PAY** State Weekly Rates of Pay for the 13 week period BEFORE the week in which the employee's

incapaci	ty starte	d. 5(	b) M	ondays only.	
(a) WK NO.		(b) ATE  MM	DD	(c) ACTUAL \ EARNI \$	WEEKLY
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					

6. **DAILY EARNINGS DURING SICKNESS** 

(a) <b>NO.</b>	FR	ЮМ	D OF		ГО		(c) TOTAL NO. OF DAYS	(d) DAILY EARNING DURING SICKNES	;
	YYYY	ММ	DD	YYYY	MM	DD		\$	С
1									
2									
3									
4									
5									

D D

<ol><li>Was Loss of Earnings CAU</li></ol>	JSED BY SICKNESS?
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If "NO", Please s	tate reason for Loss of Earnings	

5.

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: OTHER NAME(S)						
POSITION:						
COMPANY STAMP (If any)  DATE:						
SECTION "D" - FOR OFFICIAL USE						
APPLICATION RECEIVED BY:						
PART "I" - CUSTOMER SERVICE REPRESENTATIVE						
NAME: SURNAME OTHER NAME(S)						
1. NAME, N.I. NO. AND DATE OF BIRTH CONFIRMED ON I.A. SYSTEM?						
2. IS THE CLAIMANT LINKED TO EMPLOYER?						
3. IS THE REGISTRATION RECORD COMPLETE?  (If "NO" complete forms NI 4/NI 165/NI 182 as applicable).  YES NO						
4. CHECK FOR DUPLICATE REGISTRATION. (SIRF file included)  YES  NO						
5. IS REGISTRATION RECORD UPDATED?  (If "NO", state reason)  YES  NO						
6. CLAIM HISTORY GENERATED. YES NO						
7. HAS THIS INSURED PERSON APPLIED FOR A BENEFIT PREVIOUSLY?						
8. (a) CONTRIBUTION RECORD GENERATED?						
(b) OUTSTANDING CONTRIBUTION RECORDS CAPTURED? YES NO						
9. APPLICATION COMPLETE AND ACCEPTABLE FOR PROCESSING?						
SERVICE CENTRE RECEIVED STAMP  DATE: YYYY M M D D						

SECTION "D" - FOR OFFICIAL U	USE (CONT'D)					
PART "II" - SUPERVISOR/ CLERICAL	OFFICER II					
1. Details of Claim Profile Verified?		YES NO				
2. Claim Authorised?		YES NO				
3. Voucher Generated and Authorised?		YES NO				
SIGNATURE OF SUPERVISOR/CLERICAL OFF	FICER II	DATE: YYYY MM DD				
PART "III" - DETERMINATION OF A	APPLICATION					
1. DOES THE APPLICANT SATISFY AGE CON	YES NO					
2. WAS THE APPLICANT IN INSURABLE EMP	YES NO					
3. WAS LOSS OF EARNINGS SUFFERED?	YES NO					
4. IS THE "10 IN 13" TEST SATISFIED? (See Section "C", Question 5 on page 4)  YES NO						
5. DOES APPLICATION LINK WITH AN EARL (If "YES", state period):	IER SPELL OF INCAPACITY:	YES NO				
6. WAS APPLICANT INJURED ON THE JOB? (If "YES", investigate for Employment Injury	y).	YES NO				
7. DETERMINATION OF EARNINGS CLAS	SS AND LOSS EARNINGS					
(a) Total of 10 weeks of highest ea (Calculate from section C questi						
(b) Average weekly earnings 7(a) = \$						
10 (c) Earnings Class Determined						
(d) Average daily earnings prior to Sickness $\frac{7b}{7}$ = \$						
(e) Daily Earnings during Sickness:						
PERIOD OF ABSENCE FROM TO YYYY   MM   DD   YYYY   MM   DD	NO. OF DURING OF	(v) FAL LOSS EARNINGS (ii) x 7(e) (iv) ] \$				

//NI 15								
SECTION "D" - FOR OFFICIAL USE (CONT'D)								
PART "III" - DI	ETERMINATION	OF APPL	CATIO	ON (CC	NT'D	<u>))</u>		
8. (a) WEEKLY	RATE OF BENEFI	T IN CLASS		=	\$		(See Section	"D", Part III Question 7(c)).
(b) DAILY RA	ATE OF BENEFIT I	N CLASS			3(a) 7	= \$		
	day waiting period mend payment at							7(e) (iv) is less than
(c) APPLIC	ATION RECOMME	NDED FOR	ALLOV	VANCE A	S FOL	•		
	DAILY PERIOD WEEKS DA		DAYS					
	MATE	FROM TO						
		YYYY MM	1 DD	YYYY MI	√ DD			
	<del> </del>							
		_				<u> </u>		
9 APPLICATIO	N RECOMMENDE	D FOR DISA	HOWA	VICE OV	I THE (	GROUNDS I	ΓΗΔΤ·	
0. 7th Eleganic	TO THE COMMITTEE	3 1 011 B1071		WOL OI		GIIOOIIDO I		
SIGNATURE OF PROCESSING OFFICER  DATE:								
10 DECISION/A	AUTHORISATION:							
			ND AL	ITHORIS	ED, FC	R THE PER	OD AND RATE	E, AT 8(c) ABOVE.
(b) SICKNESS BENEFIT DISALLOWED ON THE GROUNDS AT 9 ABOVE.								
(c) APPLICA	ANT NOTIFIED OF	DECISION (	ON FOF	RM NI 44	-/ NI 53	3;	DATE:	YYYY MM DD
(d) DECISION RECORDED ON I.A. SYSTEM:  DATE:					:			
YYYY MM DD								
SIGNATURE OF M	ANAGER/SUPERV	ISOR/C.O. I	Ī				DATE:	YYYY MM DD

08/2011