NI 19

THE NATIONAL INSURANCE BOARD
INJURY BENEFIT APPLICATION

(Please Use Block Capitals)

NOTE: **This Application must be submitted within 14 days of the date of the Accident/Development of the Prescribed Industrial Disease.**

FOR OFFICIAL USE

ACCIDENT NO.:

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. MARITAL STATUS: SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. OCCUPATION:

10. EMPLOYER'S NAME:

11. *EMPLOYER'S ADDRESS: (STREET)
(CITY/DISTRICT/COUNTY)

12. NAME OF ACTUAL PLACE OF WORK: (e.g.School/Department/Division)

13. ADDRESS Of ACTUAL PLACE OF WORK: (STREET)
(CITY/DISTRICT/COUNTY)

14. 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)

15. DATE AND TIME ACCIDENT OCCURRED: YYYY MM DD TIME: _____ am/pm.

16. LAST DATE WORKED: YYYY MM DD

17. DATE RESUMED WORK: YYYY MM DD

*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)

18. EXACT PLACE/LOCATION WHERE ACCIDENT OCCURRED: _____

19. DID ACCIDENT OCCUR WHILE TRAVELLING IN EMPLOYER'S TRANSPORT?: ☐ YES ☐ NO

(If "YES" give details).

(i) Place of Embarkation:

(ii) Destination:

(iii) Purpose of Presence on Vehicle: _____

(iv) Was vehicle owned/rented by employer? ☐ YES ☐ NO

(If "NO" was vehicle used by an arrangement with employer? (Describe)).

20. STATE CLEAR DETAILS OF THE CAUSE OF ACCIDENT: _____

21. STATE DETAILS OF INJURY SUSTAINED: _____

22. GIVE NAME AND ADDRESS OF ANY WITNESS TO THE ACCIDENT:

SURNAME

OTHER NAME(S)

(STREET)

(CITY/DISTRICT/COUNTY)

23. WAS ACCIDENT REPORTED TO YOUR EMPLOYER?: ☐ YES ☐ NO

(If "YES", state date of report).

YYYY MM DD

24. DATE OF FIRST VISIT TO MEDICAL PRACTITIONER:

YYYY MM DD

25. NAME OF MEDICAL PRACTITIONER:

SURNAME

OTHER NAME(S)

26. ADDRESS OF MEDICAL PRACTITIONER

(STREET)

(CITY/DISTRICT/COUNTY)

27. DID YOU MEET THE COST OF MEDICAL EXPENSES? ☐ YES ☐ NO

(If "YES", complete a Form NI 114).

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

28. **RELAPSE:**

IS THIS APPLICATION IN SUPPORT OF A RELAPSE? ☐ YES ☐ NO

(i) (If "YES", describe the activities in which you were engaged when the relapse occurred).

(ii) (State the exact place/location where the relapse occurred).

29. PLEASE INDICATE THE 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:

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 hereby give consent for the Medical Report at Section "B" to be sent to the National Insurance Board in support of my Application for Injury Benefit.

SIGNATURE OR MARK OF APPLICANT

DATE: YYYY MM DD

PARTICULARS OF WITNESS TO MARK (Where applicant 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" - TO BE COMPLETED BY MEDICAL PRACTITIONER

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

was examined by me on ____ ____ ____ as a result of an accident sustained/disease developed at work on
YYYY MM DD

____ ____ ____
YYYY MM DD

I found the following injuries/industrial disease: _____

_____

_____

_____

My findings are/are not consistent with the description of the accident/disease. I hereby recommend that the patient be granted

_____ days/weeks leave with effect from ____ ____ ____ .
(In words and figures) YYYY MM DD

NAME OF MEDICAL PRACTITIONER: _____ _____
SURNAME OTHER NAME(S)

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.

MEDICAL PRACTITIONER'S STAMP

_____
SIGNATURE OF MEDICAL PRACTITIONER

DATE: ____ ____ ____
YYYY MM DD

NOTE: National Insurance Legislation provides that Employment Injury Benefit may be paid for a maximum of 52 calendar weeks. At the end of the injury leave period the insured person's extent of disability as a result of the accident is assessed to determine eligibility for Disablement Benefit.

SECTION "C" - 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. EMPLOYER'S NAME:

2. EMPLOYER'S REGISTRATION NO:

3. TELEPHONE NO: --

4. TYPE OF BUSINESS: _____

5. DESCRIBE THE WORK THE INJURED PERSON DOES: _____

6. IS HE/SHE AN APPRENTICE?: ☐ YES ☐ NO

7. STATE BELOW THE WAGES/SALARY PAID OR PAYABLE IN:

   (i) Week/Month prior to the week of accident. $

   (ii) Week/Month in which accident occurred. $

   Formula:
   Weekly Earnings = $\frac{\text{Monthly Earnings}}{13} \times 3$
   (e.g $\$ \frac{800 \times 3}{13} = \$ 184.62$)

8. ARE THE PARTICULARS STATED AT NOS. 15 TO 27 OF SECTION "A" ACCURATE? ☐ YES ☐ NO
   (If "NO", please give details):

   _____

   _____

   _____

9. (i) DID ACCIDENT OCCUR DURING WORKING HOURS? ☐ YES ☐ NO

   (ii) WAS EMPLOYEE ENGAGED IN HIS/HER DUTIES AT THE TIME OF THE ACCIDENT? ☐ YES ☐ NO
   (If "NO" to either (i) or (ii) give details):

   _____

   _____

   _____

10. (i) DID THE INJURED PERSON WORK DURING THE INJURY PERIOD? ☐ YES ☐ NO

    (If "YES", please state period): _____

11. DID EMPLOYEE DIE AT THE TIME OF THE ACCIDENT OR AFTER? ☐ YES ☐ NO
    (If "YES", please state date of death): YYYY MM DD

12. HAS THE ACCIDENT BEEN ENTERED IN THE EMPLOYER'S ACCIDENT BOOK? ☐ YES ☐ NO

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

DATE: YYYY MM DD

SECTION "D" (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. AND DATE OF BIRTH CONFIRMED ON I.A. SYSTEM? ☐ YES ☐ NO

2. REGISTRATION (1.A) RECORD COMPLETE?
(If "NO" complete forms NI 4/NI 165/NI 182 as applicable). ☐ YES ☐ NO

3. SYSTEM CHECK FOR DUPLICATE REGISTRATION COMPLETED. (SIRF file included)? ☐ YES ☐ NO

4. REGISTRATION RECORD UPDATED? ☐ YES ☐ NO
(If "NO" state reason) _____

5. CLAIM HISTORY GENERATED? ☐ YES ☐ NO

6. HAS THIS INSURED PERSON APPLIED FOR A BENEFIT PREVIOUSLY? ☐ YES ☐ NO
(If "YES", request Benefit Unit)

7. APPLICATION COMPLETED AND ACCEPTED FOR PROCESSING? ☐ YES ☐ NO

_____

CUSTOMER SERVICE REPRESENTATIVE

DATE: _____ _____ _____

YYYY MM DD