ST. CHRISTOPHER AND NEVIS SOCIAL SECURITY BOARD

CLAIM FOR 'ASSISTANCE'
NON-CONTRIBUTORY PENSION

Striving for Social Justice

Section - A

Warning: Any person who knowingly makes any false statement, or false representation for the purpose of obtaining benefit, will be liable to prosecution.

Details of Insured Person:

1. Social Security No.

2. **FIRST NAME** **MIDDLE NAME** **SURNAME**

3. Home Address

4. P.O. Box

5. E-mail Address

6. Tel./Cellular No.

7. Date of Birth *(dd/mm/yyyy)*

8. Gender ☐ Male ☐ Female

9. Occupation

10. I present here my current Social Security Card ☐ Passport ☐

Employer Details:

11. Name of Last Employer

12. Employer's Social Security No.

13. My last day at work was: _____

14. I hereby declare that:

☐ I am in NEED

☐ I am an invalid incapable of gainful employment

☐ I have attained the age of 62 years

☐ I am ordinarily a resident in the Federation of St. Christopher and Nevis

☐ I am not in gainful employment as a wage earner nor as a self-employed person.

15. Please answer the following questions:

(a) How long have you been living in the Federation of St. Christopher and Nevis? (years) _____

(b) Are you receiving Age Pension☐ Invalidity Pension☐ Survivor's Pension☐ Pension from overseas source☐

(c) How long have you lived overseas ? In which country(ies)? _____

16. Do you receive cash income from any source inside or outside the Federation whether by way of pension, rent, investments, contributions to your maintenance or otherwise? Yes ☐ No ☐

17. If yes, state the amount received whether weekly, monthly or annually ($) _____

18. If married state the name of your spouse

19. Is your spouse receiving cash income from any source, whether locally or abroad Yes ☐ No ☐

20. If yes, state the source and amount received whether *weekly/monthly/annually ($) _____

I hereby state that the information given above is true to the best of my knowledge and belief. I will notify the Director of Social Security if I am working as an employed, or self-employed person, or if there is any improvement in my circumstances affecting my continued right to receive assistance. I will notify the Director of Social Security of any period that I will be absent from the Federation of St. Christopher and Nevis.

Disclosure agreement: I hereby expressly and irrevocably authorize you to obtain from person, firms or companies in the federation any information which you may require relative to this application including, but not limited to confidential information within the meaning of the Confidential Relationships Act 1985. This authorization is a continuing authorization given to the St. Christopher and Nevis Social Security Board by me the undersigned.

21. Claimant's signature _____ 22. Date *(dd/mm/yyyy)*

23. Witness to thumb print /mark if unable to write _____

24. Name of Witness _____

(Affix right thumb print here if unable to write)

* deleted words not applicable

Section - B
MEDICAL CERTIFICATE

(TO BE COMPLETED BY A MEDICAL PRACTITIONER)

1. I certify that Mr./Mrs./Ms. _____

was examined by me on _____ and was found incapable of work as a result of (illness code) _____

2. Nature of Illness/Injury/Disease/Disablement _____

3. In my opinion this person is incapable of work from the period of: *(dd/mm/yyyy)* _____

To the period of: *(dd/mm/yyyy)* _____

4. Name of Medical Practitioner _____

5. Address of Practitioner's Office _____

6. Practitioner's Signature _____

Certificate given on *(dd/mm/yyyy)* _____

Other remarks by Practitioner _____

Affix office stamp here

Note to Practitioner: ***The statement of the incapacitating disease/disablement shall specify the cause of incapacity as precisely as the practitioner's knowledge of the insured person's condition at the time of the examination.***

For Official Use

Date Received _____

Claim Number

Verification Document Received _____
