ST. CHRISTOPHER AND NEVIS SOCIAL SECURITY BOARD

CLAIM FOR DISABLEMENT/DISABILITY BENEFIT

Striving for Social Justice

PLEASE READ CAREFULLY

ANY CHANGES OR ALTERATIONS MADE TO INFORMATION ON THIS FORM MUST BE INITIALLED BY THE PERSON AUTHORIZED TO SIGN THE SPECIFIED SECTION OF THE FORM.

SECTION - A

Details of Insured Person: 1. Social Security No.

2. **FIRST NAME** **MIDDLE NAME(S)** **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 Present/Last Employer

12. Address of Employer

13. Employer's Social Security No. 14. My last day at work was: _____ 15. Time _____

Other Employer for whom I have worked during the last three (3) years:

16. Name of Employer

17. Address

Please enter your **Bank** details for payment of your benefit:

18. Name on Account _____ 19. Account No. _____

20. Name of Bank Institution

I hereby authorize the disclosure to the Social Security Board of the doctor's diagnosis for the purpose of the St. Christopher and Nevis Social Security Act 1977 and Regulations made thereunder.
I hereby declare that the information given in this claim is true to the best of my knowledge and belief and that I will not receive or keep any benefit arising from this claim in respect of the period during which I was at work.
I undertake that if a pension is awarded to me as a result of this claim, I shall inform the Social Security Office within one week of any change in my circumstance (e.g. If I return to work) affecting my continued right to receive the pension.

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)

Section - B

TO BE COMPLETED ONLY WHEN THE INSURED PERSON WAS DISABLED IN THE COURSE OF EMPLOYMENT

Injury Details:

Please supply answers to the following:

25. Is your incapacity a result of an accident/illness contracted in the course of your employment? Yes ☐ No ☐

26. Are you currently in receipt of any Social Security/Assistance Benefit? Yes ☐ No ☐

27. I suffered an injury, accident/illness at work on *(dd/mm/yyyy)* ☐☐☐☐☐☐☐☐ 28. Time of occurrence ________

29. Briefly explain how the accident/illness was caused ________

____

30. Briefly explain what injury/illness was sustained ________

31. I reported the incident to my employer on *(dd/mm/yyyy)* ☐☐☐☐☐☐☐☐ 32. Time reported ________

I declare that the information given above is true to the best of my knowledge and belief.

33. Claimant's signature ________ 34. Date *(dd/mm/yyyy)* ☐☐☐☐☐☐☐☐

35. Witness to thumb print /mark if unable to write ________

36. Name of Witness ________

Section - C

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 ________ 7. Certificate given on ☐☐☐☐☐☐☐☐ (dd/mm/yyyy)

8. 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 ________

Signature of Receiving Officer ________