ST. CHRISTOPHER AND NEVIS SOCIAL SECURITY BOARD

CLAIM FOR MEDICAL/TRAVEL EXPENSES INCURRED AS A RESULT OF EMPLOYMENT INJURY

Striving for Social Justice

REASONABLE MEDICAL/TRAVEL EXPENSES INCURRED AS A RESULT OF AN ACCIDENT/ILLNESS WILL BE REIMBURSED TO YOU OR YOUR EMPLOYER.

SECTION A

Details of Insured Person:

1. Social Security No.

2. **FIRST NAME** **MIDDLE NAME(S)** **SURNAME**

3. Mailing 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

Employer Details:

10. Name of Present/Last Employer

11. Address of Employer

12. I suffered an accident/illness at

13. Date of accident/illness *(dd/mm/yyyy)*

14. Time of accident/illness

15. I reported it to my employer on *(dd/mm/yyyy)*

16. Time reported

17. Explanation of accident/illness

To obtain a refund of your portion of the medical/travel expenses incurred, please complete the following:

18. I hereby claim refund of my reasonable medical/travel expenses in the amount of ($)

19. My original receipt(s) in support of this claim *is/are attached Yes ☐ No ☐

20. Please indicate whether your expenses were met by your employer. Yes ☐ No ☐

21. If "Yes" please state amount paid ($)

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

22. Name on Account

23. Account No.

24. 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.

25. Claimant's signature _____ 26. Date *(dd/mm/yyyy)* | | | | | | | | |

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

28. Name of Witness _____

(Affix right thumb print here if unable to write)

Note: Please submit to the Social Security office no later than 10 days from the date of the medical examination, or the date when the expenses were paid.

SECTION B

MEDICAL CERTIFICATE

To be completed by Medical Practitioner in the case of Employment Injury when no sick leave is given

Medical Practitioner, please complete in confidence for:-

1. Mr./Mrs./Ms./Miss. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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. Name of Medical Practitioner | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

4. Practitioner's Signature _____

5. Address of Practitioner's Office | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

6. Date certificate was given *(dd/mm/yyyy)* | | | | | | | | |

7. Other remarks by Practitioner _____

Affix office stamp here

FOR OFFICIAL USE

Date Received *(dd/mm/yyyy)* | | | | | | | | | Claim No. | | | | | | | | |

No. of receipts received _____ Amount ($) _____

Signature of receiving officer _____ Internal Audit _____

Verified by: _____ Date *(dd/mm/yyyy)* | | | | | | | | |

*delete words not applicable