ST. CHRISTOPHER AND NEVIS SOCIAL SECURITY BOARD

CLAIM FOR SICKNESS/INJURY BENEFIT

Striving for Social Justice

PLEASE READ CAREFULLY

This form is divided into three (3) sections - A to C.
Section A - To be completed by the person claiming.
Section B - To be completed by a Medical practitioner (Doctor).
Section C - To be completed by the Employer.

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

(TO BE COMPLETED BY THE PERSON CLAIMING)

Part - 1

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

Employer Details:

10. Name of Present/Last Employer

11. Address of Employer

12. Employer's Social Security No.

13. My last day at work was: _____ 14. Time _____

15. Other Employers for whom I have worked during the last three (3) months: 16. Vacation Period _____

17. Name of Employer

18. Address

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

19. Name on Account _____ 20. Account No. _____

21. Name of Bank Institution

Part - 2

If your incapacity was a result of an accident/illness arising out of, or in the course of your employment, please complete this section.

22. Briefly explain how the accident/illness was caused _____

23. I reported the incident to my employer on *(dd/mm/yyyy)* 24. Time _____

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 in respect of the period during which I was at work or on vacation.

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)

Please tear off this perforated section and submit it to your employer. To assist Social Security in expediting the processing of your claim, please ask your employer to complete 'Section C' before presenting it to Social Security.

Section - B
MEDICAL CERTIFICATE (PARTS 1&2) TO BE COMPLETED BY A MEDICAL PRACTITIONER

Part - 1

Note: For observation by Medical Practitioner

i. Claims for Sickness/Injury benefit MUST be made not later that ten (10) days from the date of the Medical Examination.

ii. If disclosure to the insured person of the precise cause would be prejudicial to his/her well being the certificate may contain a less precise statement of the nature of incapacity.

iii. If in your opinion the insured person will become fit to resume work on a day within seven (7) days , (including Sundays) after a Medical Examination, the certificate shall specify the first mentioned day to resume work.

iv. In any other case, the period of incapacity from work as certified must not exceed twenty-eight (28) days, unless the incapacity has already continued for twenty-eight (28) days; in which case it must not exceed thirteen (13) weeks (Sundays included).

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 should be fit to resume employment on *(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

Section - C
(TO BE COMPLETED BY THE EMPLOYER)

Please complete the following:

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

has been employed up to _____

and has not reported to work on account of illness/injury/termination/suspension of employment *(please indicate which one)*

2. He/She is expected to resume duties on *(dd/mm/yyyy)* _____

3. His/Her weekly/monthly rate of pay is ($) _____ and was paid up to: *(dd/mm/yyyy)* _____

4. Name of Employer/Agent _____

5. Signature of Employer _____

6. Date signed *(dd/mm/yyyy)* _____

Affix Office Stamp here:

For Official Use

Date Received _____

Claim Number _____

Verified By: _____

Part - 2
MEDICAL CERTIFICATE FOR EMPLOYER

I certify that _____ was examined by me on _____ and has been granted sick/injury leave for the period of _____ up to and including _____

Name of Medical Practitioner _____ Signature of Medical Practitioner _____

Date signed *(dd/mm/yyyy)* _____