



ST. CHRISTOPHER AND NEVIS SOCIAL SECURITY BOARD

CLAIM FOR 'ASSISTANCE'
NON-CONTRIBUTORY PENSION

Striving for Social Justice

Section - A			1. Social Security No.
Details of Insured Person:			
2.	FIRST NAME	MIDDLE NAME(S)	SURNAME
MAIDEN NAME	3. Date of Birth (dd/mm/yyyy) <div></div>	4. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	5. Tel./Cellular No.
6. Home Address			
7. P.O. Box	8. E-mail Address	9. Occupation	
10. I agree for my mailing address to be updated with the address provided on this form			Yes <input type="checkbox"/> No <input type="checkbox"/>
11. I present here my current Social Security Card <input type="checkbox"/> Passport <input type="checkbox"/>			
Employer Details:			
12. Name of Last Employer			
13. Employer's Tel. No.		14. My last day at work was: (dd/mm/yyyy) <div></div>	
15. I hereby declare that:			
<input type="checkbox"/> I am in NEED <input type="checkbox"/> I am an invalid incapable of gainful employment			
<input type="checkbox"/> I have attained the age of 62 years <input type="checkbox"/> I am ordinarily a resident in the Federation of St. Christopher and Nevis			
<input type="checkbox"/> I am not in gainful employment as a wage earner nor as a self-employed person.			
16. Please answer the following questions:			
(a) How long have you been living in the Federation of St. Christopher and Nevis? (years)			<div></div>
(b) Are you receiving Age Pension <input type="checkbox"/> Invalidity Pension <input type="checkbox"/> Survivor's Pension <input type="checkbox"/> Pension from overseas source <input type="checkbox"/>			
(c) How long have you lived overseas ? In which country(ies)?			<div></div>
17. 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 <input type="checkbox"/> No <input type="checkbox"/>
18. If yes, state the amount received whether weekly, monthly or annually (\$)			<div></div>
19. If married state the name of your spouse			
20. Is your spouse receiving cash income from any source, whether locally or abroad			Yes <input type="checkbox"/> No <input type="checkbox"/>
21. If yes, state the source and amount received whether *weekly/monthly/annually (\$)			<div></div>
<p>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.</p> <p>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.</p>			
22. Claimant's signature		23. Date (dd/mm/yyyy) <div></div>	
24. Witness to thumb print /mark if unable to write			(Affix right thumb print here if unable to write)
25. Name of Witness			

<div>Section - B</div> <div>MEDICAL CERTIFICATE</div> <div>(TO BE COMPLETED BY A MEDICAL PRACTITIONER)</div>			
1. I certify that:		First Name	Surname
		was examined by me on (dd/mm/yyyy)	
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	
<div>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.</div>			
<div><div>For Official Use</div><div>Date Received _____</div><div>Claim Number _____</div><div>Verification Documents Received _____</div></div>			