



Striving for Social Justice

# ST. CHRISTOPHER AND NEVIS SOCIAL SECURITY BOARD

## CLAIM FOR DISABLEMENT/DISABILITY BENEFIT

PLEASE READ CAREFULLY AND PRINT LEGIBLY IN BLOCK LETTERS

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)

1. Social Security No.

Details of Insured Person:

2. FIRST NAME MIDDLE NAME(S) SURNAME

MAIDEN NAME

3. Date of Birth (dd/mm/yyyy)

4. Gender

☐ Male ☐ 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 ☐ No ☐

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

Employer Details:

12. Name of Present/Last Employer 13. Employer's Tel. No.

14. Address of Employer

15. Vacation Period

16. My last day at work was: (dd/mm/yyyy)

17. Time

Other Employers for whom I have worked during the last three (3) months:

18. Name of First Employer

19. Name of Second Employer

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

20. Name on Account

21. Account No.

22. Name of Financial Institution

Select type of Account:- Savings ☐  
Chequing ☐

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.

23. Claimant's signature 24. Date (dd/mm/yyyy)

25. Witness to thumb print /mark if unable to write

26. 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:

27. Is your incapacity a result of an accident/illness contracted in the course of your employment?

Yes

☐

No

☐

28. Are you currently in receipt of any Social Security/Assistance Benefit?

Yes

☐

No

☐

29. If you were injured in the course of your employment, briefly explain how the accident/illness occurred

30. Date accident occurred

31. Time of accident

32. Date reported incident to my employer

33. Time reported

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

34. Claimant's signature

35. Date (dd/mm/yyyy)

36. Witness to thumb print /mark if unable to write

37. Name of Witness

SECTION - C

MEDICAL CERTIFICATE

(TO BE COMPLETED BY A MEDICAL PRACTITIONER)

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

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