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

(TO BE COMPLETED BY THE PERSON CLAIMING)

Details of Insured Person:

1. Social Security No.

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 ☐

Employer Details:

11. Name of Present/Last Employer | **12.** Employer's Tel. No.

13. Address of Employer

14. Please provide a briefly explain how the accident/illness occurred in the course of your employment

15. Date accident occurred | **16.** Time of accident | **17.** Date reported incident to my employer | **18.** Time reported

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

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

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

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

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

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

23. Name on Account | **24.** Account No.

25. 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.

26. Claimant's signature _____ **27.** Date *(dd/mm/yyyy)*

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

29. 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. 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 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)*

Affix office stamp here

8. Other remarks by Practitioner

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