NATIONAL INSURANCE AND SOCIAL SECURITY ACT, 1969
NOTICE OF ACCIDENT

(This form is to be completed by the employer in duplicate;
one copy to be taken to the nearest National Insurance Office
and one to be retained by the employer)

(PLEASE READ NOTES BEFORE COMPLETING FORM)

WARNING: Any person who knowingly makes a false statement or false representation for the purpose of obtaining any payment for himself or for some other person under the National Insurance and Social Security Act, 1969, or produces or furnishes any document or information which he knows to be false in a material particular, renders himself liable to prosecution.

1. PARTICULARS OF EMPLOYER:

(a) NAME OF EMPLOYER/BUSINESS:

(b) NATURE OF BUSINESS:

(c) ADDRESS OF BUSINESS:

(d) EMPLOYER'S REGISTRATION NUMBER:

2. PARTICULARS OF EMPLOYEE:

(a) NAME OF INJURED PERSON:

(b) HOME ADDRESS:

(c) N.I.S NUMBER:

(d) I.D. NUMBER:

(e) SEX:

(f) OCCUPATION:

(g) D.O.B

3. PARTICULARS OF EMPLOYMENT:

(a) Last date injured person worked

(b) Salary/Wages paid to employee for last 2 months/8 weeks worked:

MONTH	SALARY
1.	$
2.	$

WEEK ENDING	WAGES
1.	$
2.	$
3.	$
4.	$

WEEK ENDING	WAGES
5.	$
6.	$
7.	$
8.	$

(c) How much injured person will be paid per week/month when absent from work:
(To be completed only when employee will be paid during absence.)

$..... From ..... To .....

4. PARTICULARS OF ACCIDENT:

(a) Date accident occurred

(b) Place of accident

(c) Time accident occurred

(d) Cause of accident (give brief details on how it happened) _____

_____

(e) Working hours on day accident occurred. From

To

(f) Date accident was reported

(h) Time Reported

(g) Was accident Fatal?

(i) Was accident recorded in Accident Register?

I certify that the above statements are true to the best of my knowledge and belief and I assume full responsibility as to their correctness.

Signature of Employer: .....
(or representative)

Date: .....

FORM IBI
R & P Dept (February 2012)

STAMP

FOR OFFICIAL USE

1. DOCUMENTS SUBMITTED WITH CLAIM

1.....

2.....

3.....

2. DECISION

Allowed	
Disallowed	

(Tick appropriate box)

IF ALLOWED

3. CALCULATION OF RATE

*MONTH	SALARY	
	Actual	Insurable
1.		
2.		
3.		
Total		
Avg. Monthly		

*WEEK ENDING	WAGES	
	Actual	Insurable
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
Total		
Avg. Weekly		

Rate = 0.7 x wkly/mthly ins. Earnings

(To be completed if salary is paid by the employer)

a) Average monthly/weekly earnings $_____

b) 70% average monthly/weekly insurable earnings $_____

c) Salary/Wages paid $_____

d) Total Item b) and Item c) $_____

e) Item d) - Item a) $_____
(Enter 0 if answer is negative)

f) Rate of benefit (Item b - Item e)

$ _____ Per month/week

$ _____

4. PARTICULARS OF PAYMENT

Date of Commencement ___ Stop Date ___ Review Date ___

Payments Made:

	FROM	TO	AMT. PAID $	C	PREPARED BY	DATE	CHECKED BY	DATE	AUTH. BY	DATE	BPV NO.	DATE
1.												
2.												
3.												
4.												

5. IF DISALLOWED

1. Date Claim disallowed ___

2. Reason for disallowance:_____

3. Date claimant notified ___

6. IF DISQUALIFIED
PERIOD OF DISQUALIFICATION:

From ___ To ___

REASON FOR DISQUALIFICATION:

….....

.....

7. NOTIFICATION:

Department/Section	
Form No.	
Date Sent	
Signature	
Remarks	

*Complete where applicable

Certified By: .....

Date: .....