FOR OFFICIAL USE

The receipt(s) No. _____ dated _____ for $_____

_____ _____ _____

_____ _____ _____

_____ _____ _____

as paid National Insurance contributions were seen by me and I hereby also certify the correctness of the information stated at item 8.

Signature .....
(NI Clerk)

Date .....

NATIONAL INSURANCE AND SOCIAL SECURITY ACT, 1969
SELF-EMPLOYED PERSONS CLAIM FOR SICKNESS BENEFIT - MEDICAL CARE

WARNING: Any person who knowingly makes a false statement or false representation for the purpose of obtaining a 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.

I, the undersigned hereby apply for reimbursement of Medical Care Expenses under the National Insurance and Social Security Act, 1969 and furnish information with regard to such Medical Care charges and the following particulars:

1. **PARTICULARS OF INSURED PERSON**

a) Name in full

b) Address

c) NIS No.

d) ID No.

e) Date of Birth **D M Y**

f) Sex

g) Date of Commencement of Illness **D M Y**

Last Date Worked **D M Y**

2. **PARTICULARS OF MEDICAL CARE**

a) I was examined by .....
Name of Doctor (Hospital)
of .....
Address

b) My expense was $ ..... and I have attached receipt(s) to the value of $ ..... which sum was paid by me for such medical care.

See breakdown overleaf at (c)

(c) **BREAKDOWN OF COSTS**

DATE OF MEDICAL ATTENTION OR HOSPITALIZATION	COST OF MEDICAL CARE				
	DOC. FEES (MED. EXAM)	DRUGS & DRESSINGS	X-RAYS	OTHER TREATMENT	TOTAL COST

Grand Total
$.....

(d) **TYPE AND QUANTITY OF DRUGS USED**

TYPE	QUANTITY	TYPE	QUANTITY

(Attach prescription when necessary)

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

....

Date Signature or mark of Claimant

NOTE: Where the Insured Person cannot sign his/her name, he/she should make his/her mark and have it witnessed by a responsible person (Doctor, Lawyer, Teacher, J.P. etc.) who should sign on the line below.

Witness to mark _____

Profession/Occupation _____

Address _____

Date _____

FORM SB6A1
(Research & Planning Dept. Oct, 2009)

NATIONAL INSURANCE AND SOCIAL SECURITY ACT, 1969
SELF-EMPLOYED PERSON'S STATEMENT IN SUPPORT OF SICKNESS BENEFIT - MEDICAL CARE

This form is to be completed by the Self-Employed Person and taken to the nearest National Insurance Office

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.

PARTICULARS OF SELF-EMPLOYED PERSON

1. **NAME**: _____
2. **ADDRESS OF BUSINESS**: _____
   _____
3. **HOME ADDRESS**: _____
   _____
4. **NATIONAL INSURANCE NO**. | | | | | | | | | | |
5. **NATIONAL REGISTRATION NO.** | | | | | | | | | | |
6. **DATE OF BIRTH** | | | | 7. **LAST DATE WORKED** | | | |
8. **DECLARED INCOME FOR PREVIOUS YEAR**: $

9. **CONTRIBUTIONS PAID TO NATIONAL INSURANCE FOR LAST 2 MONTH/8 WEEKS WORKED:**

MONTH	CONTRIBUTIONS
1.	
2.	

WEEK-ENDING	CONTRIBUTIONS
1.	
2.	
3.	
4.	

WEEK-ENDING	CONTRIBUTIONS
5.	
6.	
7.	
8.	

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 .....
(Self-Employed Person)

Date .....