(c)

Date of Medical	COST OF MEDICAL CARE											
nttention or Hospitalization	Doc. Fees (Med. Exam)	Drugs & Dressing	X-ray	Other Treatment	Total Cost							
(d)	TYPE	AND QUANTITY	OF DRUGS U									
TYPE	QUANT		TYPE	_	UANTITY							
3. I declare that the	(Atta	ch prescription n here is true a			nowledge							
and belief.	g											
	Date		Signat	ure or mark of 0	Claimant							
	sed by a responsib				e his/her mark and h who should sign on							
Witness to mark .												
Profession/Occup	oation											
Addross												

B700F1 SB R0 (b) **Revision Date: October, 2019**

Date

NATIONAL INSURANCE AND SOCIAL SECURITY ACT, 1969 EMPLOYER'S STATEMENT IN SUPPORT OF SICKNESS BENEFIT/MEDICAL CARE

This Form is to be completed by the Employer and given to the Employee to take or send 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 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) Employer's Address:						
d) Employer's Registration Number:						
2. PARTICULARS OF EMPLOYEE						
a) Name of Employee:						
b) Address of Employee:						
c) National Insurance Number:						
d) National Registration Number:						
e) Sex f) Date of Birth						
3. PARTICULARS OF EMPLOYMENT						
a) Date of commencement of Employm	ent					
b) Last date Employee worked						
c) Date of commencement of absence f	rom work					
d) Was work available on date of comm	encement	of ab	senc	e from v	vork?	
		7	Zes	No		

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(e) Has employee been in your	employment over the	last 50 weeks?	?									
If no, state number of wee	ks											
(f) How many contributions h	f) How many contributions have you paid for employee during period referred to at e) above?											
g) Were contributions paid for employee for the last 13 weeks before commencement of												
illness?	illness?											
If yes, state number of cor	ntributions											
4. STATEMENT OF EARNINGS: (Complete this Section only if there is loss of earnings – disregard when claim is for Medical Expenses only).												
a) Salary/Wage paid to Employee for the last 3 months/13 weeks worked.												
MONTH SALARY	WEEK-ENDING	WAGE	WEEK-ENDING	WAGE								
1	1		_8									
2.	2.		9.									
3.	3.		10.									
	4.	11.	11.									
	5. 12.											
	6.	13.										
	7.											
b) Rate of Salary/Wage to be paid to Employee when absent from work:												
per m	onth/week from		to									
(To be completed only who	en the Employee will b	e paid during t	the period of illness)									
I certify that the above statemen responsibility as to their correct		of my knowledge	e and belief and I assum	ne full								
Signature of Employer/Represer	ntative:											
Date:												
Employer's Stamp												

B700F1 SB R0 (d) Revision Date: October, 2019

NATIONAL INSURANCE AND SOCIAL SECURITY ACT, 1969 CLAIM FOR SICKNESS BENEFIT – MEDICAL CARE

WARNING:

Any person who knowingly makes a false statement or false representation for the purpose of obtaining any payment for himself or 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	S OF	INSU	RED	PEF	sc	N												
a)	Name in Full																		
b)	Address																		
c)	NIS No.]						
d)	ID No.]		e)	Dat	e of	Birth	
f)	Sex				g) [Date	of C	omr	nenc	eme	ent o	f illn	ess					
h)	Last Date Wo	rked																	
2.	PARTICULARS	S OF	MEDI	ICAL	CAI	RE													
a)	I was examine	d by				 Naı	 me d	of Do	octo	r (Ho	spita	 al)							
	of									ress									
b)	My expense w	2 e ¢									•					9	nd I	havo	attacher
υ <i>)</i>	receipt(s) to th																		
	See breakdow	n ove	erleaf	at (c	:)														

B700F1 SB R0 (a) Revision Date: October, 2019