CLAIM FOR SICKNESS BENEFIT

I, the undersigned hereby apply for Sickness Benefit under the National Insurance and Social Security Act, 1969, and furnish a Medical Certificate at back hereof, and the following particulars:

1. My full name is (please print) .........................................................

2. My address is .................................................................

3. My National Insurance Number is ................................................

4. When I became ill I was employed by. ........................................

5. My occupation was ..............................................................

6. I finished working there on ........................................ at ............... a.m./p.m

7. In Industrial Accident cases state date of accident ......................

I declare that the information given above 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 dotted line below.

Witness to mark ........................................................................

Address ..................................................................................

Profession or Occupation .........................................................

Date ......................................................................................

B700F6 SB R0 (a) Revision Date: October, 2019
MEDICAL CERTIFICATE

I………………………………………………………………………………

a duly qualified registered medical practitioner hereby certify that
M……………………………………………………………………………...

(Name)
of………………………………………………………………………………...

(Address)
was examined by me on………………………………………………a.m/p.m*
at ……………………………….. for the *first/second time and in my opinion *he/she was at the time of examination suffering from
…………………………………………………………………………………..

As a result of this disability *he/she –
(Complete )
(a) will be fit to resume work *today/
or (b) tomorrow/ on + …………………………….
whichever (b) will remain incapable of work for a period of
is appropriate) @ ………………………………………...

days
Any other remarks by Doctor………………………………………………..

………………………………………………………………………………

………………………………………………………………………………

Date ……………………………………………………………
…………………………………………………………

Doctor’s Signature
Address ………………………………………………………………………
____________________________________________________________

+The date indicated must be more than seven days (Public Holidays, including Sundays included) after the date of examination.

@ The period entered must not exceed 14 days (Public Holidays including Sundays included) in the case of a first or second certificate or 28 days for a third or subsequent certificate.

*Delete where inapplicable

Revision Date: October, 2019