MISSION STATEMENT

To establish and maintain a system of Social Security through which enough income is secured to take the place of earnings when such are interrupted by sickness, medical care or accident.

To provide for retirement through age, suddent death of a breadwinner and to meet exceptional expenses as those concerned with birth and death.

To ensure that monies collected which have to be used for future payments are invested in such a manner that the economy of the country would reap maximum benefit.

MEMORANDUM ON

BENEFITS PAYABLE

THE NATIONAL INSURANCE AND SOCIAL SECURITY SCHEME

Produced By: The Research & Planning Department

January, 2017

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BENEFITS PAYABLE

INTRODUCTION

The National Insurance Scheme extends Social Insurance Coverage on a compulsory basis, to all persons between the ages of sixteen (16) and sixty- (60) years who are engaged in Insurable Employment. Coverage is also extended on a voluntary basis, to persons who cease such employment before reaching age sixty- (60) years, until the attainment thereof. Employed Persons outside this age range who are in Insurable Employment are also covered, but for Industrial Benefits only. However, Self-employed Contributors are not covered for Industrial Benefits.

Insured Persons are covered up to an Insurable Ceiling of *$220,000.00 per month, and *$50,769.00 for weekly paid workers. Both the Employer and Employee pay Contributions into the Scheme. The total Contribution for Employed Contributors is 14% of the actual Wage / Salary paid to the Employee. This is derived from a 5.6% deduction from the Employee's pay and the remaining 8.4% by the Employer on behalf of the Employee.

Self-employed Persons contribute 12.5% of their Declared Income as Contributions, while Voluntary Contributors pay 9.3% of their Insurable Earnings as determined during the last two years of their employment.

Presently, the Scheme provides for the payment of the following Benefits, which are grouped under three branches as follows:

LONG TERM	**SHORT TERM**	**INDUSTRIAL**
Old Age Benefit	Sickness Benefit	Injury Benefit
Invalidity Benefit	Sickness Benefit Medical Care	Disablement Benefit
Survivors Benefit	Maternity Benefit	Industrial Death Benefit
Funeral Benefit		

* ***Figures subject to change in response to changes in Minimum Wage in the Public Sector***

OLD AGE

1. Definition

Old Age Benefit is payable to Insured Persons who have attained the age of sixty- (60) years. The Benefit can be in the form of a Periodical Payment (Pension) or a Grant (lump-sum).

2. Qualifying Conditions

A. To qualify for an Old Age Pension, the Insured Person must have:

i) Paid not less than one hundred and fifty (150) Contributions.

ii) Paid or been credited with, or paid and been credited with not less than seven hundred and fifty (750) Contributions.

iii) Attained the age of sixty- (60) years.

B. To qualify for an Old Age Grant, the Insured Person must have:

i) Paid not less than fifty- (50) Contributions.

ii) Attained the age of sixty- (60) years.

3. Rate of Benefit

A. *Old Age Pension*

The weekly rate of Old Age Pension is 40% of the relevant wage, supplemented by an additional 1% of that wage for each group of fifty Contributions in excess of seven hundred and fifty (750) Contributions.

To Calculate Rate of Pension:

a) Obtain Contribution Record for last five (5) years before age sixty- (60) years, when the Insured Person paid at least thirteen (13) weeks / three (3) months Contributions annually.

b) Obtain best three (3) years in the five (5) years mentioned at item **(a)**.

OLD AGE CONT'D

To Calculate Rate of Pension Cont'd:

c) Sum the Annual Insurable Earnings for 'best' three (3) years.

d) Sum the number of Contribution Weeks for 'best' three (3) years.

e) Divide item **(c)** by item **(d)** = Average Weekly Insurable Earnings.

f) Weekly Pension = (40% **x** item **(e)**) + (1% **x** item **(e)**) for each group of fifty- (50) Contributions in excess of seven hundred and fifty (750) Contributions.

The Rate of Pension however, must not be less than 50% of the existing Public Service Minimum Wage, nor greater than 60% of the Average Weekly Insurable Earnings.

N.B: One (1) year refers to twelve (12) months before the birth month of the Insured Person.

'Best' year means the year with the highest Annual Insurable Earnings.

B. ***Old Age Grant***

Old Age Grant is a lump-sum payment equal to one-twelfth (1/12) times the Average Annual Insurable Earnings for each group of fifty- (50) Contributions, whether paid or credited or paid and credited.

a) Obtain the total Contribution Record.

b) Obtain the Annual Insurable Earnings for each year of Contribution.

c) Sum the Annual Insurable Earnings for all the years of Contribution.

d) Sum the number of Contribution Weeks for all the years of Contribution.

e) Divide item **(c)** by item **(d)** = Average Weekly Insurable Earnings.

f) Item **(e) x** 52 = Average Annual Insurable Earnings.

OLD AGE CONT'D

B. ***Old Age Grant Cont'd***

g) Grant = 1/12 **x** item **(f) x** Number of Groups of fifty- (50) Contributions (in total Contribution Record).

N.B: One (1) year refers to a Calendar Year.

4. Duration of Benefit

An Old Age Pension is paid to the Insured Person, for as long as he / she is alive.

An Old Age Grant is a single payment.

5. Method of Payment

Old Age Pensioners are issued with "Pension Order" Books, which contain six Benefit Payment Vouchers each. These Payment Vouchers become eligible for encashment on a monthly basis. New books are prepared and issued upon submission of "Life Certificates", which attest to the Pensioner being alive.

The recipient of an Old Age Grant is issued with a Single Benefit Payment Voucher, which can be encashed at the abovementioned places.

6. Manner of Claiming

A Claim for Old Age Benefit must be made by completing Form OAB1 - Claim for Old Age Benefit. This Form must be taken to the nearest National Insurance Office, along with the Insured Person's Birth Certificate, Social Security Card and National Identification Card.

1.

NATIONAL INSURANCE AND SOCIAL SECURITY ACT, 1969

CLAIM FOR OLD AGE BENEFIT

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, Cap. 36:01, or produces or furnishes any document or information which he knows to be false in a material particular, renders himself liable to prosecution.

Name of Insured Person…….
(Block Letters) (Surname)

…….
(Other Names)

National Insurance No: ☐☐☐☐☐☐☐☐☐

Date of Birth: ……

Address: ……

2.

I, ……

declare that I *have reached the age of 60/will reach the age

of 60 on …….
Date

I have been a contributor to National Insurance and apply for Old Age Benefit.

I last contributed as an *employed/self-employed person/ voluntary contributor.

I last worked as an *employed/self-employed person on……..
……
Date

My *last/present employer's name and address *was/is

Name of Employer: ……...

Address: ……

My *husband's/wife's name is …….

and *his/her Date of Birth is …….

I have …… *child/children under 18 years as stated below

Name(s) Date(s) of Birth

……..
……
……

* Delete where inapplicable

3.

I have *never/last made a claim for benefit at the National Insurance Office at:……
……...

I wish to have payment made at the *Post Office/National Insurance Office at:……
……..

Indicate by a tick, which Pension you are already receiving:

Invalidity ☐
Death ☐
Survivors' ☐

……..
Signature of Claimant

……..20…….
Date

If claimant cannot sign, he / she should make his / her mark, which should be witnessed.

Signature of witness to mark ……
Address: ……
Date: ……20……...

If application was made one (1) year after attaining age 60 please state reason(s) for the late submission……
……
……

4.

Note: Documents to be submitted in support of claim:

1. Birth Certificate
2. National Registration Identity Card
3. Social Security Card
4. **(a)** Affidavit / Deed Poll (if necessary)
   (b) Marriage Certificate (if necessary)
5. A list of your last four (4) Employers

(if applicable)

PERIOD OF EMPLOYMENT	NAME OF EMPLOYERS	ADDRESS

Form OAB 1
(R. & P. Dept.)
Revised Feb. 2008

INVALIDITY

1. Definition

Invalidity Benefit is paid to an Insured Person who is:

a) Incapable of work otherwise than as a result of Employment Injury;

b) Has been so incapable for a period of not less than twenty-six (26) weeks; and

c) Is likely to be permanently so incapable.

2. (a) Qualifying Conditions

An Insured Person is entitled to Invalidity Pension if he / she:

i) Is an Invalid (as defined in item one (1) above);

ii) Has paid not less than one hundred and fifty (150) Contributions;

iii) Has paid or been credited with, or has paid and been credited with, not less than two hundred and fifty (250) Contributions;

iv) Is under sixty- (60) years of age; and

v) Is not in receipt of Sickness Benefit.

(b) An Insured Person who does not satisfy the Qualifying Conditions at item 2 (a), but who:

i) Is an Invalid (as defined in item one (1) above),

ii) Has paid not less than fifty (50) Contributions; and

iii) Is under sixty (60) years of age,

becomes entitled to an Invalidity Grant.

INVALIDITY CONT'D

3. Rate of Benefit

The Weekly Rate of Invalidity Pension is thirty percent (30%) of the Relevant Wage, supplemented by one percent (1%) of that wage for each fifty Contributions in excess of two hundred and fifty (250) Contributions. The Weekly Rate must not exceed sixty per cent (60%) of the Average Insurable Earnings, nor be less than forty percent (40%) of the existing Minimum Wage.

To Calculate the Rate of Pension:

1. Obtain Contribution Record for at least five (5) years before commencement of Invalidity, when Insured Person paid at least thirteen (13) weeks / three (3) months Contribution annually (1 year = 12 months before month of commencement of Invalidity).

2. Find the 'best' three (3) years in the five (5) years mentioned in item **(1)**, where the 'best' year means the year with the highest Annual Insurable Earnings.

3. Invalidity Credits are then calculated by subtracting the age of the Invalid at his / her last birthday before commencement of Invalidity, from 60.

The difference is then multiplied by 25, and the resulting amount is the number of Invalidity Credits to which the Insured Person is entitled.

The Invalidity Credits are then added to the number of paid and credited Contributions, to give the total number of Contributions.

4. The Annual Insurable Earnings for the 'best' three (3) years is summed.

5. The number of Contribution Weeks for the 'best' three (3) years is summed.

6. Divide item **(4)** by item **(5)** to get the Average Weekly Insurable Earnings.

7. Weekly Pension: (30% of item **(6)**) **+** (1% of item **(6)**) for each group of fifty-(50) Contributions in excess of two hundred and fifty (250) Contributions.

8. Monthly Pension: (Weekly Pension **x** 52) **÷** 12.

INVALIDITY CONT'D

To Calculate the Grant Payable:

9. Where the Insured Person is entitled to an Invalidity Grant, the sum payable is equal to one twelfth (1/12) times the Average Annual Insurable Income for each group of fifty- (50) Contributions, whether paid or credited or paid and credited.

10. Obtain total Contribution Record.

11. Sum the Insurable Earnings for all the years of Contributions.

12. Sum the Contribution Weeks for all the years of Contribution.

13. Divide item **(11)** by item **(12)**. This gives the Average Weekly Insurable Earnings.

14. Multiply item **(13)** by 52, to give the Average Annual Insurable Earnings.

15. Divide the total number of Weekly Contributions by 50, which gives the number of groups of fifty- (50) Contributions.

16. The amount of the Grant payable, would be equal to 1/12 **x** Average Annual Insurable Earnings **x** Number of Groups of fifty- (50) Contributions.

4. Duration of Benefit

Invalidity Pension is payable to the Insured Person for as long as Invalidity continues, or until the attainment of age sixty- (60) years, where an Old Age Pension may be paid.

Invalidity Grant is a single payment to the Insured Person.

5. Method of Payment

Invalidity Pensioners are issued with "Pension Order" Books, which contain six (6) Benefit Payment Vouchers to be encashed on a monthly basis. New Books are prepared and issued upon submission of "Life Certificates", which attest to the Pensioner being alive.

Recipients of Invalidity Grant are issued with a single Benefit Payment Voucher.

Vouchers can be encashed at National Insurance Offices, Post Offices and some Commercial Banks.

INVALIDITY CONT'D

6. Manner of Claiming

A Claim for Invalidity Benefit must be made by completing and submitting Form Inv. B1 to the nearest National Insurance Office.

NATIONAL INSURANCE – GUYANA
CLAIM FOR INVALIDITY BENEFIT

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.

(Note A claim for Invalidity Benefit cannot be made unless a person is an Invalid.
An Invalid is defined by Regulation 2 (4) of the National Insurance and Social Security (Benefit) Regulations, 1969.

As a person who:-

a) Is incapable of work otherwise than as a result of employment injury;
b) has been so incapable for a continuous period of not less than 26 weeks; and
c) is likely to be permanently so incapable).

Name of Insured Person ……
(Block Capitals) (Surname) (Other Name)

Date of Birth …… N.I. No. | | | | | | | | | |

Address ……
……

Name of Last Employer …………

Address ……

Answer all Questions

(1) How long have you been continuously incapable of work? ……
(2) What is the nature of your illness or disease? ……
(3) Why do you consider yourself permanently incapable of work? ……
(4) Are you now receiving Sickness Benefit? ……
(5) If so, for how long have you been receiving it? ……

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

……
(Signature of Claimant)

……20……..
(If claimant cannot sign, he should make his mark, which should be witnessed).

Signature of Witness to mark……
Address…….
Date ……20……..

FORM INV. B1
(R & P Dept. May, 1999)

SURVIVORS

1. General

Survivors Benefit shall be payable to or for the Benefit of the Dependants of a Deceased Insured Person.

2. Qualifying Conditions

At the time of death, the Insured Person:

(a) Was in receipt of Old Age Pension or Invalidity Pension; or

(b) Had satisfied the Contribution Requirement for the Award of the Invalidity Pension; or

(c) Was sixty- (60) years of age or over, and would have been entitled to Old Age Benefit had he made a Claim for such Benefit.

3. Entitlement

The Dependants of a Deceased Insured Person entitled to claim Survivor's Benefit are:

(a) The Widow of the Deceased provided that:

(i) She is forty-five (45) years of age or over, or incapable of work and this incapacity is likely to be permanent; or

(ii) She is pregnant by her late husband; or

(iii) She has the care of a Child or Children of his or their marriage, under sixteen (16) years of age, and was either residing with him or receiving, or entitled to receive from him periodical payments for the maintenance of herself or the Children or both, of not less than five dollars ($5.00) weekly.

(b) The Widower of the Deceased provided that:

(i) He is over forty-five (45) years of age or incapable of work, and that incapacity is likely to be permanent; or

SURVIVORS CONT'D

3. Entitlement Cont'd

(ii) He has the care of her child or a child of their marriage, the child being under sixteen years of age; or.

(iii) He had no income from any source, whether by way of Pension or otherwise other than Public Assistance under the Poor Relief Act, or Non-contributory Pension under the Old Age Pension Act.

(c) Every Unmarried Dependant Child who becomes an Orphan, if at the death of the Surviving Parent he / she:

(i) Is left with no Parent;

(ii) Is under the age of eighteen (18) years, and had been wholly or partially maintained by a Deceased Insured Parent in his lifetime; and

(iii) Had no Stepmother or Stepfather with a prior Claim.

(d) If the Deceased is not survived by a Widow, Widower or Child; a lump-sum shall be payable to a Dependant or Dependants being Member(s) of the Family of the Deceased, and wholly or partially maintained by the Deceased provided that:

(i) If the Dependant is a Man, he is permanently incapable of self-support;

(ii) If the Dependant is a Woman, is herself permanently incapable of self-support.

(iii) If the Dependant is a Child, he / she is under the age of eighteen (18) years, or being above that age, is permanently incapable of self-support.

4. A Pension is payable to the Dependants mentioned at items **(a)** to **(c)** above, provided that the Deceased Insured Person was in receipt of, or entitled to received Old Age Pension or Invalidity Pension.

5. A Grant (lump-sum payment) is payable, if the Deceased Insured Person would have been entitled to an Old Age or Invalidity Grant had a Claim been made, or if the Dependant falls in the category mentioned at item **(d)** above.

SURVIVORS CONT'D

6. The Rate of Pension Payable to each category of Dependants is shown in Schedule I below.

SCHEDULE I

Beneficiary	**Basic Rate Of Pension**	**Increase per Dependant**	**Maximum Pension Payable**
Widow/Widower	50% of Old Age or Invalidity Pension paid or which would have been payable	16 2/3% of Old Age or Invalidity Pension paid or which would have been payable Subject to a maximum of three (3) dependants	100% of Old Age or Invalidity pension paid or which would have been payable
Orphan	33 1/3% Old Age or Invalidity Pension Subject to a maximum of three (3) dependants	-	100% of Old Age or Invalidity Pension

7. Period For Which Pension Is Payable

Survivor's Pension is payable:

A. To a Widow, from the date of death of her Husband for life.

B. To a Widower, from the date of death of his Wife for life.

SURVIVORS CONT'D

7. Period For Which Pension Is Payable Cont'd

C. To an Orphan, from the date of death of the Surviving Parent, until the age of sixteen (16) years. Payment will continue beyond age sixteen (16) years, if the Orphan:

(i) Is between the ages of sixteen (16) and eighteen (18) years and is an Unpaid Apprentice and not otherwise employed for gain, or is receiving fulltime education; or is unmarried and permanently incapable of work.

8. In cases where the Insured Person would have been entitled to a Grant but died before a Claim for such Benefit had been made, the amount of the Survivors Benefit payable to those persons mentioned in item **3 (a)** to item **3 (c)** above, would be the amount of the Grant to which the Insured Person would have been entitled.

9. Where there is more than one Dependant, the amount payable shall be distributed as the General Manager thinks reasonable.

10. Where the payment of a Grant results in an individual Beneficiary receiving an amount in excess of sixty monthly payments of the Minimum Pension Payable, an Annuity or Periodical Payment shall be made.

11. The Annuity for a Child under the age of sixteen (16), shall be calculated as if it were ceasing at the age of sixteen (16) years, and shall not exceed the amount of an Orphan's Pension.

12. After the age of sixteen (16) years, the Child shall be subject to the same conditions as for the continuation of a Pension to an Orphan.

NATIONAL INSURANCE & SOCIAL SECURITY ACT, 1969

CLAIM FOR SURVIVOR'S BENEFIT

(Under the Benefit Regulations, 1969)

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.

The General Manager, N.I.S. Date ..... 20.....

Name of deceased person .....
(Block Letters)

Address .....

.....

Date of Birth ..... Date of Death .....
(attach his/her birth certificate)

Deceased person's National Insurance Number | | | | | | | | | | |

Name of last employer before death .....

Address of last employer .....

.....

Was the deceased person in receipt of any benefit from NIS? Answer Yes or No

If 'Yes' please state type of benefit .....

Is claimant in receipt of any benefit from NIS? Answer Yes or No

If 'Yes' please state:-

(a) Type of Benefit .....

(b) National Insurance Number of Claimant | | | | | | | | | | |

Is the Claimant the widow/widower of the deceased person? .....

If neither, state relationship .....

Date of Birth of Claimant .....

If the claimant is not the widow/widower of the deceased person, has he/she the care of the children of the deceased person? .....

Was the claimant married to the deceased person? Yes or No

If yes, attach marriage certificate and state date of marriage.....

Was the claimant wholly or partially dependent on the deceased person? .....

If the claimant is the widow, was she residing with the deceased person at the time of death? Yes or No

If she was not residing with the deceased person, was she receiving or entitled to receive from him periodical payment for maintenance of herself and children, or was she maintained by the deceased voluntarily or by Court Order? .....

*Delete where inapplicable

FORM SG 1

If she was receiving any payment, how much? .....

If a widower, has he any Income, including pension, from any source? .....

If so, how much? .....

Give the particulars of the children of the deceased person:-

Name of Child/ Children	Father's Name	Mother's Name	Date of Birth	Place of Birth

(Attach the birth certificate of each child under 18 years of age)

If the claim is made by a person having the care of the child/children* of the deceased person state:-

a) the name of the wife of the deceased person .....

b) maiden name of wife .....

c) address, if known .....

d) if she is dead give the date of death .....

If the claim is being submitted later than three months after the death of the insured person, please state why it was not made earlier .....

.....

.....

DECLARATION:

I declare that the information given above is true and correct to the best of my knowledge and belief, and I claim Survivor's benefit under the Benefit Regulations, 1969, in respect of the above named deceased person.

(Mr./Mrs./Miss)* .....

(Signature/Mark of Claimant)

Name .....
(In Block Letters)

Address .....

.....

Telephone No.....

Witness to mark .....

Address .....

Occupation of Witness .....

Date .....

*Delete where inapplicable

FORM SG 1
(R & P Dept. Jan. 2000)

FUNERAL BENEFIT

1. Definition

Funeral Benefit is paid to offset the Funeral Expenses of a Deceased Insured Person or his/her Spouse.

2. Qualifying Conditions

Funeral Benefit is payable on the death of:

a) A person who is or has been an Insured Person, and who at the time of death had paid not less than fifty- (50) Contributions; or

b) The Spouse of a person who is or has been an Insured Person, and who at the time of the death of his/her Spouse has paid not less than fifty- (50) Contributions.

The Benefit is payable to the person who has met or is liable to meet the Funeral Expenses.

3. Rate of Benefit

The amount paid as Funeral Benefit is determined by the National Insurance Board from time to time.

4. Method of Payment

A Benefit Payment Voucher is issued to the Recipient of the Benefit. This can be encashed at the National Insurance Office, Post Office or some Commercial Banks.

5. Method of Claiming

The Claimant must complete the Form FB1 and submit it to the nearest National Insurance Office, along with the Death Certificate of the Deceased Person and Receipt(s).

NATIONAL INSURANCE AND SOCIAL SECURITY ACT 1969

CLAIM FOR FUNERAL GRANT

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.

PART I PARTICULARS OF DECEASED INSURED PERSON

SURNAME OF DECEASED INSURED PERSON .....
(Block Letters)

OTHER NAMES .....
(Block Letters)

N.I. No. OF DECEASED PERSON (if any) | | | | | | | | | | |

LAST ADDRESS .....

NAME OF LAST EMPLOYER .....

ADDRESS .....

DATE OF BIRTH | | | | DATE OF DEATH | | | |

CERTIFIED CAUSE OF DEATH .....

OCCUPATION AT TIME OF DEATH .....

PART 2 PARTICULARS OF CLAIMANT

NAME OF CLAIMANT (SURNAME FIRST) .....
(Block letters)

N.I. No. OF CLAIMANT (if any) | | | | | | | | | | |

ADDRESS .....

TO: General Manager, National Insurance:

I hereby claim funeral grant in respect of the above-named deceased person by virtue of his/her/my* National Insurance Contributions.

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Are you related to the insured deceased person? Yes/No*

If related, in what capacity? .....

If not related, in what capacity are you making claim - Administrator/Executor/Others*

(please specify) .....

Who has paid, or is liable to pay the funeral expenses of the deceased person? .....

.....

Was the death due to Industrial Accident? .....

*Delete where inapplicable

CLAIM FOR FUNERAL GRANT CONTINUED

I attach the documents listed below:-

1. A copy of the deceased person's certificate of death or cause of death.
2. His/her Social Security Card bearing number | | | | | | | | | | |
3. Receipt(s) and/or bill for cost of funeral.

If any of the above documents are not submitted with this claim, please give reasons .....

.....

.....

Date: ..... Signature or mark of claimant: .....

Witness to mark where claimant cannot sign.

Name: .....

Occupation: .....

Address: .....

Date: .....

FORM FB. 1
(R & P Dept. March 98)

SICKNESS BENEFIT

1. Definition

Sickness Benefit is payable to an Insured Person who is rendered temporarily incapable of work, otherwise than as a result of an Employment Injury.

2. Qualifying Conditions

To qualify for the Benefit, the Insured Person must have:

a) Been engaged in Insurable Employment immediately prior to the day on which incapacity commenced;

b) Paid not less than fifty- (50) Contributions since his/her entry into insurance; and

c) Been employed and paid Contributions during at least eight (8) Contribution Weeks in the period of thirteen (13) Contribution Weeks immediately preceding the week in which incapacity commenced.

3. Rate of Benefit

The Daily Rate of Sickness Benefit is 70% of the Insured Person's Average Weekly Insurable Earnings, divided by six (6).

The Relevant Wage, for the purpose of Sickness Benefit, is the total earnings on which Contributions were paid and credits awarded, during each of the last eight (8) weeks in the period of thirteen (13) weeks immediately prior to the week in which the incapacity commenced.

To Calculate Benefit Rate:

A. For Weekly Paid Employees:

a) Sum the Weekly Insurable Earnings in the last eight (8) weeks worked before the week in which incapacity commenced.

b) Divide item **(a)** by 8 **=** Average Weekly Insurable Earnings.

c) Weekly Rate = 70% **x** item **(b)**.

SICKNESS BENEFIT CONT'D

d) Daily Rate **=** item **(c) ÷** 6

B. For Monthly Paid Employees

a) Sum the Monthly Insurable Earnings in last two (2) months worked before the month in which incapacity commenced.

b) Divide item **(a)** by 2 **=** Average Monthly Insurable Earnings

c) Monthly Rate **=** item **(b) x** 70%

d) Daily Rate **=** item **(c) ÷** 26

4. Duration of Benefit

Sickness Benefit is not paid for the first three days of incapacity, but for each day (excluding Sunday) commencing on the fourth day, for as long as incapacity for work continues, subject to a maximum of twenty-six (26) weeks in any continuous period of incapacity for work.

Where there are two or more periods of incapacity for work which are not separated by more than eight (8) weeks, the periods will be treated as one continuous period of incapacity for work, starting on the first day of the first period.

The Daily Rate of Benefit payable for the second and subsequent periods of incapacity, which are to be treated as one continuous period, shall be the same as that paid during the first period.

5. Method of Payment

Payment of Sickness Benefit is made by way of Benefit Payment Vouchers, which can be encashed at any of the National Insurance Offices, Post Offices and Commercial Banks.

6. Method of Claiming

A Claim for Sickness Benefit is made by the Insured Person completing the Claim for Sickness Benefit Form (reverse of the Form SB6) after the Doctor has completed the Medical Certificate (Form SB6).

SICKNESS BENEFIT CONT'D

If the Insured Person is employed, his/her Employer must complete the Form SB1 - Sickness Benefit Statement of Earnings, and this is submitted along with the Form SB6 to National Insurance.

If the Insured Person is self-employed, he/she must complete the Form SB6A1 - Certificate by Self-Employed Person in Support of Sickness Benefit, and this is submitted along with the completed SB6 Form.

NATIONAL INSURANCE AND SOCIAL SECURITY ACT, 1969

(In accordance with the National Insurance and Social Security (Medical Certification) Regulations, No. 36 of 1969)

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) or (b) whichever is appropriate)

(a) will be fit to resume work *today/ tomorrow/ on +……..or

(b) will remain incapable of work for a period of @……..days

Any other remarks by Doctor……..

……

……

Date …….. ……

Doctor's Signature

Address ……..

+The date indicated must not be more than seven days (Public Holidays and Sundays included) after the date of examination.

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

***Delete where inapplicable**

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 ……

Form SB6

R & P Dept. (May 2009)

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 Employment | | | |

b) Last date Employee worked | | | |

C) Date of commencement of absence from work | | | |

d) Was work available on date of commencement of absence from work?

Yes	No

(e) Has employee been in your employment over the last 50 weeks? ……..

If no, state number of weeks ……

(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? ……

If yes, state number of contributions ……

---

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.
	5.	12.
	6.	13.
	7.	

(b) Rate of Salary/Wage to be paid to Employee when absent from work:

…… per month/week from …….. to ……

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/Representative: ……..

Date: ……..

Employer's Stamp

Form SB1
(R&P Dept. Amended October 2009)

SICKNESS BENEFIT MEDICAL CARE

1. Definition

Sickness Benefit Medical Care involves the limited reimbursement of Medical Expenses incurred by an Insured Person, who is rendered temporarily incapable of work. This Benefit is available for Medical Care Expenses incurred both locally and overseas.

2. Qualifying Conditions

The Qualifying Conditions for the receipt of Sickness Benefit Medical Care are the same as those for the receipt of Sickness Benefit.

However, if the Claim is for the reimbursement of the cost of providing Orthopedic or Prosthetic Appliances, it is not necessary for the Insured Person to show that he was incapable of work (i.e. it is not compulsory that the Medical Certificate show incapacity days).

The Benefit is available to Insured Persons who are sixteen (16) years and over, but below sixty- (60) years of age. There is however an exception for persons who are in receipt of Invalidity and Old Age Benefit, providing such persons can show that they have a history of the particular Medical Condition, before receiving Invalidity or Old Age Benefit.

3. Rate of Benefit

Reimbursement of Medical Expenses is subjected to specific rates for the various aspects of Medical Care.

Recipients of Invalidity and Old Age Benefit are provided with free Dental and Spectacle Care (subject to specific limits).

4. Duration of Benefit

An Insured Person is entitled to the reimbursement of Medical Expenses from the date on which he is rendered incapable of work, for as long as the need for such care continues.

SICKNESS BENEFIT MEDICAL CARE CONT'D

5. Method of Payment

Benefit Payment Vouchers are issued to Recipients of this Benefit, and these can be encashed at the National Insurance Offices, Post Offices or some Commercial Banks.

Recipients of Old Age and Invalidity Benefit are issued with Coupons to access free Dental and Spectacle care. These Coupons are taken to the Optometrist / Dentist who would be reimbursed by the National Insurance Scheme.

The 'Coupon System' is also available to Contributors who are desirous of obtaining Spectacle Care without having to pay cash (the Benefit is limited to a specific amount).

6. Manner of Claiming

To claim Sickness Benefit Medical Care, the Insured Person must complete the Form SB6A and have his Employer complete the Form SB1 - Employer's Statement in Support of Sickness Benefit Medical Care. These, together with all receipts and a Medical Certificate, must be taken to the nearest National Insurance Office.

Where the Contributor is accessing the Coupon System for Spectacle Care, he/she is required to visit the National Insurance Office with his/her Social Security Card, and (if Spectacles are to be worn for the first time) a Medical Certificate would also be required.

1.

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 OF INSURED PERSON

a) Name in Full

b) Address

c) NIS No.

d) ID No.

e) Date of Birth

f) Sex

g) Date of Commencement of illness

h) Last Date Worked

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)

2.

(C)

Date of Medical attention or Hospitalization	COST OF MEDICAL CARE				
	Doc. Fees (Med. Exam)	Drugs & Dressing	X-ray	Other Treatment	Total Cost

Grand Total
$.....

(d) TYPE AND QUANTITY OF DRUGS USED

TYPE	QUANTITY	TYPE	QUANTITY

(Attach prescription when necessary)

3. 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 dotted line below.

Witness to mark .....

Profession/Occupation.....

Address .....

.....

Date .....

FORM SB6A
(R&P Dept. Amended Feb 09)

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 Employment | | |

b) Last date Employee worked | | |

C) Date of commencement of absence from work | | |

d) Was work available on date of commencement of absence from work?

Yes	No

(e) Has employee been in your employment over the last 50 weeks? .....

If no, state number of weeks .....

(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?

.....

If yes, state number of contributions .....

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.
	5.	12.
	6.	13.
	7.	

b) Rate of Salary/Wage to be paid to Employee when absent from work:

..... per month/week from ..... to .....

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/Representative: .....

Date: .....

Employer's Stamp

Form SB1
(R&P Dept. Amended October 2009)

MATERNITY BENEFIT

1. Definition

Maternity Benefit (Allowance and Grant) is payable in the case of Pregnancy and Confinement of a Woman who is an Insured Person, or whose Spouse is an Insured Person.

2. Qualifying Conditions

Maternity Allowance is payable if the Insured Woman:

a) Has paid not less than fifteen (15) Contributions since her entry into insurance; and

b) Has been engaged in and paid Contributions for Insurable Employment during at least seven (7) Contribution Weeks in the period of twenty-six (26) Contribution Weeks preceding the week in which Benefit is claimed.

Maternity Grant is payable to:

c) Any Insured Woman who has satisfied the conditions at items 2 (a) and 2 (b) above;

d) Any woman whether insured or not, who was confined and who has not satisfied the conditions at items 2 (a) and 2 (b) above, but whose Spouse is an Insured Person and has satisfied the Contribution Conditions.

3. Rate of Benefit

The Weekly Rate of Maternity Allowance is seventy per cent (70%) of the Average Weekly Insurable Earnings.

Calculation of Rate of Maternity Allowance:

Weekly Paid Persons -

i) Sum the Weekly Insurable Earnings for the best seven (7) weeks worked in the twenty-six (26) weeks period preceding the week in which the Benefit is due to commence.

ii) Divide item **(i)** by 7 **=** Average Weekly Insurable Earnings.

MATERNITY BENEFIT CONT'D

Calculation of Rate of Maternity Allowance Cont'd:

Weekly Paid Persons Cont'd -

iii) Weekly Rate of Benefit **=** item **(ii) x** 70%.

Monthly Paid Persons -

iv) Sum the Monthly Insurable Earnings for the best two (2) months worked in the six (6) months period immediately preceding the month in which the Benefit is due to commence.

v) Divide item **(iv)** by 2 **=** Average Monthly Insurable Earnings.

vi) Divide item **(v)** by 26 and multiply the result by 6 **=** Average Weekly Insurable Earnings.

vii) Weekly Rate of Benefit **=** item **(vi)** x 70%.

The amount of the Maternity Grant is two thousand dollars ($2,000.00).

4. Duration of Benefit

Maternity Allowance is normally paid for a period of thirteen (13) weeks. This Benefit can be extended for an additional thirteen (13) week period if the Insured Woman is still incapable of work as a result of complications arising directly out of the pregnancy and delivery.

If the Woman so desires, the Benefit can be paid for a period starting from the week not earlier than six (6) weeks before the expected week of confinement, and continue until six (6) weeks after the week of confinement or from the week of confinement.

Two or more periods of incapacity for work that are not separated by more than eight (8) weeks, will be treated as one continuous period, starting from the first day of the first period. The Rate of Maternity Benefit payable in respect of any period after the first period of incapacity will be the same rate paid during the first period.

MATERNITY BENEFIT CONT'D

5. Method of Payment

Benefit Payment Vouchers are issued to the Recipients of Maternity benefit. The Vouchers can be encashed at the National Insurance Offices, Post Offices and Commercial Banks.

6. Method of Claiming

The following documents must be submitted when claiming Maternity Allowance:

Form MB2	-	Claim for Maternity Benefit
Form Med 2	-	Medical Certificate of Confinement; or
Form Med 3	-	Medical Certificate of Expected Confinement
Form MB1	-	Maternity Benefit Statement of Earnings (to be completed by the Employer)
Form MB1A	-	Certificate by Self-employed in support of Maternity Benefit Claim (to be completed by Self-employed Person)

If the Insured Woman is incapable of work after the completion of the normal thirteen (13) week period of Benefit, she must submit the following to claim the extended Benefit.

Form MB 1(b) - Claim for Extended Maternity Allowance; and

Form Med 1(a) - Medical Certificate - Post Confinement

Where a Claim is made using Medical Certificate of Expected Confinement, the Medical Certificate of Confinement must also be submitted by the Woman, when confinement takes place.

The following documents must be submitted when claiming Maternity Grant:

Form MB-2A	-	Claim for Maternity Grant
Form MB-2B	-	Declaration by Spouse to support Claim for Maternity Grant
Form Med 2	-	Medical Certificate of Confinement

MATERNITY BENEFIT CONT'D

6. Method of Claiming Cont'd

It should be noted that if the claim for Maternity Grant is being made by an Insured Woman who has satisfied the Qualifying Conditions for receipt of Maternity Allowance, only Form MB-2A must be submitted.

However, where the Woman is not insured or does not satisfy the Qualifying Conditions for the receipt of Maternity Allowance, but her Spouse does, Form MB-2A and Form MB-2B, along with Form Med 2 must be submitted.

NATIONAL INSURANCE AND SOCIAL SECURITY ACT, 1969
CLAIM FOR MATERNITY BENEFIT

I hereby apply for Maternity Benefit under the National Insurance and Social Security Act, 1969, and furnish a *Certificate of Confinement/Certificate of Expected Confinement at back hereof, and the following particulars:-

1. My full name is .....
(Block Letters)
2. My Address is .....
3. My National Insurance Number is | | | | | | | | | | |
4. I am/was employed by .....

as a/an .....

5. I last worked there on .....
6. *I do not expect to receive any wages or salary from my employer during my absence from work./I will be given ..... weeks leave from .....20..... to.....20..... during which period I will be paid..... per week/month.

.....
Signature of Claimant

.....
Date
(If unable to write mark X and have it witnessed)

Witness to Mark

.....
Name

.....
Occupation

.....
Address

.....
Date

Note: 1. Maternity Benefit cannot be paid for any period earlier than six weeks before the week of expected confinement as certified by the Medical Practitioner or Registered Midwife, nor can it be paid for any period before the date of your claim.
2. Maternity Benefit will be reduced if, together with any wages paid by your employer for maternity leave granted by him, it exceeds your average weekly wage for the last thirteen weeks before the week in which your claim is made.
3. Maternity Benefit will not be paid for any period during which you are engaged in paid employment.

*Delete where inapplicable
FORM MB2

NATIONAL INSURANCE AND SOCIAL SECURITY ACT, 1969
CERTIFICATE OF CONFINEMENT

(In accordance with National Insurance and Social Security (Medical Certification) Regulations, No. 36 of 1969)

(To be given by a Registered Medical Practitioner or Registered Midwife. This Certificate must be attached to the Claim Form and sent or delivered to the nearest convenient National Insurance Local Office immediately after confinement. Late submission can result in loss of Benefit.)

I certify that I attended ..... in connection with her *confinement which took place at..... (address)

and that she was there delivered of a child children on the .....

day of ..... 20.....

(It is important that where the Medical Practitioner or Midwife considered that the *confinement took place before the @week in which it was expected, the following paragraph should be completed. In any other case, it should be struck through).

Containing the .....day of ..... 20.....

Signature .....

(If Registered Midwife, add

register number.....

or address and date of qualification)

.....
Date of examination .....

Date of Signing.....

NOTES:

*Confinement is so defined by the National Insurance and Social Security (Benefit) Regulations, 1969, that this certificate can only be given:-

(i) Where labour results in the issue of a living child
Or
(ii) Where labour results in the issue of a dead child and pregnancy has lasted for at least 28 weeks.

+ Insert number of children, if more than one.
@ The week referred to is a contribution week, i.e., one which begins on a Monday.

FORM Med 2
R & P Dept (Revised June 2010)

NATIONAL INSURANCE AND SOCIAL SECURITY ACT, 1969
CLAIM FOR MATERNITY BENEFIT

I hereby apply for Maternity Benefit under the National Insurance and Social Security Act, 1969, and furnish a *Certificate of Confinement/Certificate of Expected Confinement at back hereof, and the following particulars:-

1. My full name is .....
(Block Letters)
2. My Address is .....
3. My National Insurance Number is | | | | | | | | | | |
4. I am/was employed by .....
as a/an .....
5. I last worked there on .....
6. *I do not expect to receive any wages or salary from my employer during my absence from work./I will be given ..... weeks leave from.....20..... to.....20..... during which period I will be paid..... per week/month.

.....
Signature of Claimant

.....
Date
(If unable to write mark X and have it witnessed)

Witness to Mark

.....
Name

.....
Occupation

.....
Address

.....
Date

Note: 1. Maternity Benefit cannot be paid for any period earlier than six weeks before the week of expected confinement as certified by the Medical Practitioner or Registered Midwife, nor can it be paid for any period before the date of your claim.
2. Maternity Benefit will be reduced if, together with any wages paid by your employer for maternity leave granted by him, it exceeds your average weekly Wage for the last thirteen weeks before the week in which your claim is made.
3. Maternity Benefit will not be paid for any period during which you are engaged in paid employment.

*Delete where inapplicable
FORM MB2

NATIONAL INSURANCE AND SOCIAL SECURITY ACT, 1969

MEDICAL CERTIFICATE OF EXPECTED CONFINEMENT

(In Accordance with National Insurance and Social Security (Medical Certification) Regulations No. 36 of 1969)

(To be given by a Registered Medical Practitioner or Registered Midwife not earlier than the beginning of the ninth week* before the week* containing the day of expected confinement)

To.....

I certify that I examined you on the under mentioned date and that in my opinion you may expect to be confined in the week* which will include the .....day of .....20.....
(Here insert the expected date of confinement)

Signature .....

(If Registered Midwife, add register number.....

or address and date of Qualification).....

Date of Examination .....

Date of Signing .....

Any other remarks by Doctor or Midwife .....

.....

***The week referred to is a contribution week, i.e. one which begins on a Monday.**

FORM Med. 3

Research & Planning Dept. (Revised June 2010)

NATIONAL INSURANCE AND SOCIAL SECURITY ACT, 1969
MATERNITY BENEFIT STATEMENT OF EARNINGS

(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 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 EMPLOYEE:

(b) ADDRESS OF EMPLOYEE:

(C) NATIONAL INSURANCE NO:

(d) NATIONAL REGISTRATION NO:

3. **PARTICULARS OF EMPLOYMENT**:

(a) Has Employee been in your employment over the last 15 weeks? Yes | No
If the answer to (a) above is No,

(b) How long has employee been in your employment? .....

(c) How many contributions have you paid for employee during period referred to at (a) or (b) above?

(d) Salary/wage paid to employee for last 6 months/26 weeks worked

MONTH	SALARY
1.	$
2.	$
3.	$
4.	$
5.	$
6.	$

WEEK ENDING	WAGE
1.	$
2.	$
3.	$
4.	$
5.	$
6.	$
7.	$
8.	$
9.	$
10.	$
11.	$
12.	$
13.	$

WEEK ENDING	WAGE
14	$
15.	$
16.	$
17.	$
18.	$
19.	$
20.	$
21.	$
22.	$
23.	$
24.	$
25.	$
26.	$

(E) Last date employee worked:

(f) Rate of salary/wage to be paid to employee when absent from work:

$..... per month/week. From ..... to.....

((f) above to be completed only when employee will be paid during period of maternity benefit)
I certify that the above statements are true to the best of my belief and knowledge and I assume full responsibility as to their correctness.

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

Date: .....

FORM MB1 (REVISED 95)
(R & P Dept. May 1999)

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.		
Total		
Avg. Monthly		

WEEK	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 employer)

(a) Average monthly/weekly earnings $ .....

(b) 70% avg. mthly/wkly insurable earnings $ .....

(c) Salary/wage paid $.....

(d) Total item b) and c) $.....

(e) Item d) – item a)
(enter 0 if answer is negative) $.....

(f) Rate of Benefit (Item 6 - Item e)

$ Per month/week

Rate per month/week – 26/6

$ Per day

4. PARTICULARS OF PAYMENT

Date of Commencement Payment Made: Stop Date Review Date

FROM	TO	AMT. $	PAID C	Prepared By	Date	Checked By	Date	Auth. By	Date	B.P.V No.	Date
1.											
2.											
3.											
4.											

5. IF DISALLOWED

1. Date claim was Disallowed
2. Reason for Disallowance .....
3. Date claimant was notified

6. IF DISQUALIFIED
Period of Disqualification

From To

Reason for Disqualification.....

7. NOTIFICATION

Department/Section	
Form No.	
Date Sent	
Signature	
Remark	

NATIONAL INSURANCE AND SOCIAL SECURITY ACT, 1969
CERTIFICATE BY SELF-EMPLOYED PERSON IN SUPPORT OF MATERNITY BENEFIT CLAIM

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

PARTICULARS OF SELF-EMPLOYED PERSON

1. **NAME:**
2. **ADDRESS OF BUSINESS:**
3. **HOME ADDRESS:** **(if different from 2)**
4. **NATIONAL INSURANCE NUMBER**
5. **NATIONAL REGISTRATION NUMBER**
6. **DATE OF BIRTH**
7. **LAST DATE WORKED:**
8. **DATE OF CONFINEMENT/EXPECTED CONFINEMENT:**
9. **DECLARED INCOME FOR PREVIOUS YEAR 20……** $
10. **Contributions paid to National Insurance for last 2 months/7 weeks worked:**

Month	Contributions	Week Ending	Contributions	Week Ending	Contributions
		1.			
1.		2.		5.	
2.		3.		6.	
		4.		7.	

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:……

FOR OFFICIAL USE

The receipt (s) nos. _____ **dated** _____ **for** _____ **as**

_____ _____ _____

_____ _____ _____

paid National Insurance contributions were examined by me and I hereby also certify the correctness of the information stated at item 9 above.

Signature:……

(N.I. Clerk)

Date:……

Form MB1A (Revised Oct. 2009)

FOR OFFICIAL USE

1. **Documents submitted with claims**

1. _____
2. _____
3. _____

2. **Decision**

Allowed	
Disallowed	

(tick appropriate box)

3. **IF ALLOWED**

Calculation of rates:

MONTH RELEVANT SALARY

	Actual	Insurable
1.		
2.		
TOTAL		
AVG. MONTHLY		

WEEK ENDING RELEVANT WAGE

	Actual	Insurable
1.		
2.		
3.		
4.		
5.		
6.		
7.		
TOTAL		
AVG. WEEKLY		

RATE OF BENEFIT: $ PER MONTH/WEEK

(70% avg. monthy/weekly insurable salary/wage)

4. **PARTICULARS OF PAYMENT**

Date of commencement Stop Date Review Date

Payments made:

From	To	Amt. Pd.	Prepared by	Date	Checked by	Date	B.P.V.No.	Date
1.								
2.								
3.								
4.								

5. **IF DISALLOWED**

1. Date Claim disallowed
2. Date claimant notified
3. Reason for disallowance ……

……

6. **NOTIFICATION**

Department/Section	Form No.	Date
1.		
2.		
3.		

Certified by:……

Date:……

NATIONAL INSURANCE AND SOCIAL SECURITY ACT CHAPTER 36:01

(In according with the national and Social Security (Medical Certification) Regulations No. 36 of 1969)

MEDICAL CERTIFICATE POST CONFINEMENT

I, ...

A duly qualified registered Medical Practitioner, hereby certify that

* Miss/Mrs. .....

(Name)

of .....

(Address)

was examined by me on .....

at ..... for the *first/second .....

time and in my opinion she was at the time of examination suffering from .....

.....which has resulted from her

*pregnancy/confinement.

As a result she

(a) will be fit to resume work *today/tomorrow/on .....

..... or

(b) will remain incapable of work for a period of ..... days.

Any other remarks by doctor: .....

.....

.....

.....

.....

Date Doctor's Signature

Address: .....

.....

* Delete where inapplicable

** The date indicated must not be more that seven days (Public Holidays, including Sundays) 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.

FORM Med. 1(a)

CLAIM FOR EXTENDED MATERNITY ALLOWANCE

I, the undersigned hereby apply for extended maternity allowance under the National Insurance and Social Security (Amendment) Act, 1986, and furnish a medical certificate at back hereof and the following particulars: -

1. My full name is (in BLOCK LETTERS) .....
2. My address is .....
3. My National Insurance Number is .....
4. My employer is .....
5. My occupation is/was .....
6. I last worked there on .....
7. I was confined on .....

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 claimant cannot sign her name she should make her mark and have it witnessed by a responsible person (Doctor, Layer, Teacher, Justice of Peace etc.) who should complete the dotted lines below.

Signature of Witness or mark: .....

Profession or occupation: .....

Address: .....

Date: .....

Form MB 1(b)

NATIONAL INSURANCE – GUYANA
CLAIM FOR MATERNITY GRANT

WARNING:
Any person who knowingly makes a false statement or false representation for the purpose of obtaining any payment of Maternity Grant under the National Insurance and Social Security Act or produces or furnishes any document or information which is known to be false in a material particular, shall be liable to prosecution.

SECTION A: (1) I, ……
Name of Claimant in (Block Letters)
Of ……
(Address)
hereby make claim for Maternity Grant based on my own */spouse's contributions and make the following declaration:-

(2) (a) My date of birth is ☐☐☐ (D M Y)

(b) My National Insurance Number is ☐☐☐☐☐☐☐☐☐☐

(c) My Marital Status is (Please indicate by ticking the appropriate box) ☐ Single ☐ Widowed ☐ Common Law ☐ Married ☐ Divorced ☐ Separated

(d) I was confined on ☐☐☐ (D M Y)

(e) My confinement Certificate is *attached/was submitted on ☐☐☐ (D M Y) to N.I.S. Office at ……

(f) My Spouse's Name is: ……..

(g) I have …… children under the age of 18 years.
Their particulars are given below:-

(h)

NAME	D.O.B.			SEX	NAME	D.O.B.			SEX
	D	M	Y			D	M	Y	
1.					4.				
2.					5.				
3.					6.				

(3) …….. ……
Signature/Mark of Claimant Date
Witness to mark ……. ……
Date
…….. ……
Date

NOTE: SECTION A must be completed in ALL CASES
*Delete where inapplicable
FORM MB-2A (Amended)
Research & Planning Dept (May 2010)

DECLARATION BY SPOUSE TO SUPPORT CLAIM FOR MATERNITY GRANT

WARNING:
Any person who knowingly makes a false statement or false representation for the purpose of obtaining any payment of Maternity Grant under the National Insurance and Social Security Act or produces or furnishes any document or information which is known to be false in a material particular, shall be liable to prosecution.

D E C L A R A T I O N
(TO BE COMPLETED BY SPOUSE)

SECTION B: (1) I, …….. hereby declare that I am the father of the issue from confinement of ……
Name of Mother
Which took place on ☐☐☐ (D M Y) and that the particulars given hereunder are correct:-

(2) a. My full Name is …… (Surname / Other Names)

b. My National Insurance Number is ☐☐☐☐☐☐☐☐☐☐

c. My address is: ……..

d. My Employer is: …….

e. My occupation is: ……

f. *I was married to: ……..
Name of Spouse
on ☐☐☐ (D M Y) (see marriage certificate attached)

g. *I have been living with …….. during
Name of Spouse
period ……. to …….. As man and wife.

h. My Marital Status is (Please indicate by ticking the appropriate box) ☐ Single ☐ Widowed ☐ Common Law ☐ Married ☐ Divorced ☐ Separated

(3) …… …….
Signature/Mark of Claimant Date
Witness to Mark (1) …… ……
Date
(2) …… ……
Date

*Delete where inapplicable.
NOTE: Section B must be fully completed by Spouse in cases where benefit is claimed on spouse's contributions.
FORM MB-2B
Research & Planning Dept (May 2010)

CONSTANT ATTENDANCE BENEFIT

1. Definition

Constant Attendance Benefit is payable to a person who is either an Invalidity or a Disablement Pensioner. The Benefit was introduced to offset charges, which would be incurred as a result of dependency upon someone else for Custodial Care, in carrying out the activities of daily living.

2. Qualifying Conditions

The Qualifying Condition for the Benefit is that, it shall only be payable to the Pensioner who is dependent on Custodial Care for carrying out the activities of daily living.

3. Rate of Benefit

The Daily Rate of the Benefit is fixed at two hundred dollars.

4. Duration

Constant Attendance Benefit shall be paid for such period as the General Manager may determine, taking into consideration the particular circumstances of the Case, but not exceeding a period of twenty-six (26) weeks; provided that Sunday or such other day in the week as may be determined by the General Manager in any particular Case or Class of Case, shall not be disregarded in computing any period of consecutive days.

5. Method of Payment

A Benefit Payment Voucher is issued to the Recipient of this Benefit, and this can be encashed at the National Insurance Scheme Offices, Post Offices and Commercial Banks.

6. Manner of Claiming

To claim for this Benefit, the Pensioner must fill out Form CAB1 and submit same to the nearest National Insurance Office, supported by a Certificate from a Registered Medical Practitioner, or by such other evidence as the General Manager may require for the purpose of establishing the Insured Invalidity or Disablement Pensioner's incapacity for work.

NATIONAL INSURANCE – GUYANA

CLAIM FOR CONSTANT ATTENDANCE BENEFIT

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. Name of Claimant: ……...

2. Address: ……

……

3. Date of Birth: …….. **4. Sex: ……**

5. Are you an Invalidity or Disablement Pensioner? ……

If yes, a) please state which: …….

b) state N. I . number: ……

Signature / Mark of Claimant: ……...

Date: ……...

Witness to mark: ……..

Address: ……

Date: ……...

Form CAB 1 (October 1997)

INJURY BENEFIT

1. Definition

Injury Benefit falls under the Industrial Benefit Branch. This benefit is payable to an Insured Person who becomes incapable of work as a result of an Injury or Prescribed Disease, arising during the course of or directly resulting from employment.

2. Qualifying Conditions

There are no Contribution Conditions for the receipt of Injury Benefit. However, the Insured Person must be employed. Self-employed Persons are not covered for Benefits under the Industrial branch.

3. Rate of Benefit

The Daily Rate of Injury Benefit is 70% of the Average Weekly Insurable Earnings, divided by six (6).

Calculation of Rate of Benefit:

For Weekly Paid Insured Persons -

i) Sum the Weekly Insurable Earnings in the last weeks (maximum of 8) worked before the week of the Accident.

ii) Divide item **(i)** by the number of weeks **=** Average Weekly Insurable Earnings.

iii) Weekly Rate **=** item **(ii) x** 70%

iv) Daily Rate **=** item **(iii) ÷** 6

For Monthly Paid Insured Persons -

i) Sum the Monthly Insurable Earnings in the last 2 months worked before the month of the Accident.

ii) Divide item **(i)** by the number of months = Average Monthly Insurable Earnings.

iii) Item **(ii) x** 70% = Monthly Rate.

INJURY BENEFIT CONT'D

iv) Item **(iii) ÷** \26 = Daily Rate.

If the Insured Person suffers an Accident during the first week/ month on the job, then the Weekly/Monthly Earnings that would have been paid (subject to the Insurable Earnings Ceiling) would be used when calculating the Rate of Benefit.

4. Duration of Benefit

Injury Benefit is paid for each day (excluding Sunday) as long as incapacity for work continues, subject to a maximum period of twenty-six (26) weeks in any continuous period of incapacity.

Where there are two or more periods of incapacity for work arising out of the Injury/Prescribed Disease, which are not separated by more than eight (8) weeks, the periods are treated as one continuous period of incapacity starting from the first day of the first period.

Injury Benefit is not paid for the first three (3) days of incapacity, unless the period of incapacity exceeds three (3) days.

5. Method of Payment

Payment is made using Benefit Payment Vouchers, which can be encashed at the National Insurance Offices, Post Offices or some Commercial Banks.

6. Manner of Claiming

The Employer is required to complete the Form IB1 - Notice of Accident, and give it to the Employee for submission, along with a Medical Certificate, to the nearest National Insurance Office.

1. **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 monnths/8 weeks worked:

MONTH	SALARY	WEEK ENDING	WAGES	WEEK ENDING	WAGES
1.	$	1.	$	5.	$
2.	$	2.	$	6.	$
		3.	$	7.	$
		4.	$	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 IB1

2. **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		

* WAGES	WEEK ENDING 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	AMTPAID $	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: ……

INJURY BENEFIT MEDICAL CARE

1. Definition

Injury Benefit Medical Care involves the limited reimbursement of Medical Expenses incurred by an Insured Person, who is rendered temporarily incapable of work as a result of an Industrial Accident or Occupational Diseases.

This Benefit is available for treatments received both locally and overseas.

2. Qualifying Conditions

The Qualifying Conditions for the receipt of Injury Benefit Medical Care are the same as those for the receipt of Injury Benefit.

The Benefit is available to all Insured Persons, with no age restriction, so even if you are under sixteen (16) years or over sixty- (60) years of age, once you are employed, you are covered for Industrial Injury Med-Care.

3. Rate of Benefit

Reimbursement of Medical Expenses is subject to specific rates for the various aspects of Medical Care.

4. Duration of Benefit

An Insured Person is entitled to the reimbursement of Medical Care Expenses from the date on which he is rendered incapable of work, for as long as need for such care continues.

5. Method of Payment

Benefit Payment Vouchers are issued to Recipients of this Benefit, and this can be encashed at the National Insurance Office, Post Offices and Commercial Banks.

6. Manner of Claiming

To claim for Injury Benefit Medical Care, the Insured Person must first fill out Form MED. 11 in support of reimbursement of fees for Medical Referee and Cost of Treatment, and have his Employer complete the Form IB1in support of Injury Medical

INJURY BENEFIT MEDICAL CARE CONT'D

6. Manner of Claiming Cont'd

Care. These, together with all receipts and a Medical Certificate, must be taken to the nearest National Insurance Office.

The Insured Person can also fill out Form MED. 12 to claim for reimbursement of Travelling Expenses and Subsistence.

1.

NATIONAL INSURANCE AND SOCIAL SECURITY ACT, 1969

CLAIM FOR FEES FOR MEDICAL CERTIFICATION AND TREATMENT FOR EMPLOYMENT INJURY AND/OR SICKNESS CASES

PERIOD: From: …….. To: …….

Name of Person/Firm making claim: …….

(State whether Medical Practitioner, approved Para-medical Person, Pharmacist, Hospital in cases of employment injury only)

……

Postal Address: ……...

National Insurance Number of Insured Persons	Name of Insured Person (Surname First)	State Whether Employment Injury or Sickness	Nature of Injury or Illness	Date	Date(s) of medical attention (including certification)	Particulars of Drugs used and Treatment given	Quantity	Charges as per scale			
								Medical Examination Including certification	Treatment	Drugs And Dressings	Others (please specify)
								$	$	$	$

2.

National Insurance Number of Insured Persons	Name of Insured Person (Surname First)	State Whether Employment Injury or Sickness	Nature of Injury or Illness	Date	Date(s) of medical attention (including certification)	Particulars of Drugs used and Treatment given	Quantity	Charges as per scale			
								Medical Examination Including certification	Treatment	Drugs And Dressings	Others (please specify)
								$	$	$	$

I hereby certify that this is a true account of the expenses incurred in the Medical Care and Treatment of employment injury and/or sickness cases for the period stated above.

Date: …….

Signature of Claimant or Authorised Representative.

Totals _____

Grand Total _____

FOR OFFICIAL USE ONLY

I hereby certify that the charges above are fair and reasonable

Date: …… Medical Adviser: ……

BENEFITS DIVISION

Number – M.C.No.

1. **Checked by: ……**
   Date: ……..
2. **Authorised for payment subject to check**
   Amount claimed: ……..
   Date: …… S.E.O: ……
3. **Checked by: ……..**
4. **Payment Voucher No…….**

Form Med 11

(R&P Dept. Amended July 97)

1. **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:
   (f) OCCUPATION: (e) SEX:
3. PARTICULARS OF EMPLOYMENT: (g)D.O.B.
   (a) Last date injured person worked

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

MONTH	SALARY	WEEK ENDING	WAGES	WEEK ENDING	WAGES
1.	$	1.	$	5.	$
2.	$	2.	$	6.	$
		3.	$	7.	$
		4.	$	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): ……

FORM IB1 Date: ……..

2. **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	AMTPAID $	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: ……..

Claim for Travelling and Allowance for
Loss of Pay Due to Employment Injury

Injured Person's Surname ……

Other Names ……

Home Address…….

……..

Place of Employment where injury occurred ……

Date of Employment Injury ……

National Insurance Number | | | | | | | | | | | | |

DATE	HOUR OF DEPARTURE	FROM	TO	HOUR OF ARRIVAL	MEANS OF TRANSPORT	PURPOSE OF TRAVEL	NO. OF HOURS	TRAVELLING $	SUBSISTENCE $	LOSS OF PAY $	TOTAL $
										TOTAL	

CERTIFICATE
(To be completed by employer when a claim is made for an allowance for loss of pay).

I certify that …….
(Name of Claimant)

National Insurance No. | | | | | | | | | | | Will not be paid

wages for the period …… during which he has attended for medical treatment due to the employment injury sustained

on ……..

Date ……..

I certify that the expenses claimed above were incurred and are due in connection solely with the treatment for the employment injury sustained by me, the above-named person, on the date mentioned above and that the facts given are correct.

……
Signature of Claimant/Authorised Representative

……
Witness where Claimant cannot sign

…….
Date

……
Signature of Employer or Authorised Representative

Med. 12
R & P Dept. Feb. 98

DISABLEMENT BENEFIT

1. Definition

Disablement Benefit is payable to an Insured Person who has suffered loss of Faculty due to an Industrial Accident.

2. Qualifying Conditions

There are no Contributions Conditions to be satisfied. The Insured Person however, must be employed as Self-employed Persons are not covered for this Benefit.

3. Rate of Benefit

An assessment of the Degree of Disablement is made and stated in the form of a percentage.

Where the extent of the Disablement is assessed at less than fifteen percent (15%), Disablement Benefit is payable as a Grant (lump-sum).

To Calculate the Amount of the Grant:

a) Calculate the Weekly Rate of Injury Benefit (see instructions under Injury Benefit).

b) Calculate five (5) Annuities **=** 5 **x** 52 **=** 260.

c) Grant **=** Assessed Percentage **x** item **(a) x** item **(b)**.

Where the extent of the Disablement is assessed at fifteen percent (15%) or more, the Benefit is payable as a Pension.

To Calculate the Rate of Pension Payable:

d) Adjust the Assessed Percentage as follows:

i) If the assessment is not a multiple of 5, then adjust to the nearer multiple of 10.

ii) If the assessment is a multiple of 5, then adjust to the next higher multiple of 10.

iii) If the assessment is a multiple of 10, then no adjustment is needed.

DISABLEMENT BENEFIT CONT'D

To Calculate the Rate of Pension Payable:

e) Calculate the Rate of Injury Benefit (see instructions under Injury Benefit).

f) Weekly Pension **=** Assessed Percentage **x** item **(e)**.

4. Duration of Benefit

An Insured Person is not entitled to Disablement Benefit during the first three (3) days, beginning with the day of the Accident. The Benefit is payable either for the duration of the Claimant's life, or to a definite date on which a further assessment would be made.

5. Method of Payment

Recipients of Disablement Pension are issued with "Pension Order" Books, which usually contain six (6) Benefit Payment Vouchers to be encashed on a monthly basis. New books are prepared and issued upon submission of "Life Certificates" which attest to the Pensioner being alive.

Recipients of Disablement Grant are issued with a single Benefit Payment Voucher.

Benefit Payment Vouchers can be encashed at National Insurance Offices, Post Offices or Commercial Banks.

6. Manner of Claiming

A Claim for Disablement Benefit must be made by the completion of Form IB22 - Claim for Disablement Benefit, and submitting it along with a Medical Certificate, to the nearest National Insurance Office.

NATIONAL INSURANCE & SOCIAL SECURITY ACT, 1969

CLAIM FOR DISABLEMENT BENEFIT

(Under the Industrial Benefit Regulations, 1969

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,

To: The General Manager, National Insurance Date: ……

Name of Claimant: ……Sex: ……

(Block Letters)

Address: ……

Date of Birth: …….. …. N.I. No. | | | | | | | | | |

Occupation: ……....

Name of Employer: ……

Address: ……

Give (a) the date the accident happened: ……

(b) time: …… a.m./p.m.

State exactly where the accident happened: ……

……..

Where were you employed when the accident happened? ……..

……..

What were you doing when the accident happened? ……..

……..

Cause or nature of the accident: ……..

Was it caused by machinery? ……..

If so, give the name of the machine and part: ……..

……...

Give the nature and extent of the injury (e.g. Loss of finger, fracture, loss of arm, etc): ……

……..

For what period (if any) were you unable to work? ……

Were you hospitalized during the period you were unable to work? ……...

Is so, state name of the institution at which you were hospitalized: ……

……...

Are/were you in receipt of wages/salary from your employer during the period you were unable to work?

……...

If so, at what rate? ……

When will you be fit to resume duty? ……..

If you have resumed duty give the date of resumption: ……...

Date: …… Signature/Mark of Claimant: ……...

Witness to mark: ……..

Address: ……...

Date: ……

FORM IB22
(R & P Dept. Feb. 2000)

INDUSTRIAL DEATH BENEFIT

1. Definition

Industrial Death Benefit is payable to the Dependants of a Deceased Insured Person who died as a result of an Industrial Accident.

2. Qualifying Conditions

There are no Contribution Conditions to be satisfied by the Insured Person. However, the Dependants of the Deceased Insured Person must satisfy specific conditions in order to qualify for the Benefit.

The Dependants of the Deceased Insured Person who are entitled to claim Industrial Death Benefit are:

(a) The Widow of the Deceased if at the time of his death:

i) She is over forty-five (45) years of age or incapable of work, and this incapacity is likely to be permanent; or

ii) She is pregnant by her late Husband; or

iii) She has the care of a Child of his or their Marriage under eighteen (18) year of age, and was either residing with him or receiving, or entitled to receive from him, periodical payments for the maintenance of herself or the children or both.

(b) The Widower of the Deceased if at the time of her death:

i) He is over fifty-five (55) years of age and incapable of work, and this incapacity is likely to be permanent; and

ii) He has no income from any source whether by way of Pension or otherwise, other than Public Assistance under the Poor Relief Act or Non-contributory Pension under the Old Age Pensions Act.

(c) Every Unmarried Dependent Child who becomes an Orphan as a result of the death of:

i) An Insured Person due to an Industrial Accident

ii) A Widow or Widower in receipt of Death Benefit and who has no Stepmother or Stepfather with a prior Claim.

INDUSTRIAL DEATH BENEFIT CONT'D

(d) A Parent of the Deceased who is permanently incapable of self-support, and who was being wholly or partially maintained by the Deceased, or who would, but for the Accident, have been so maintained;

(e) Where there is no Widow, Widower, Child or Parent, other Dependants who are members of the family of the Deceased, and who were wholly or partially maintained by the Deceased or would, but for the Relevant Accident, have been so maintained:

i) If the Dependant is a man, he must be permanently incapable of self-support;

ii) If the Dependant is a woman, she must be permanently incapable of self-support, or is living with her Husband who is permanently incapable of self-support;

iii) If the Dependant is a child, he/she must be under the age of eighteen (18) years or, if over that age, is permanently incapable of self-support.

If there is more than one Dependant, the amount payable shall be distributed in such a manner, as the General Manager may consider reasonable.

(f) Where there is no Dependant entitled to Death benefit, the smaller of the following amounts shall be payable to the Creditors or Estate of the Deceased Insured Person:

i) A sum equal to the reasonable expenses for Medical Attendance on the Deceased for the Relevant Injury, and the reasonable expenses of his/her Burial; or

ii) The sum of two hundred and fifty dollars ($250).

3. Rate of Benefit

The Weekly Rates of Death Benefit Payable are shown below:

BENEFICIARY	BASIC RATE	INCREASE FOR EACH DEPENDANT	MAXIMUM BENEFIT PAYABLE
1. Widow	35% of the relevant wage	11 2/3% of the relevant wage	70% of the relevant wage
2. Widower	35% of the relevant wage	11 2/3% of the relevant wage	70% of the relevant wage
3. Orphan	23 1/3% of the relevant wage	23 1/3% of the relevant wage	70% of the relevant wage
4. Parent	35% of the relevant wage	11 2/3% of the relevant wage	70% of the relevant wage

INDUSTRIAL DEATH BENEFIT CONT'D

Where the Benefit is payable as a lump sum (to Dependants at item **(e)**), the amount shall not exceed one hundred (100) times the Relevant Wage, nor be less than two thousand seven hundred dollars ($2,700.00).

If the lump sum payable results in the award to an individual Beneficiary of an amount exceeding sixty- (60) monthly payments of the Minimum Pension, then an Annuity or Periodical Payment would be made.

4. Duration of Benefit

Death Benefit is payable to:

(a) A Widow, from the date of death of her Husband for life, provided that:

i) If she remarries or cohabits with a man not her Husband, her Basic Rate of Benefit, but not the increases already awarded for her Dependants, shall cease from the date of her remarriage or cohabitation;

ii) If she remarries, she shall be entitled to a Gratuity on termination of her Basic Rate of Benefit, of an amount equal to 52 times the Weekly Rate of the Basic Benefit to which she was then entitled, but not of the increases already awarded in respect of her Dependants.

(b) A Widower, from the date of death of his Wife for life, or

i) Until he is declared by a Medical Board to have become capable of work; or

ii) Until the General Manager is satisfied that his circumstances have been changed by remarriage or otherwise, that he no longer fulfils the conditions at item **2 (b)** above.

(c) An Orphan, from the date of death of his/her surviving Parent until the age of sixteen (16) years. Payment will continue beyond age sixteen (16) if the Orphan :

i) Is between the ages of sixteen (16) and eighteen (18) years and is an Unpaid Apprentice, and not otherwise employed for gain, or is receiving full-time education; or

ii) Is unmarried and permanently incapable of work.

(d) A Parent, from the date of death of the Deceased for life or:

i) Until the General Manager is satisfied that the circumstances of the Parent have changed by remarriage or otherwise, that he/she would no longer have been dependant on the Deceased Person if he had survived.

5. Method of Payment

Recipients of Death Benefit are issued with "Pension Order" Books, which contain six (6) Payment Vouchers to be encashed on a monthly basis. New Books are prepared and issued upon submission of "Life Certificates" which attest to the fact that the Pensioner is alive.

Vouchers can be encashed at National Insurance Offices, Post Offices and Commercial Banks.

6. Manner of Claiming

A Claim for Death Benefit must be made by completing the Form IB15 - Claim for Death Benefit, and submitting it to the nearest National Insurance Office.

The Claimant must also submit supporting documents such as the Death Certificate of the Deceased Insured Person, Marriage Certificate (if Claim is made by Spouse) and Birth Certificates of Children under eighteen (18) years.

1. **NATIONAL INSURANCE & SOCIAL SECURITY ACT, 1969**
CLAIM FOR DEATH BENEFIT

Under the Industrial Benefit Regulations, 1969

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.

TO: The General Manager, National Insurance Date: ……. 20 ……

I. Name of deceased person ……..
(Block Capitals)

Address ……

Date of Birth ……. Date of Death ……
(Attach Death Certificate)

National Insurance No. | | | | | | | | | |

Name of employer at time of death ……

Address of employer ……

State exactly where deceased was employed at the time of the relevant accident ……..

……..……

Give the date the accident happened ……

Was the deceased person in receipt of injury benefit or disablement pension or any other benefit prior to death? ……

Is the claimant the widow/widower* of the deceased person? ……...

If neither, state relationship ……

Age of claimant ……..

If the claimant is not the widower/widow* of the deceased person has he/she* the care of the children of the deceased person? Yes/No*

If "Yes" attach marriage certificate and state date of marriage ……

Was the claimant wholly or partially dependent on the deceased person

……

If the claimant is the widow, was she residing with the deceased person at the time of Death? Yes/No*

If she was not residing with the deceased person was she receiving or entitled to receive From him periodical payments for maintenance of herself and children, or was she Maintained by the deceased voluntarily or by Court Order? ……

If she is receiving any payment how much? ……

If a widower, have you any income, including pension, from any source?

……

If so, how much? ……

FORM IB 15

2. Give the particulars of the children of the deceased person:-

Name of Child (Children	Father's Name	Mother's Name	Date of Birth	Place of Birth

(Attach the birth certificate of each child under 18 years of age)

If the claim is made by a person having the care of the child/children of the deceased person state:-

(a) the name of the wife of the deceased person ……

(b) maiden name of wife ……

(c) address, if known ……

(d) if she is dead give the date of death ……

DECLARATION:-

I declare that the information given above is true and correct to the best of my knowledge and belief and I claim Death Benefit under the Industrial Benefit Regulations, 1969, in respect of the abovenamed deceased person who died as a result of an accident arising out of and in the course of his/her* employment.

……
Signature/Mark of claimant

Name (in block letters) ……

Address ……

Telephone No. ……

Witness to mark ……...

Address ……

……

Occupation of witness ……

Date: ……

* Delete where inapplicable

FORM IB 15

(R & P Dept. Feb. 2000)