NATIONAL INSURANCE SCHEME
CLAIM FOR SICKNESS BENEFIT

For official use only
Accepted by: _____
Date: _____
Claim No.: _____

SECTION I – To Be Completed by The Claimant

Names on claim form **MUST** be the same as they appear on official birth certificate, marriage certificate and other official documents. Please note that you may be required to submit official documents, if necessary.

Surname

First Name

Other Name(s)

Maiden Name

Aliases

NIS No. —

Date of Birth
Y Y Y Y M M D D

Gender Male ☐ Female ☐

Occupation _____

E-mail Address _____

Marital Status Married ☐ Divorced ☐ Single ☐

Address

Contact Numbers

Home

Work

Mobile

Postal Address (if different from above): _____

Employer(s) worked with in the last 8 months: (Beginning with your present employer)

1…… Address_____

2…… Address_____

SECTION II– To Be Completed by The Claimant

Claimant's Account Details (Complete if benefit will be paid to you)

Name of Financial Institution: _____ Account No.

Name on Account _____ Account Type: Savings ☐ Chequing ☐

Claimant's signature _____ Date:
Y Y Y Y M M D D

Assignment to Employer (Complete if benefit will be paid to employer)

I _____authorize and instruct the Director of the National Insurance Scheme to pay to

my employer_____ sickness benefit resulting from this claim.

_____
Claimant's Signature

Y Y Y Y M M D D

Witness Statement where claimant cannot sign or is overseas

I hereby certify that _____ appeared before me and

affixed his/her "mark" as indicated above. ☐☐☐☐☐☐☐☐☐☐

Witness Name …… Tel. No.

Witness Title …….. E-mail Address ……
(For overseas claimant)

Witness Signature and Stamp …….. Notary Public Registration No._____

Witnesses must be a Notary Public, Justice of Peace, Medical Practitioner, School Principal, Snr. Civil Servant, Minister of Religion, or Barrister-at-Law. (Claimants residing in a foreign country MUST have their claim form attested by a registered Notary Public).

SECTION III – To Be Completed by Employer

Employer's/Business Name _____ Registration No. ☐☐☐☐☐☐☐☐

Commencement date of employment: ☐☐☐☐☐☐☐☐ Y Y Y Y M M D D Tel. No. ☐☐☐☐☐☐☐☐☐☐

Date last worked immediately before illness: ☐☐☐☐☐☐☐☐ Y Y Y Y M M D D

Will employee be paid his/her full salary for the period? Yes ☐ No ☐

If yes, is he/she required to reimburse, the employer? Yes ☐ No ☐

Name of Employer's Financial Institution: _____ Account No. ☐☐☐☐☐☐☐☐☐☐

Name on Account _____ Account Type: Savings ☐ Chequing ☐

I, _____ **hereby certify the information given is true and correct.**

_____ ☐☐☐☐☐☐☐☐ Y Y Y Y M M D D

Employer's Signature

BUSINESS STAMP

SECTION IV – To Be Completed by The Claimant and A Medical Doctor

I, _____hereby authorize that the Director of the National Insurance Scheme be provided with the specific disease or bodily or mental disablement in respect of my claim.

_____
Claimant's Signature or Mark

Y	Y	Y	Y	M	M	D	D

I hereby certify that Mr./Mrs./Miss _____ is incapable

of work from

Y	Y	Y	Y	M	M	D	D

to

Y	Y	Y	Y	M	M	D	D

Specific disease or bodily or mental disablement: _____

_____

or Equivalent ICD code _____

Medical Practitioner: Name: _____ Registration No.: _____

_____
Medical Practitioner's Signature

Y	Y	Y	Y	M	M	D	D

DOCTOR'S STAMP

Warning: Any person who knowingly makes any false statement or false representation for the purpose of obtaining a benefit commits a criminal offence punishable by fine or imprisonment or both.