NATIONAL INSURANCE SCHEME

CLAIM FOR EMPLOYMENT INJURY BENEFIT

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

SECTION 1 - TO BE COMPLETED BY THE CLAIMANT

(Please submit original birth and marriage certificates)

Surname

First Name

Other Name(s)

Maiden Name

Aliases

Marital Status Married ☐ Divorced ☐ Single ☐

NIS No. ☐☐☐☐☐☐—☐

Date of Birth ☐☐☐☐☐☐☐☐ (Y Y Y Y M M D D)

Gender Male ☐ Female ☐

Occupation _____

E-mail Address _____

Telephone Numbers

Address

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_____

3…… Address _____

Banking Details

Name of Bank ☐☐☐☐☐☐☐☐☐☐ Account No. ☐☐☐☐☐☐☐☐☐☐

Name on Account _____

I, _____ hereby certify that the information given is true and correct. (Print Name)

_____
Claimant's Signature or Mark

☐☐☐☐☐☐☐☐ (Y Y Y Y M M D D)

Where claimant cannot sign or where claimant is overseas

Witness Statement

I hereby certify that _____ appeared before me and affixed his "mark" as indicated above.

Witness Name ……. Tel. No. ☐☐☐☐☐☐☐☐☐☐

Witness Title ……..…….... E-mail Address…….……

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

(For overseas claimant)

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 2 - TO BE COMPLETED BY THE CLAIMANT AND A MEDICAL DOCTOR

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

_____ Y Y Y Y M M D D

Claimant's Signature or Mark

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.: _____

_____ Y Y Y Y M M D D

Signature

DOCTOR'S STAMP

SECTION 3 - TO BE COMPLETED BY THE EMPLOYER

Employer's/Business Name _____

_____ Employer's 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 this employee be entitled to his/her full salary for the period? Yes ☐ No ☐

I, _____ hereby certify the information given is true and correct. (Print Name)

_____ Y Y Y Y M M D D

Employer's Signature

BUSINESS STAMP

SECTION 4- TO BE COMPLETED BY THE CLAIMANT AND THE EMPLOYER

Date of accident Y Y Y Y M M D D Time of accident: _____ Date reported Y Y Y Y M M D D

Location of the accident _____ Injury sustained _____

Name(s) of witness(es) to the accident _____

Details of the accident _____

_____

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

(Print Name)

_____ Y Y Y Y M M D D

Claimant's Signature or Mark

Was the claimant required to be in the place where the incident occurred for the purpose of his/her work? Yes ☐ No ☐

Claimant's normal hours of work _____ Nature of the claimant's job _____

Was the injury reported to his/her Supervisor at the time it occurred? _____

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

Employer's Signature_____ Y Y Y Y M M D D

BUSINESS 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.

IMPORTANT: You may qualify for a disablement benefit. You should ask our Customer Service department for further information.