NATIONAL INSURANCE SCHEME

CLAIM FOR INVALIDITY 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

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

Telephone Numbers

Home

Work

Mobile

Postal Address (if different from above): _____

Banking Details

Name of Bank

Account No.

Name on Account _____

What benefit(s) are you currently receiving from the NIS?

Age ☐ Survivors ☐ Sickness ☐ Employment Injury ☐

Disablement ☐ None ☐

Have you received an Invalidity Benefit from the NIS before? Yes ☐ No ☐

Section II - Work History – Provident Fund

Were you a member of the Agricultural Workers Provident Fund (1970 – 1983)? Yes ☐ No ☐

If Yes, please complete below:

ADDRESS	PERIOD WORKED		SUPERVISOR'S NAME
_____	_____	_____	_____
_____	_____	_____	_____

Section III - Work History (April 1983 – Present)

Please list all employers you have worked with in Grenada commencing with the most recent)

NAME OF EMPLOYERS	Year/Period worked
_____	_____
_____	_____
_____	_____
_____	_____

Have you worked in any other countries in the Caribbean and/or in Canada? Yes ☐ No ☐

If yes, please complete below.

COUNTRY	NIS/SOCIAL SECURITY #	PERIOD WORKED
_____	_____	_____
_____	_____	_____

Contribution Statement:

I declare that I have reviewed my contribution statement and I agree ☐ disagree ☐ with the information contained therein. (Please indicate the areas of disagreement on a separate sheet with your signature attached).

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

_____

Claimant's Signature or Mark

☐☐☐☐☐☐☐☐
Y Y Y Y M M D D

Witness Statement (where claimant cannot sign or where claimant is overseas)

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 the 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 to by a registered Notary Public).

Section IV- To Be Completed By A Registered Medical Practitioner

I certify that I have examined _____ and in my opinion he/she is permanently incapable of work /incapable of work for the period

_____to _____20 ……..

"Meaning of Invalid. The term "Invalid" means a person incapable of work as a result of a specific disease or bodily or mental disablement which is likely to remain permanent".

2. Please describe specific findings that contribute to the Insured Person's incapacity for work.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Details of Medical Practitioner:

Surname: _____ Name(s): _____

Office Address: _____ Tel. No. | | | | | | | | | | |

_____ Registration No.: _____

_____

_____

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.