THE NATIONAL INSURANCE BOARD
EMPLOYMENT INJURY BENEFIT
APPLICATION FOR MEDICAL EXPENSES

NI 114

(PLEASE USE BLOCK/CAPITALS)

(FOR OFFICIAL USE)
CLAIM NO:
SERVICE CENTRE CODE:

NOTE: This form must be submitted within three(3) months of the date on which the expense(s) was/were incurred.
Please read instructions on Page 6 carefully before completing this form.

SECTION "A" - TO BE COMPLETED BY APPLICANT

1. NAME: SURNAME OTHER NAME(S)
2. HOME ADDRESS: (STREET) (CITY/DISTRICT/COUNTY)
3. *POSTAL ADDRESS (if different from above): (STREET) (CITY/DISTRICT/COUNTY)
4. NATIONAL INSURANCE NO.:
5. DATE OF BIRTH: YYYY MM DD
6. GENDER: ☐ MALE ☐ FEMALE
7. TELEPHONE NUMBERS: (HOME) (OFFICE/WORK) (CELLULAR)
8. EMPLOYER'S NAME:
9. *EMPLOYER'S ADDRESS: (STREET) (CITY/DISTRICT/COUNTY)
10. EMPLOYER REGISTRATION NO.
11. DATE OF ACCIDENT/DEVELOPMENT OF INDUSTRIAL DISEASE: YYYY MM DD
12. TIME OF ACCIDENT: _____ a.m./p.m.
13. PERIOD FOR WHICH MEDICAL EXPENSES ARE CLAIMED: YYYY MM DD TO YYYY MM DD
14. DID YOU MEET TOTAL COSTS OF MEDICAL EXPENSES ? ☐ YES ☐ NO. If "YES", complete questions 15 to 17 for your expenses.
15. STATEMENT/BILLS FOR THE FOLLOWING EXPENSES ARE ATTACHED IN SUPPORT OF MY CLAIM:
    - ☐ MEDICAL PRACTITIONER'S VISITS (OFFICE/HOME/HOSPITAL)
    - ☐ SURGERY
    - ☐ MAGNETIC RESONANCE IMAGING (MRI) where injury occurs on or after 07/01/08
    - ☐ SPECIALIST CONSULTATION
    - ☐ DRUGS/X-RAY/LAB. TEST
    - ☐ CONSTANT ATTENDANCE AND CARE
    - ☐ HOSPITALISATION
    - ☐ PARAMEDICAL TREATMENT/ EQUIPMENT
    - ☐ TRAVELLING
16. DATE SEEN: YYYY MM DD
17. NAME AND ADDRESS OF FIRST MEDICAL PRACTITIONER WHO ATTENDED TO YOU AS A RESULT OF THE INJURY/DISEASE.
    NAME: SURNAME OTHER NAME(S)
    ADDRESS: (STREET) (CITY/DISTRICT/COUNTY)

* EXAMPLE: Light Pole No. 8, Southern Main Road, Couva OR Near Bertie's Parlour, Industry Lane, Belmont.

SECTION "A" - TO BE COMPLETED BY APPLICANT

17. PLEASE INDICATE THE METHOD OF PAYMENT OF BENEFIT:

MAIL TO: ☐ POSTAL ADDRESS DEPOSIT TO: ☐ FINANCIAL INSTITUTION

FINANCIAL INFORMATION

(If method of payment is "FINANCIAL INSTITUTION", complete below).

The NIBTT considers the foregoing information as instructions from you regarding the deposit of your benefit payment to the financial institution of your choice.

The NIBTT is not liable for any payment issued to an inaccurate financial institution or account based on these instructions.

NAME OF FINANCIAL INSTITUTION:

ADDRESS:

(STREET)

(CITY/DISTRICT/COUNTY)

ACCOUNT NUMBER:

DETAILS OF CLAIM:

(a) MEDICAL PRACTITIONER'S VISITS (If you visited the medical practitioner, state his address, if the medical practitioner visited you, state address of home/hospital visited and time visited).

NAME OF MEDICAL PRACTITIONER	OFFICE ADDRESS OF MEDICAL PRACTITIONER	DATES OF VISITS YYYY	MM	DD	TIME VISITED am/pm	FEES PAID $	FOR OFFICIAL USE AMOUNT APPROVED $
					TOTAL		

(b) HOSPITALISATION (To include the Cost of Investigations, Drugs, X-Rays, etc.).

NAME OF HOSPITAL/ NURSING HOME	HOME/HOSPITAL ADDRESS	PERIOD OF STAY FROM YYYY	MM	DD	TO YYYY	MM	DD	PARTICULARS OF ITEMS CLAIMED	AMOUNT PAID $	FOR OFFICIAL USE AMOUNT APPROVED $
								TOTAL		

SECTION "A" - TO BE COMPLETED BY APPLICANT (Cont'd)

(c) SURGERY/OPERATIONS (Enclose Medical Practitioner's description of surgery).

NAME OF MEDICAL PRACTITIONER	DATE(S) OF SURGERY YYYY	MM	DD	TYPE OF SURGERY (Minor, Major Intermediate)	AMOUNT PAID $	FOR OFFICIAL USE AMOUNT APPROVED $
				TOTAL		

(d) DRUGS, DRESSINGS, X-RAYS (As Prescribed for Persons NOT Hospitalised)

NAME OF PHARMACY/SUPPLIER	ADDRESS OF PHARMACY	REFERRED BY (Name of Medical Practitioner)	DATE PRESCRIPTION FILLED YYYY	MM	DD	AMOUNT PAID $	FOR OFFICIAL USE AMOUNT APPROVED $
					TOTAL		

(e) PARAMEDICAL TREATMENT/EQUIPMENT/APPLIANCE (To be Certified by the Attending Medical Practitioner) - List here any Therapeutical Treatment received.

NAME OF PARAMEDIC/ SUPPLIER	ADDRESS OF PARAMEDIC/ SUPPLIER	REFERRED BY (Name of Medical Practitioner)	TYPE OF APPLIANCE/ EQUIPMENT FITTED/ TREATMENT RECEIVED	AMOUNT PAID $	FOR OFFICIAL USE AMOUNT APPROVED $
			TOTAL		

(f) CONSTANT ATTENDANCE AND CARE
(Provide Statement from Medical Practitioner Certifying the need for Constant Care).

NAME OF ATTENDANT	ADDRESS	NO. OF DAYS ATTENDED	AMOUNT PAID $	FOR OFFICIAL USE AMOUNT APPROVED $
		TOTAL		

SECTION "A" - TO BE COMPLETED BY APPLICANT (Cont'd)

(g) TRAVELLING EXPENSES (Provide Evidence of All Visits).

DATE OF TRAVEL YYYY MM DD	POINTS OF TRAVEL FROM	POINTS OF TRAVEL TO	MODE OF TRANSPORT	AMOUNT PAID $	FOR OFFICIAL USE AMOUNT APPROVED $
			TOTAL		
			GRAND TOTAL OF EXPENSES		

(h) MAGNETIC RESONANCE IMAGING (MRI) (To be certified by attending Medical Practitioner)

NAME OF INSTITUTION	ADDRESS OF INSTITUTION	REFERRED BY (Name of Medical Practitioner)	DATE OF VISIT(S) YYYY MM DD	COST $	FOR OFFICIAL USE AMOUNT APPROVED $

DECLARATION

I declare that to the best of my knowledge and belief the information given by me is true and correct and I am aware that if there is any statement in this declaration which is false in fact or which I know or believe to be false or do not believe to be true, I am liable on summary conviction to a fine of three thousand dollars ($3,000.00) and to imprisonment for two years in accordance with Sect 33, NI Act Chap 32:01.

SIGNATURE OR MARK OF CLAIMANT:

DATE: YYYY MM DD

PARTICULARS OF WITNESS TO MARK (Where Claimant Cannot Sign)

NAME: SURNAME OTHER NAME(S)

ADDRESS: (STREET)

(CITY/DISTRICT/COUNTRY)

VALID IDENTIFICATION: (Tick One Box) ☐ PASSPORT ☐ DRIVER'S PERMIT ☐ ELECTORAL I.D.

OCCUPATION:

NUMBER:

SIGNATURE OF WITNESS:

DATE: YYYY MM DD

SECTION "B" - TO BE COMPLETED BY LOCAL OFFICE FOR OFFICIAL USE

APPLICATION RECEIVED BY:

NAME: _____ _____
SURNAME OTHER NAME(S)

SERVICE CENTRE STAMP

SIGNATURE OF SERVICE CENTRE STAFF

DATE: YYYY MM DD

PART I - CUSTOMER SERVICE REPRESENTATIVE

1. NAME, N.I. NO. AND DATE OF BIRTH CONFIRMED AND UPDATED ON I.A. SYSTEM ☐ YES ☐ NO
2. REGISTRATION (1.A) RECORD COMPLETE? ☐ YES ☐ NO
   (If "NO" complete form NI 4/NI 165/NI 182 as applicable)
3. SYSTEM CHECK FOR DUPLICATE REGISTRATION COMPLETED (SIRF INCLUDED)? ☐ YES ☐ NO
   (Please record findings on minute sheet)
4. REGISTRATION RECORD UPDATED? ☐ YES ☐ NO
   (If "NO" state reason) _____
5. CLAIM HISTORY VIEWED? (Please record findings on minute) ☐ YES ☐ NO
6. APPLICATION COMPLETE AND ACCEPTED FOR PROCESSING? ☐ YES ☐ NO
7. CLAIM RECORDED? (Please Print and Attach Claim Profile) ☐ YES ☐ NO

SIGNATURE OF CUSTOMER SERVICE REPRESENTATIVE

DATE: Y Y Y Y M M D D

PART II - DETERMINATION OF APPLICATION

1. Application recommended for allowance as detailed below:

	AMOUNT APPROVED $	AMOUNT RECOMMENDED $
a) Medical Practitioner's visits		
b) Hospitalisation		
c) Surgery/Operation		
d) Drugs, Dressing, X-Ray		
e) Paramedical treatment Equipment/Appliances		
f) Constant care and attendance		
g) Travelling		
h) MRI		
TOTAL		

2. Application recommended for Disallowance on the grounds that:

_____

_____

_____

_____

PROCESSING OFFICER

DATE: YYYY MM DD

SECTION "B" - TO BE COMPLETED BY LOCAL OFFICE FOR OFFICIAL USE (Cont'd)

3. Details of Claim Profile Verified? ☐ YES ☐ NO

4. Claim Validated? ☐ YES ☐ NO

5. Decision/Authorisation:

☐ (a) Application Allowed and Payment Authorised for the Expenses and Amount at (1) above.

☐ (b) Application Disallowed on the grounds stated at (2) above.

(c) Benefit details and decision recorded on IA system? ☐ YES ☐ NO

(d) Applicant notified of decision by letter (NI 53/NI 44) dated ☐☐☐☐ ☐☐ ☐☐ YYYY MM DD

C.O. II/SUPERVISOR/MANAGER

DATE: ☐☐☐☐ ☐☐ ☐☐ YYYY MM DD

INSTRUCTIONS TO APPLICANT

1. **Use BLOCK/CAPITALS to complete this Form.**

2. **Ensure that all bills and receipts for medical attention, drugs and dressings, hospital treatment and operation are clearly detailed in respect of the treatment obtained. Information on these bills/receipts must indicate the:**

   (a) Dates and times of visits to the medical practitioner. In respect of time state the actual hour of visit; e.g. 3:45 p.m.;

   (b) Letter of referral from the first medical practitioner to any other medical practitioner visited;

   (c) Date(s) of hospitalisation, if applicable;

   (d) Particulars of treatment (for both in-patient and out-patient) received at the hospital;

   (e) Submission of bills/receipts from pharmacy in support of a claim for drugs/dressings;

   (f) Travelling expenses with respect to visits to the medical practitioner or hospital must be supported by some evidence from the attending medical practitioner/hospital.

   (g) The total amount of funds expended.

3. **Where it was necessary for you to have constant attendance and care as certified by the attending medical practitioner, you must state the name and address of the person you employed to provide those services and the period of such employment. You must also submit your medical practitioner's certification that constant attendance and care was necessary.**

4. **If a claim for treatment outside of Trinidad and Tobago has been made you must produce evidence that such treatment was not available in Trinidad and Tobago.**

5. **You should submit your medical practitioner's certification:**

   ***(a) Where you were required to have an MRI done.**

   (b) Where it was necessary for you to to have Paramedical Treatment/Equipment /Appliance.

6. ***** **Payment of medical expenses related to MRI is limited to two examinations per injury per body part.**

* Where injury occurs on or after 7 January 2008