NI 19A

THE NATIONAL INSURANCE BOARD
CONTINUATION CLAIM TO INJURY BENEFIT

(FOR OFFICIAL USE)
CLAIM NO:

SERVICE CENTRE CODE:

(PLEASE USE BLOCK/CAPITALS)

NOTE: Subsequent medical certificates must be submitted no later than fourteen (14) days from the last date of incapacity on the previous medical certificate.

SECTION "A" - TO BE COMPLETED BY APPLICANT

I, SURNAME OTHER NAMES hereby consent to the follow-up Medical Certificate at Section "B" being submitted to the National Insurance Board.

NATIONAL INSURANCE NO.

NAME OF EMPLOYER:

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: Y Y Y Y M M D D

PARTICULARS OF WITNESS TO MARK (Where Claimant Cannot Sign)

NAME: SURNAME OTHER NAME(S)

ADDRESS: (STREET)

(CITY/DISTRICT/COUNTY)

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

OCCUPATION:

NUMBER:

SIGNATURE OF WITNESS TO MARK

DATE: Y Y Y Y M M D D

SUBSEQUENT MEDICAL CERTIFICATE

SECTION "B" - TO BE COMPLETED BY MEDICAL PRACTITIONER

I hereby certify that Mr/Mrs/Ms SURNAME OTHER NAMES

was examined by me on Y Y Y Y M M D D and found the following injuries/industrial disease _____ which is/is not consistent with an accident sustained at work on Y Y Y Y M M D D . An examination on Y Y Y Y M M D D shows that he/she is still unfit for work as a result of the injury. I hereby recommend that the patient is fit to resume duties/should be granted a a further _____ (Words and Figures) Days/Months/Years with effect from Y Y Y Y M M D D .

NOTE: National Insurance Legislation provides that Injury Benefit may be paid for a maximum of 52 calendar weeks. At the end of the injury leave period the insured person's extent of disability as a result of the accident is assessed to determine eligibility for Disablement Benefit.

SECTION "B" - MEDICAL REPORT CONT'D *(To be completed by a Registered Medical Practitioner)*

NAME OF MEDICAL PRACTITIONER: SURNAME OTHER NAME(S)

OFFICE ADDRESS: (STREET)

(CITY/DISTRICT/COUNTY)

REGISTRATION NUMBER OF MEDICAL PRACTITIONER:

TELEPHONE NUMBER: --

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.

MEDICAL PRACTITIONER'S STAMP

SIGNATURE OF MEDICAL PRACTITIONER

DATE: YYYY MM DD

SECTION "C" - FOR USE BY EMPLOYER

An employer is required to furnish the Board with information relating to any accident arising out of and in the course of employment whereby personal injury is caused to any person employed by him.

1. EMPLOYER'S NAME:

REGISTRATION NO.: TELEPHONE NO.: -

2. This is to certify that during the period recorded at Section "B" of this form, Mr/Mrs/Ms

SURNAME OTHER NAMES has been absent

from work as a result of an accident/industrial disease developed on the job on . Y Y Y Y M M D D

NOTE: If the Injured Person worked during this period, please state the period worked.

Y Y Y Y M M D D TO Y Y Y Y M M D D

3. Have you paid any of the related medical expenses? ☐ YES ☐ NO

If "YES", please state the details of the services paid for.

EMPLOYER'S 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.

NAME: SURNAME OTHER NAME(S)

POSITION:

COMPANY STAMP (If any)

SIGNATURE

DATE: Y Y Y Y M M D D

SECTION "D" - FOR OFFICIAL USE

APPLICATION RECEIVED BY:

NAME: SURNAME OTHER NAME(S)

SERVICE CENTRE STAMP

SIGNATURE OF SERVICE CENTRE STAFF

DATE: YYYY MM DD

DETERMINATION:

1. (a) Payment is approved and authorised for the period Y Y Y Y M M D D to Y Y Y Y M M D D

in Class ____ at the Rate of $ ____ per Week.

[See Medical Adviser's response at Minute ( ) and parent claim at folio ( )].

DATE: Y Y Y Y M M D D

(b) Payment is NOT approved on the grounds that:

_____

_____

DECISION/AUTHORISATION:

Applicant notified of decision on Form NI 44/NI 53 dated Y Y Y Y M M D D

Decision recorded on I. A. system Y Y Y Y M M D D

SIGNATURE OF MGR./SUPERVISOR/C.O. II

DATE: Y Y Y Y M M D D