NI 34

THE NATIONAL INSURANCE BOARD
WIDOW'S/WIDOWER'S BENEFIT - MEDICAL REPORT

(PLEASE USE BLOCK/CAPITALS)

(FOR OFFICIAL USE)
CLAIM NO:

SERVICE CENTRE CODE:

SECTION "A" - TO BE COMPLETED BY APPLICANT

PARTICULARS OF DECEASED:

1. DECEASED NAME: SURNAME OTHER NAME(S)

2. DATE OF DEATH: YYYY MM DD

3. NATIONAL INSURANCE NO.:

PARTICULARS OF APPLICANT:

1. APPLICANT'S NAME: SURNAME OTHER NAME(S)

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 APPLICANT

DATE: YYYY MM DD

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: YYYY MM DD

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

1. APPLICANT'S NAME: SURNAME OTHER NAME(S)

2. HOME ADDRESS: (STREET)

(CITY/DISTRICT/COUNTY)

3. DATE OF BIRTH OF APPLICANT: YYYY MM DD

4. (a) Is applicant physically disabled? ☐ YES ☐ NO

(b) Is applicant mentally disabled? ☐ YES ☐ NO

5. If the answer to question 4 (a) or (b) is "Yes"

(a) Please give a full clinical description of the disability.

(b) Please state the date on which the disability was diagnosed.

DATE: YYYY MM DD

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

6. How long have you been treating this patient? _____ Days/Months/Years.
(Words and Figures)

7. Please state the date disability rendered him unable to work? (Applicable to widowers only). DATE: YYYY MM DD

PARTICULARS OF 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 OFFICIAL USE

APPLICATION RECEIVED BY:

NAME: SURNAME OTHER NAME(S)

SERVICE CENTRE STAMP

_____
SIGNATURE OF SERVICE CENTRE STAFF

DATE: YYYY MM DD