## THE NATIONAL INSURANCE BOARD SICKNESS BENEFIT APPLICATION

## (Please Use Block Capitals)

NOTE: This Application must be submitted within 3 months of onset of Illness or Loss of Earnings which ever is later.

FOR OFFICIAL USE											
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SECTION "A" - TO BE COMPLETED BY APPLICANT
1. NAME:
SURNAME OTHER NAME  2. HOME 3. NATIONAL INSURANCE NO
ADDRESS:  (STREET)  3. NATIONAL INSURANCE NO.
(CITY/DISTRICT/COUNTY)
4. POSTAL
ADDRESS (if STREET) 5. TELEPHONE NUMBER (STREET)
from above:
(CITY/DISTRICT/COUNTY)  6. DATE OF BIRTH:
YYYY MM DD 7. SEX: MALE FEMALE
8. OCCUPATION:
9. MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED SEPARATED
10. EMPLOYER'S NAME:
11. REGISTRATION NO.
12.*EMPLOYER'S ADDRESS:
(STREET)
(CITY/DISTRICT/COUNTRY)
13. NAME AND ADDRESS OF ACTUAL PLACE OF WORK:
(e.g. School/Department/Division) (STREET)
(CITY/DISTRICT/COUNTRY)
14. ARE YOU CURRENTLY EMPLOYED ELSEWHERE? YES NO
If "YES", state Business Name and Address of other employer.
BUSINESS NAME OF EMPLOYER:
EMPLOYER'S ADDRESS:
(STREET)
(CITY/DISTRICT/COUNTY)
15. IS SICKNESS AS A RESULT OF INJURY ON THE JOB? YES NO
16. LAST DATE WORKED:  YYYY MM DD
17. DATE LOSS OF EARNINGS STARTED: YYYY MM DD
18. WAS EVIDENCE OF DATE OF BIRTH PREVIOUSLY SUBMITTED?  YES  NO
If "NO" submit Birth Certificate, or a VALID Driver's Permit, or Passport with this application.

18. METHOD OF PAYMENT OF CHECUE:  MAIL TO POSTAL ADDRESS DEPOSIT TO: BANK CREDIT UNION  NAME OF BANK /CREDIT UNION:  ACCOUNT NUMBER  (CITY/DISTRICT/COUNTRY)  DATE: YYYY M. M. D.D.  PARSPORT  SIGNATURE OF WITNESS TO MARK  OTHER NAME(S)  OTHER NAME(S)  ACCOUNT NUMBER  (CITY/DISTRICT/COUNTRY)  DATE: YYYY M. M. D.D.  PASSPORT  OTHER NAME(S)  CITY/DISTRICT/COUNTRY)  DATE: YYYY M. M. D.D.  PASSPORT  OTHER NAME(S)  CITY/DISTRICT/COUNTRY)  DATE: YYYY M. M. D.D.  PASSPORT  OTHER NAME(S)  CITY/DISTRICT/COUNTRY)  DATE: YYYY M. M. D.D.  PASSPORT  OTHER NAME(S)  CITY/DISTRICT/COUNTRY)  DATE: YYYY M. M. D.D.  PASSPORT  OTHER NAME(S)  CITY/DISTRICT/COUNTRY)  DATE: YYYY M. M. D.D.  PASSPORT  OTHER NAME(S)  CITY/DISTRICT/COUNTRY)  DATE: YYYY M. M. D.D.  PASSPORT  OTHER NAME(S)	SECTION "A" - TO BE COMPLETED BY APPLICANT (CONT'D)
NAME OF BANK (CREDIT UNION:  ADDRESS:  (CITY/DISTRICT/COUNTRY)  DECLARATION  WARNING! Pursuant to Section 33 of the National Insurance Act, a person who makes any false statement is liable on summary conviction to a fine of \$3,000.00 and to imprisonment for two (2) years.  I declare that I am losing earnings, have not worked as a result of my illness and that the information given is true and correct.  I hereby give consent for the Medical Certificate at Section "8" to be sent to the National Insurance Board of Trinidad and Tobago.  I hereby give permission for NiBTT to update information from this form.  PARTICULARS OF WITNESS TO MARK (WHERE APPLICANT CANNOT SIGN)  PARTICULARS OF WITNESS TO MARK (WHERE APPLICANT CANNOT SIGN)  NAME:  SURNAME  OCCUPATION:  PASSPORT  OTHER NAME(S)  (CITY/DISTRICT/COUNTRY)  DATE:  YYYY MM DD  PASSPORT  OTHER NAME(S)  (CITY/DISTRICT/COUNTRY)  DATE:  YYYY MM DD  This patient will remain incapable of work for a period of (in words and figures) days starting from	18. METHOD OF PAYMENT OF CHEQUE:
ADDRESS:    CITY/DISTRICT/COUNTRY)   DECLARATION	MAIL TO POSTAL ADDRESS DEPOSIT TO: BANK CREDIT UNION
WARNING! Pursuant to Section 33 of the National Insurance Act, a person who makes any false statement is liable on summary conviction to a fine of \$3,000.00 and to imprisonment for two (2) years.  I declare that I am losing earnings, have not worked as a result of my liness and that the information given is true and correct.  I hereby give consent for the Medical Certificate at Section "B" to be sent to the National Insurance Board of Trinidad and Tobago.  I hereby give permission for NIBTT to update information from this form.  DATE:  YYYY M.M. D.D  PARTICULARS OF WITNESS TO MARK (WHERE APPLICANT CANNOT SIGN)  NAME:  SURNAME  OCCUPATION:  OTHER NAME(S)  (CITY/DISTRICT/COUNTRY)  DATE:  YYYY M.M. D.D  TO BE COMPLETED BY MEDICAL PRACTITIONER  I hereby certify that Mr/Mrs/Ms  SURNAME  OTHER NAME(S)  Was examined by me on YYYY M.M. D.D  This patient will remain incapable of work for a period of (In words and figures) days starting from	I I I I I I I I I I I I ACCOUNTNUMBER
DECLARATION WARNING! Pursuant to Section 33 of the National Insurance Act, a person who makes any false statement is liable on summary conviction to a fine of \$3,000.00 and to imprisonment for two (2) years.  I declare that I am losing earnings, have not worked as a result of my iliness and that the information given is true and correct.  I hereby give consent for the Medical Certificate at Section "B" to be sent to the National Insurance Board of Trinidad and Tobago.  I hereby give permission for NBTT to update information from this form.  DATE:  YYYY MM DD  PARTICULARS OF WITNESS TO MARK (WHERE APPLICANT CANNOT SIGN)  NAME:  SURNAME  OCCUPATION:  DENTIFICATION:  OTHER NAME(S)  OTHER NAME(S)  (Inck One Box)  DRIVER'S PERMIT  ELECTORAL I.D.  (CITY/DISTRICT/COUNTRY)  DATE:  YYYY MM DD  DATE:  YYYY MM DD  Thereby certify that Mr/Mrs/Ms  SURNAME  OTHER NAME(S)  OTHER	
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DATE: YYYY M M D D  PARTICULARS OF WITNESS TO MARK (WHERE APPLICANT CANNOT SIGN)  NAME: SURNAME  SURNAME  OCCUPATION: PASSPORT  OTHER NAME(S)  TOTHER NAME(S)  SIGNATURE OF WITNESS TO MARK  (CITY/DISTRICT/COUNTRY)  DATE: YYYY M M D D  TOTHER NAME(S)  SIGNATURE OF WITNESS TO MARK  YOU MAY BE ELIGIBLE FOR AN INVALIDITY BENEFIT AFTER RECEIPT OF 52 WEEKS OF SICKNESS BENEFIT.  SECTION "B" - TO BE COMPLETED BY MEDICAL PRACTITIONER  I hereby certify that Mr/Mrs/Ms  SURNAME  OTHER NAME(S)  And in my opinion was at the time suffering from  This patient will remain incapable of work for a period of (In words and figures) days starting from	I declare that I am losing earnings, have not worked as a result of my illness and that the information given is true and correct.
SIGNATURE OR MARK OF APPLICANT  PARTICULARS OF WITNESS TO MARK (WHERE APPLICANT CANNOT SIGN)  NAME: SURNAME   OCCUPATION: PASSPORT   PASSPORT   OTHER NAME(S)   (Tick One Box)   DRIVER'S PERMIT   ELECTORAL I.D.   OCCUPATION: PASSPORT   OTHER NAME(S)   ORIVER'S PERMIT   ELECTORAL I.D.   OCCUPATION: PASSPORT   OTHER NAME(S)   DRIVER'S PERMIT   ELECTORAL I.D.   OCCUPATION: ORIGINAL   OTHER NAME(S)   DRIVER'S PERMIT   ELECTORAL I.D.   OCCUPATION: PASSPORT   OTHER NAME(S)   DRIVER'S PERMIT   ELECTORAL I.D.   OCCUPATION: ORIGINAL   OTHER NAME(S)   DRIVER'S PERMIT   ELECTORAL I.D.   OTHER NAME(S)   OTHER NAME	I hereby give consent for the Medical Certificate at Section "B" to be sent to the National Insurance Board of Trinidad and Tobago.
PARTICULARS OF WITNESS TO MARK (WHERE APPLICANT CANNOT SIGN)  NAME: SURNAME IDENTIFICATION: PASSPORT (TICK ONe BOX) DRIVER'S PERMIT ELECTORAL I.D.  (CITY/DISTRICT/COUNTRY)  SIGNATURE OF WITNESS TO MARK  YOU MAY BE ELIGIBLE FOR AN INVALIDITY BENEFIT AFTER RECEIPT OF 52 WEEKS OF SICKNESS BENEFIT.  SECTION "B" - TO BE COMPLETED BY MEDICAL PRACTITIONER  I hereby certify that Mr/Mrs/Ms SURNAME OTHER NAME(S)  was examined by me on YYYY M M D D  This patient will remain incapable of work for a period of (In words and figures) days starting from	I hereby give permission for NIBTT to update information from this form.
PARTICULARS OF WITNESS TO MARK (WHERE APPLICANT CANNOT SIGN)  NAME: SURNAME IDENTIFICATION: PASSPORT (Tick One Box) DRIVER'S PERMIT ELECTORAL I.D.  (STREET) NUMBER: VYYY MM DD  YOU MAY BE ELIGIBLE FOR AN INVALIDITY BENEFIT AFTER RECEIPT OF 52 WEEKS OF SICKNESS BENEFIT.  SECTION "B" - TO BE COMPLETED BY MEDICAL PRACTITIONER  I hereby certify that Mr/Mrs/Ms SURNAME OTHER NAME(S)  was examined by me on YYYY MM DD  This patient will remain incapable of work for a period of (In words and figures) days starting from	
NAME: SURNAME  SURNAME  OTHER NAME(S)  (Tick One Box)  OTHER NAME(S)  (CITY/DISTRICT/COUNTRY)  DATE: LILECTORAL I.D.  (CITY/DISTRICT/COUNTRY)  SIGNATURE OF WITNESS TO MARK  YOU MAY BE ELIGIBLE FOR AN INVALIDITY BENEFIT AFTER RECEIPT OF 52 WEEKS OF SICKNESS BENEFIT.  SECTION "B" - TO BE COMPLETED BY MEDICAL PRACTITIONER  I hereby certify that Mr/Mrs/Ms  SURNAME  OTHER NAME(S)  was examined by me on YYYY MM DD  This patient will remain incapable of work for a period of (In words and figures) days starting from	
SURNAME  OTHER NAME(S)  OTHER NAME(S)  OTHER NAME(S)  (STREET)  DATE:  (CITY/DISTRICT/COUNTRY)  DATE:  YYYY MM DD  Thereby certify that Mr/Mrs/Ms  SURNAME  UNIVER'S PERMIT  ELECTORAL I.D.  NUMBER:  OTHER NAME(S)  SIGNATURE OF WITNESS TO MARK  YOU MAY BE ELIGIBLE FOR AN INVALIDITY BENEFIT AFTER RECEIPT OF 52 WEEKS OF SICKNESS BENEFIT.  SECTION "B" - TO BE COMPLETED BY MEDICAL PRACTITIONER  I hereby certify that Mr/Mrs/Ms  SURNAME  OTHER NAME(S)  was examined by me on  YYYY M M DD  This patient will remain incapable of work for a period of  (In words and figures) days starting from	PARTICULARS OF WITNESS TO MARK (WHERE APPLICANT CANNOT SIGN)
ADDRESS:  OTHER NAME(S)  OTHER NAME(S)  (Tick One Box)  DRIVER'S PERMIT  ELECTORAL I.D.  (CITY/DISTRICT/COUNTRY)  SIGNATURE OF WITNESS TO MARK  YVYYY MM DD  YOU MAY BE ELIGIBLE FOR AN INVALIDITY BENEFIT AFTER RECEIPT OF 52 WEEKS OF SICKNESS BENEFIT.  SECTION "B" - TO BE COMPLETED BY MEDICAL PRACTITIONER  I hereby certify that Mr/Mrs/Ms  SURNAME  OTHER NAME(S)  was examined by me on YYYYY M M DD  This patient will remain incapable of work for a period of (In words and figures) days starting from	NAME:   _   _   _   _   _   _   _   _
ADDRESS:    DRIVER'S PERMIT     ELECTORAL I.D.     NUMBER:     OTHER NAME(S)     Was examined by me on     YYYY M M D D     This patient will remain incapable of work for a period of     OTHER NAME(S)     OTHER	IDENTIFICATION: PASSPORT
SIGNATURE OF WITNESS TO MARK  PATE: YYYY MM DD  YOU MAY BE ELIGIBLE FOR AN INVALIDITY BENEFIT AFTER RECEIPT OF 52 WEEKS OF SICKNESS BENEFIT.  SECTION "B" - TO BE COMPLETED BY MEDICAL PRACTITIONER  I hereby certify that Mr/Mrs/Ms  SURNAME  OTHER NAME(S)  was examined by me on YYYYY MM DD  This patient will remain incapable of work for a period of (In words and figures) days starting from	ADDRESS: DRIVER'S PERMIT
CITY/DISTRICT/COUNTRY)  DATE:	(STREET)
SIGNATURE OF WITNESS TO MARK  YOU MAY BE ELIGIBLE FOR AN INVALIDITY BENEFIT AFTER RECEIPT OF 52 WEEKS OF SICKNESS BENEFIT.  SECTION "B" - TO BE COMPLETED BY MEDICAL PRACTITIONER  I hereby certify that Mr/Mrs/Ms  SURNAME  OTHER NAME(S)  was examined by me on  YYYY M M D D  This patient will remain incapable of work for a period of (In words and figures)  (In words and figures)  (In words and figures)	
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I hereby certify that Mr/Mrs/Ms  SURNAME  OTHER NAME(S)  was examined by me on YYYY MM DD  This patient will remain incapable of work for a period of (In words and figures)  (In words and figures)	
SURNAME  was examined by me on YYYY MM DD  This patient will remain incapable of work for a period of (In words and figures)  OTHER NAME(S)  and in my opinion was at the time suffering from  (In words and figures)	SECTION "B" - TO BE COMPLETED BY MEDICAL PRACTITIONER
This patient will remain incapable of work for a period of (In words and figures) days starting from	
(iii words and rigures)	
(iii words and rigures)	
(iii words and rigures)	This patient will remain incapable of work for a period of
YYYY MM DD Confidential information has/has not been sent to the Board's Medical Adviser.	Confidential information has/has not been sent to the Board's Medical Adviser.
NAME IN BLOCK LETTERS  OR STAMP OF DOCTOR:  TELEPHONE NO.	NAME IN BLOCK LETTERS  OR STAMP OF DOCTOR:  TELEPHONE NO.
SURNAME	SURNAME
OTHER NAME(S)  DATE: YYYY M M D D	() I HER NAME(S)

SECTION "B" - TO BE COMPLETED BY MEDICAL PRACTITIONER (CONT'D)										
ADDRESS:										
(STREET)										
(CITY/DISTRICT/COUNTY)										
SIGNATURE OF DOCTOR										
NOTE: In the case of a FIRST or SECOND CERTIFICATE the period entered must not exceed 14 DAYS including Sundays and Public Holidays.  In the case of a THIRD OR SUBSEQUENT CERTIFICATE THE PERIOD entered must not exceed 28 DAYS including Sundays and Public Holidays.										
ALSO: National Insurance Legislation 1999 provides that Sickness Benefit will be paid, if there is a loss of earnings, for a period of 52 WEEKS. At the end of this period, if the recipient is still ill, he may be eligible for Invalidity Benefit.										
SECTION "C" - TO BE COMPLETED BY EMPLOYER										
INSTRUCTIONS FOR COMPLETION										
(i) This Section must be completed by the Employer before the Application is submitted to the Board.										
(ii) In completing Column 4 (c), 5 (d) and 5 (e) below proceed as follows:										
(a) Weekly Earnings = $\frac{\text{Monthly Earnings}}{13}$ x 3 (e.g \$ $\frac{800}{13}$ x 3 = \$ 184.62 ) OR;										
(b) Weekly Earnings = Fortnightly Earnings (e.g \$ 200 = \$ 100.00)										
$\frac{1}{2} \qquad \qquad \frac{1}{2} \qquad \qquad \frac{1}$										
(c) Daily Earnings = $\frac{\text{Weekly Earnings}}{7}$ e.g. $\$ \frac{100}{7}$ = $\$14.29$										
(iii) Earnings and Loss of Earnings must be calculated at the daily rate.										
1. EMPLOYER NAME:										
REGISTRATION NO: TELEPHONE NO:										
2. This is to certify that Mr/Mrs/Ms  SURNAME  OTHER NAME(S)										
has been absent from work continuously since  YYYY MM DD										
Is Sickness a result of an accident on the job?  YES  NO.										
3. Is Applicant still employed? YES NO										
If "NO", state reason (s):  DATE OF SEPARATION:										

SECTIO	ON "C	)" -	TO E	BE COMP	LETED E	BY EN	1PLO'	YER	(CC	NT	'D)					
4.	WE	5.	Daily E	arnings	s prior	to S	ickness	\$								
State We	State Weekly Rates of Pay for the 13 week period BEFORE the week in which the employee's								5 pi.c.		101111000	¥			<u> </u>	
incapacit	incapacity started.								DAI	LY E	ARNING	S DUR	ING SICKN	IESS		
(a) WK		(b) ATE		(c) ACTUAL		(a) PERIOD OF ABSENCE TOTAL								/		
NO.	YYYY		DD	EARNINGS \$	S C		NO.	'	1		NO. 0		EARNIN DURIN	GS G		
1								YYYY			T0 YYYY		DAYS	SICKNE \$	SS   c	
2							1									
3							2									
4							3									
5			_				5									
6			_													
7						7.	. Was	Loss of	f Earn	ings	CAUSE	D BY S	SICKNESS?			
8			-				(a)		YES		(b)		NO			
10							If "N	O", Ple	ase st	tate r	eason fo	or Loss	of Earning:	S		
11																
12			+													
13																
WAR	NING!	Purs	uant t	to Section 3: viction to a f	3 of the Na	tional I	nsuran	ce Act	t, a pe	ersoı	n who r	makes	any false	statement	is	
liable	on sun	nmary	conv	iction to a f	ine of \$3,0	00.00	and to	impris	onme	ent f	or two	(2) ye	ars.			
					EMP	LOYI	ER D	ECL	ARA	ATIO	NC					
													С	OMPANY	STAI	MР
l decl	are that	t the ir	nforma	ation given is	true and cor	rect.										
				J												
NAME:				SURNAME		OT	HER NA	ME(S)						-		
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5001714																
POSITIO	ON:						SIG	SNATUI	RE			– DA	TE:			
													·	YYYY	M	M DD

SECTION "D" - FOR OFFICIAL USE			
PART I" - CUSTOMER SERVICE REPRESENTATIVE			
1. NAME, N.I. AND DATE OF BIRTH CONFIRMED ON I.A. SYSTEM?	YES	NO	
2. IS THE REGISTRATION RECORD COMPLETE? (If "NO" complete forms NI 4/NI 165/NI 182 as applicable).	YES	NO	
3. CHECK FOR DUPLICATE REGISTRATION. (SIRF file included)	YES	NO	
4. IS REGISTRATION RECORD UPDATED? (If "NO", state reason)	YES	NO	
5. CLAIM HISTORY VIEWED.	YES	NO NO	
6. HAS THIS INSURED PERSON APPLIED FOR A BENEFIT PREVIOUSLY?	YES	NO	
7. APPLICATION COMPLETE AND ACCEPTABLE FOR PROCESSING?	YES	NO	
CUSTOMER SERVICE REPRESENTATIVE	DATE	::	M M D D
PART II - DETERMINATION OF APPLICATION			
1. DOES THE APPLICANT SATISFY AGE CONDITION? (16 years to retirement)		YES	NO
2. WAS THE APPLICANT IN INSURABLE EMPLOYMENT WHEN INCAPACITY COMMI	ENCED?	YES	NO
3. WAS LOSS OF EARNINGS SUFFERED?		YES	NO
4. IS THE "10 IN 13 TEST" SATISFIED? (See Section "C", Question 4 on page 3)		YES	NO
<ol><li>DOES APPLICATION LINK WITH AN EARLIER SPELL OF INCAPACITY: (If "YES", state period):</li></ol>		YES	NO
WAS APPLICANT INJURED ON THE JOB?     (If "YES", investigate for Employment Injury).		YES	NO

	JETERIVII JINATION C I of 10 wee	F LOS	S OF EA	ARNIN	IGS	CATIO	N (C	CONT'					
(b) Aver	rage weekly	earnir	ıgs	<u>7(a)</u> 10				= \$					
	age daily ea				nocc			= \$					
(C) Avei	question 5	on pa	ge 4)	JOICK	11633			= Φ					
(d) Daily	earnings d			S:						•	i		
	(i) (ii) (iii) (iv) (v)  PERIOD OF ABSENCE  NO. OF DAILY EARNINGS DAILY LOSS TOTAL LOSS											(v) TOTAL LOSS	
	FROM TO					NO. OF DAYS		DURIN SICKNI	١G	OF EARNINGS (7(d)(ii) × 7(d)(iv)]			
	YYYY M	M <sub>I</sub> DD	YYYY	MM	DD							\$	
				1						ТОТ	Al		
(b) Aver	age contribu	ution v	alue	8 (a 10	<u> </u>	1	)		=				
(a) W (b) Da	rded class EEKLY RAT AILY RATE der 3 day v mend payi	OF BEI	NEFIT IN	N CLA	.SS econ	nmend	oaym	= ] <u>9 (a</u> 7 nent at nere 7(d	rate cal	\$ culated at 7(i	d)(iv) where	ion "D", Part II Question 8 e 7(d)(iv) is less than 9(l	
(a) W (b) Da (Consider Recommendation Recommendatio	EEKLY RAT AILY RATE der 3 day v	OF BEI waitin ment a	NEFIT IN g perio at rate	N CLA d. R calcu	SS econ lated	nmend at 9(b	) wh	9 (a 7 nent at nere 7(d	rate cal l)(iv) is g	culated at 7(	d)(iv) where		
(a) W (b) Da (Consider Recommendation Recommendatio	EEKLY RAT AILY RATE der 3 day v mend payi	OF BEI waiting ment a	NEFIT IN g perio at rate	N CLA d. R calcu DED F	SS econ lated	nmend at 9(b	) wh	9 (a 7 nent at nere 7(d	rate cal l)(iv) is g	culated at 7(	d)(iv) where		
(a) W (b) Da (Consider Recommendation Recommendatio	EEKLY RAT AILY RATE der 3 day v mend payi	OF BEI waiting ment a	NEFIT IN g perio at rate DMMENI	N CLA d. R calcu DED F	ecom ulated	nmend d at 9(b NLLOWA	NCE PE	9 (a 7  nent at are 7 (d AS FOL  RIOD	rate cale l)(iv) is g LOWS:	culated at 7(greater than G	d)(iv) where 9(b)).		
(a) W (b) Da (Consider Recommendation Recommendatio	EEKLY RAT AILY RATE der 3 day v mend payi	OF BEI waiting ment a	NEFIT IN g perio at rate DMMENI	N CLA d. R calcu DED F	ecom ulated	nmend d at 9(b NLLOWA	NCE PE	9 (a 7  nent at are 7 (d AS FOL  RIOD	rate cal ()(iv) is g LOWS:	culated at 7(greater than G	d)(iv) where 9(b)).		
(a) W (b) Da (Consider Recommendation Recommendatio	EEKLY RAT AILY RATE der 3 day v mend payi	OF BEI waiting ment a	NEFIT IN g perio at rate DMMENI	N CLA d. R calcu DED F	ecom ulated	nmend d at 9(b NLLOWA	NCE PE	9 (a 7  nent at are 7 (d AS FOL  RIOD	rate cale l)(iv) is g LOWS:	culated at 7(greater than G	d)(iv) where 9(b)).		
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(a) W (b) Da (Consider Recommendation Recommendatio	EEKLY RAT AILY RATE der 3 day v mend payi	OF BEI waiting ment a	NEFIT IN g perio at rate DMMENI	N CLA d. R calcu DED F	ecom ulated	nmend d at 9(b NLLOWA	NCE PE	9 (a 7  nent at are 7 (d AS FOL  RIOD	rate cale l)(iv) is g LOWS:	culated at 7(greater than G	d)(iv) where 9(b)).		
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(a) W (b) Da (Consider Recome) (c) Al	EEKLY RATE  der 3 day verticken mend paying period	OF BEI	g perio at rate DMMENI	N CLA	econ econ llatec	nmend dat 9(b	PEIDM DD	nent at nere 7(d AS FOL RIOD	rate calcoloring c	weeks	d)(iv) where 9(b)).		
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SECTION "D" - FOR OFFICIAL USE (CONT'D)	
10. DECISION/AUTHORISATION:  (a) SICKNESS BENEFIT ALLOWED AND AUTHORISED, FOR THE PERIOD AND F	RATE, AT 8(c) ABOVE.
(b) SICKNESS BENEFIT DISALLOWED ON THE GROUNDS AT 8(d) ABOVE.	
(c) APPLICANT NOTIFIED OF DECISION ON FORM NI 44/NI 53:	DATE: YYYY MM DD
(d) DECISION RECORDED ON I.A. SYSTEM:	DATE: YYYY MM DD
SIGNATURE: MANAGER/SUPERVISOR/C.O. II	DATE: YYYY MM DD