NI 15

THE NATIONAL INSURANCE BOARD
SICKNESS BENEFIT APPLICATION

(Please Use Block Capitals)

FOR OFFICIAL USE
CLAIM NO.:
SERVICE CENTRE CODE:

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

SECTION "A" - TO BE COMPLETED BY APPLICANT

1. NAME: SURNAME OTHER NAME

2. HOME ADDRESS: (STREET) (CITY/DISTRICT/COUNTY)

3. NATIONAL INSURANCE NO.

4. POSTAL ADDRESS (if different from above): (STREET) (CITY/DISTRICT/COUNTY)

5. TELEPHONE NUMBER -

6. DATE OF BIRTH: Y Y Y Y M M D D

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: Y Y Y Y M M D D

17. DATE LOSS OF EARNINGS STARTED: Y Y Y Y M M D D

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.

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

SECTION "A" - TO BE COMPLETED BY APPLICANT (CONT'D)

18. METHOD OF PAYMENT OF CHEQUE:

MAIL TO ☐ POSTAL ADDRESS DEPOSIT TO: ☐ BANK ☐ CREDIT UNION

NAME OF BANK /CREDIT UNION:

ACCOUNT NUMBER

ADDRESS:

(STREET)

(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 "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.

SIGNATURE OR MARK OF APPLICANT

DATE: Y Y Y Y M M D D

PARTICULARS OF WITNESS TO MARK (WHERE APPLICANT CANNOT SIGN)

NAME:

SURNAME

OTHER NAME(S)

OCCUPATION:

IDENTIFICATION: (Tick One Box)

☐ PASSPORT

☐ DRIVER'S PERMIT

☐ ELECTORAL I.D.

NUMBER:

ADDRESS:

(STREET)

(CITY/DISTRICT/COUNTRY)

SIGNATURE OF WITNESS TO MARK

DATE: Y Y Y Y M M D D

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 Y Y Y Y M M D D and in my opinion was at the time suffering from _____

This patient will remain incapable of work for a period of _____ days starting from

(In words and figures)

Y Y Y Y M M D D . Confidential information has/has not been sent to the Board's Medical Adviser.

NAME IN BLOCK LETTERS OR STAMP OF DOCTOR:

SURNAME

OTHER NAME(S)

TELEPHONE NO.

DATE: Y Y Y Y M M D D

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 = $\frac{\text{Monthly Earnings}}{13} \times 3$ (e.g $\$ \frac{800}{13} \times 3 = \$ 184.62$) OR;

(b) Weekly Earnings = $\frac{\text{Fortnightly Earnings}}{2}$ (e.g $\$ \frac{200}{2} = \$ 100.00$)

(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

Y Y Y Y M M D D

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:

Y Y Y Y M M D D

SECTION "C" - TO BE COMPLETED BY EMPLOYER (CONT'D)

4. WEEKLY RATE OF PAY

State Weekly Rates of Pay for the 13 week period BEFORE the week in which the employee's incapacity started.

(a) WK NO.	(b) DATE YYYY	MM	DD	(c) ACTUAL EARNINGS $	c
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					

5. Daily Earnings prior to Sickness $_____ .

6. **DAILY EARNINGS DURING SICKNESS**

(a) NO.	(b) PERIOD OF ABSENCE FROM YYYY	MM	DD	TO YYYY	MM	DD	(c) TOTAL NO. OF DAYS	(d) DAILY EARNINGS DURING SICKNESS $	c
1									
2									
3									
4									
5									

7. Was Loss of Earnings CAUSED BY SICKNESS?

(a) ☐ YES (b) ☐ NO

If "NO", Please state reason for Loss of Earnings

_____

_____

_____

_____

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.

EMPLOYER DECLARATION

COMPANY STAMP

I declare that the information given is true and correct.

NAME: _____
SURNAME OTHER NAME(S)

POSITION: _____ _____
SIGNATURE

DATE: | | | | | | | | |
Y Y Y Y M M D D

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? ☐ YES ☐ NO
   (If "NO" complete forms NI 4/NI 165/NI 182 as applicable).

3. CHECK FOR DUPLICATE REGISTRATION. (SIRF file included) ☐ YES ☐ NO

4. IS REGISTRATION RECORD UPDATED? ☐ YES ☐ NO
   (If "NO", state reason)

_____

5. CLAIM HISTORY VIEWED. ☐ YES ☐ 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: ☐☐☐☐ ☐☐ ☐☐
Y Y Y Y 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 COMMENCED? ☐ 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

5. DOES APPLICATION LINK WITH AN EARLIER SPELL OF INCAPACITY: ☐ YES ☐ NO
   (If "YES", state period):

6. WAS APPLICANT INJURED ON THE JOB? ☐ YES ☐ NO
   (If "YES", investigate for Employment Injury).

SECTION "D" - FOR OFFICIAL USE (CONT'D)

PART II - DETERMINATION OF APPLICATION (CONT'D)

7. DETERMINATION OF LOSS OF EARNINGS

(a) Total of 10 weeks of highest earnings $

(b) Average weekly earnings $\frac{7(a)}{10}$ = $

(c) Average daily earnings prior to Sickness (See question 5 on page 4) = $

(d) Daily earnings during Sickness:

(i) PERIOD OF ABSENCE FROM YYYY MM DD	TO YYYY MM DD	(ii) NO. OF DAYS	(iii) DAILY EARNINGS DURING SICKNESS	(iv) DAILY LOSS [7(c) - 7(d) (iii)]	(v) TOTAL LOSS OF EARNINGS [7(d)(ii) x 7(d)(iv)] $
				TOTAL	

8. DETERMINATION OF EARNINGS CLASS

(a) Total value of the 10 highest contribution classes (Select the 10 highest classes from column 4(c) on page 4). $

(b) Average contribution value $\frac{8\ (a)}{10}$ _____ / 10 = _____

(c) Awarded class

9. (a) WEEKLY RATE OF BENEFIT IN CLASS = $ (See Section "D", Part II Question 8(c)).

(b) DAILY RATE OF BENEFIT IN CLASS $\frac{9\ (a)}{7}$ $

(Consider 3 day waiting period. Recommend payment at rate calculated at 7(d)(iv) where 7(d)(iv) is less than 9(b). Recommend payment at rate calculated at 9(b) where 7(d)(iv) is greater than 9(b)).

(c) APPLICATION RECOMMENDED FOR ALLOWANCE AS FOLLOWS:

DAILY RATE	PERIOD FROM YYYY MM DD	PERIOD TO YYYY MM DD	WEEKS	DAYS

(d) APPLICATION RECOMMENDED FOR DISALLOWANCE ON THE GROUNDS THAT:

_____

_____

SIGNATURE: _____
PROCESSING OFFICER

DATE: YYYY MM DD

SECTION "D" - FOR OFFICIAL USE (CONT'D)

10. DECISION/AUTHORISATION:

(a) ☐ SICKNESS BENEFIT ALLOWED AND AUTHORISED, FOR THE PERIOD AND 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: Y Y Y Y M M D D

(d) DECISION RECORDED ON I.A. SYSTEM: DATE: Y Y Y Y M M D D

SIGNATURE: _____ DATE: Y Y Y Y M M D D
MANAGER/SUPERVISOR/C.O. II