THE NATIONAL INSURANCE BOARD EMPLOYMENT INJURY BENEFIT APPLICATION

(Please Use Block Capitals)

NOTE: This Application must be submitted within 3 months of the date of the Accident/Development of the Prescribed Industrial Disease.

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	SERVICE CENTRE CODE:									
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SECTION "A" - TO BE COMPLETED BY APPLICANT								
1. NAME:								
SURNAME OTHER NAME (S)								
3. POSTAL 2. NATIONAL INSURANCE NO.								
ADDRESS: (STREET)								
4. TELEPHONE NUMBER								
(CITY/DISTRICT/COUNTY)								
5. DATE OF BIRTH: YYYY MM DD 6. SEX: MALE FEMALE								
7. OCCUPATION:								
8. EMPLOYER'S NAME:								
9.*EMPLOYER'S								
ADDRESS: (STREET)								
(CITY/DISTRICT/COUNTY)								
10. NAME AND ADDRESS OF								
ACTUAL PLACE OF WORK: (e.g. School/Department/Division) (STREET)								
(CITY/DISTRICT/COUNTY)								
11. 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)								
12. DATE AND TIME ACCIDENT OCCURRED:								
YYYY MM DD								
13. LAST DATE WORKED: YYYY MM DD								
14. DATE RESUMED WORK: YYYY MM DD								
15. EXACT PLACE/LOCATION ————————————————————————————————————								
16. DID ACCIDENT OCCUR WHILE TRAVELLING IN EMPLOYER'S TRANSPORT?: YES NO								
(If "YES" give details). (i) Place of Embarkation:								
(ii) Destination:								
(iii) Destination.								

(If "NO" was	ed/rented by employer? YES NO
(If "NO" was	ehicle used by an arrangement with employer? (Describe)).
STATE CLEAR I	
	,
STATE DETAILS	OF INJURY SUSTAINED:
GIVE NAME AN	ADDRESS OF ANY WITNESS TO THE ACCIDENT:
WAS ACCIDENT	REPORTED TO YOUR EMPLOYER?: YES NO
(If "YES", stat	e date of report).
DATE OF FIRST	VISIT TO DOCTOR: YYYY MM DD
NAME AND ADO	SURNAME OTHER NAME(S)
	OTHER NAME(S)
	(STREET)
	(CITY/DISTRICT/COUNTY)
	THE COST OF MEDICAL EXPENSES? YES NO plete a Form NI 114).
RELAPSE:	
IS THIS APPLICA	TION IN SUPPORT OF A RELAPSE?
(i) (If "YES", de	cribe the activities in which you were engaged when the relapse occurred).
(ii) (State the ex	act place/location where the relapse occurred).

SECTION "A" - TO BE COMPLETED BY APPLICANT (CONT'D)
25. METHOD OF PAYMENT OF CHEQUE:
MAIL TO: POSTAL ADDRESS DEPOSIT TO: BANK CREDIT UNION (If Method of Payment is "BANK" or "CREDIT UNION", Complete Below).
NAME OF BANK/ CREDIT UNION ACCOUNT NUMBER
ADDRESS: (STREET)
(CITY/DISTRICT/COUNTY)
DECLARATION
I DECLARE THAT THE INFORMATION GIVEN IS TRUE AND CORRECT. I hereby give consent for the Medical Report at Section "B" to be sent to the National Insurance Board in support of my Application for Employment Injury Benefit.
SIGNATURE OR MARK OF APPLICANT DATE:
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 years.
PARTICULARS OF WITNESS TO MARK (WHERE APPLICANT CANNOT SIGN)
NAME: OCCUPATION: SURNAME
OTHER NAME(S) IDENTIFICATION: (Tick (✓) One Box)
ADDRESS: DRIVER'S PERMIT (STREET) DRIVER'S PERMIT ELECTORAL I.D.
(CITY/DISTRICT/COUNTY) NUMBER:
SIGNATURE OF WITNESS TO MARK DATE:
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 I found the following injuries/industrial disease:
My findings are/are not consistent with the description of the accident/disease. I hereby recommend that the patient be granted (In words and figures) days/weeks leave with effect from YYYY MM DD

SECTION	"B" -	то	BE	CON	IPLETED	BY	ME	DICAL	PR	ACTIT	IONER	(CONT'D)
NAME IN BLO							NI DAIA	ME				TELEPHONE NO.
							SURNA					
ADDRESS:								IAME(S)				
						(STR	EET)					
					(CITY/I	DISTR	IICT/C	OUNTY)				
SIGNATURE	OF DO	CTOR	<u> </u>									DATE: YYYY MM DD
				gislatior	1999 provio	ies t d per	hat En son's	nploymen extent of	injur disab	y Benefit lity as a r	may be i	paid for a maximum of 52 weeks. At e accident is assessed to determine
eligi	DIIITY TOP	DISAC	oleme	nt bene	nt.							

SECTION "C" - TO BE COMPLETED BY EMPLOYER	
(This Section must be completed by the employer before the application is	submitted to the Board).
1. EMPLOYER NAME:	
2. EMPLOYER REGISTRATION NO: 3. TELEPHONE NO:	
4. TYPE OF BUSINESS:	
5. DESCRIBE THE WORK THE INJURED PERSON DOES:	
6. IS HE/SHE AN UNPAID APPRENTICE:	NO
7. STATE BELOW THE WAGES/SALARY PAID OR PAYABLE IN: (i) Week/Month prior to the week of accident. \$	
(ii) Week/Month in which accident occurred.	
8. ARE THE PARTICULARS STATED AT NOS. 11 TO 23 OF SECTION "A" ACCURATE? (If "NO", please give details):	YES NO
9. (i) DID ACCIDENT OCCUR DURING WORKING HOURS?	YES NO
(ii) WAS EMPLOYEE ENGAGED IN HIS/HER DUTIES AT THE TIME OF THE ACCIDENT? (If "NO" to either (i) or (ii) give details):	YES NO
10. (i) DID THE INJURED PERSON WORK DURING THE INJURY PERIOD? (If "YES", please state period):	YES NO
11. DID EMPLOYEE DIE AT THE TIME OF THE ACCIDENT OR AFTER?	YES NO
(If "YES", please state date of death): YYYY MM DD	
12. HAS THE ACCIDENT BEEN ENTERED IN THE EMPLOYER'S ACCIDENT BOOK?	YES NO
EMPLOYER DECLARATION	
I declare that the information given is true and correct.	COMPANY STAMP
NAME: SURNAME OTHER NAME(S)	
POSITION:SIGNATURE	DATE: YYYY MM DD

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 years.

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
 REGISTRATION (1.A) RECORD COMPLETE? (If "NO" complete forms NI 4/NI 165/NI 182 as applicable). 	YES NO
3. SYSTEM CHECK FOR DUPLICATE REGISTRATION COMPLETED. (SIRF file included)?	YES NO
4. REGISTRATION RECORD UPDATED? (If "NO" state reason)	YES NO
5. CLAIM HISTORY GENERATED?.	YES NO
 HAS THIS INSURED PERSON APPLIED FOR A BENEFIT PREVIOUSLY? (If "YES", request Benefit Unit) 	YES NO
7. APPLICATION COMPLETE AND ACCEPTED FOR PROCESSING?	YES NO
DATE: CUSTOMER SERVICE REPRESENTATIVE	YYYY MM DD
PART II - DETERMINATION OF APPLICATION	
Ensure that the following conditions are satisfied. If answer to any is "NO", refer to Cler Clerical Officer II/Supervisor must indicate action on Minute Sheet.	ical Officer II/Supervisor.
1 WAS APPLICANT IN INSURABLE EMPLOYMENT AT THE TIME OF THE ACCIDENT?	YES NO
2. (i) DID ACCIDENT/DISEASE ARISE IN THE COURSE OF EMPLOYMENT?	YES NO
(ii) DID ACCIDENT/DISEASE ARISE OUT OF EMPLOYMENT?	YES NO
3AGE OF APPLICANT AT THE TIME OF THE ACCIDENT?	
UNDER 16 YEARS 16 - 65 YEARS OVER 65 YEARS	
4 IS APPLICANT AN UNPAID APPRENTICE?	YES NO
DETERMINATION OF EARNINGS CLASS	
5 APPLICANT'S EARNINGS IN WEEK OF INJURY/DISCOVERY OF DISEASE? \$	EARNINGS CLASS:
6 APPLICANT'S EARNINGS IN WEEK PRIOR TO INJURY/DISCOVERY OF DISEASE? \$	EARNINGS CLASS:
7 (a) APPLICATION APPROVED FOR PAYMENT IN EARNINGS CLASS AT THE WE	EEKLY RATE OF \$
FOR THE PERIOD TO YYYY MM DD	
(Use the higher of 5 or 6 above)	
(b) APPLICATION RECOMMENDED FOR DISALLOWANCE ON THE GROUNDS THAT:	
NAME SIGNATURE	DATE:
PROCESSING OFFICER	YYYY MM DD