# THE NATIONAL INSURANCE BOARD SPECIAL MATERNITY GRANT BENEFIT APPLICATION

#### (PLEASE USE BLOCK/CAPITALS)

Please read the notes at the back of this form CAREFULLY.

NOTE: This application must be submitted within three (3) months of the Date of Delivery.

This application must be completed on/after the date of delivery.

(FOR OFFICIAL USE)										
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SECTION "A" - TO BE COMPLETED BY APPLICANT (MOTHER)
1. NAME: SURNAME OTHER NAME
2. HOME ADDRESS: (STREET)
3. *POSTAL ADDRESS (if different from above):  (CITY/DISTRICT/COUNTY)
4. NATIONAL INSURANCE NO.:  5. DATE OF BIRTH:  VOVY MM DD
6. VALID IDENTIFICATION:  BLECTORAL ID PASSPORT DRIVER'S PERMIT NUMBER:
7. MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED
8. TELEPHONE NUMBERS: - (OFFICE/WORK) (CELLULAR)
9. NAME OF FATHER OF CHILD: SURNAME OTHER NAME(S)
10. PLEASE INDICATE THE METHOD OF PAYMENT OF BENEFIT:  MAIL TO:  POSTAL ADDRESS DEPOSIT TO: FINANCIAL INSTITUTION
(If method of payment is "FINANCIAL INSTITUTION", complete below).
NAME OF FINANCIAL INSTITUTION:
ADDRESS: (STREET)
(CITY/DISTRICT/COUNTY)
ACCOUNT NUMBER:
11. ARE YOU PRESENTLY EMPLOYED? YES NO (IF "YES", HAVE YOUR EMPLOYER COMPLETE SECTION C)
EMPLOYER'S NAME
EMPLOYER'S ADDRESS: (STREET)
(CITY/DISTRICT/COUNTY)

### SECTION "A" - TO BE COMPLETED BY APPLICANT (MOTHER) DECLARATION OF APPLICANT 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. I hereby give permission to NIBTT to update the information from this form. DATE: SIGNATURE OR MARK OF APPLICANT DD PARTICULARS OF WITNESS TO MARK (Where applicant cannot sign) NAME: SURNAME OTHER NAME(S) ADDRESS: PASSPORT (STREET) DRIVER'S PERMIT VALID IDENTIFICATION: (CITY/DISTRICT/COUNTY) (Tick appropriate box) ELECTORAL I.D. NUMBER: OCCUPATION: DATE: SIGNATURE OF WITNESS TO MARK SECTION "B" - TO BE COMPLETED BY A REGISTERED MEDICAL PRACTITIONER OR MIDWIFE CERTIFICATE OF ACTUAL DELIVERY To be completed after delivery. I hereby certify that Miss/Mrs. OTHER NAME(S) was under my care for the delivery of her child/children. Her actual date of delivery was Did pregnancy last at least 26 weeks at the date of delivery? NO YES Did Delivery result in the birth of a living child/children? YES If "YES" (i) State number of children : (Words and figures) NAME OF MEDICAL PRACTITIONER /MIDWIFE: **OFFICE** ADDRESS: (STREET) (CITY/DISTRICT/COUNTY) REGISTRATION NUMBER OF TELEPHONE NUMBER: MEDICAL PRACTITIONER /MIDWIFE: 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. STAMP DATE: SIGNATURE OF MEDICAL PRACTITIONER /MIDWIFE YYYY DARKE DD

# SECTION "C" - TO BE COMPLETED BY APPLICANT'S EMPLOYER INSTRUCTIONS FOR COMPLETION OF QUESTIONS 5(a) TO 6

- (i) (a) In completing Question 5(a) refer to actual date of delivery in SECTION "B".
  - (b) Check 6 weeks before the week of delivery and enter date at 5 (b).
  - (c) Complete item 6, Table IA, columns (a),(b),(c) for the 13 week period prior to the week established at 5 (b).
- (ii) In completingTable IA determine weekly earnings as follows:
  - (a) Where pay frequency is monthly:

Monthly Earnings x 3 e.g. \$800 x 3

5=

= \$184.62 (weekly) OR;

(a) Where pay frequency is fortnightly:

Fortnightly Earnings e.g. \$200

= \$100.00 (weekly)

1. EMPLOYER'S NAME:						
2. *EMPLOYER'S ADDRESS:			П			
			(STR	EET)		
			$\prod$	TT		

(CITY/DISTRICT/COUNTY)

3.	TELEPHONE NUMBER:				

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5. (a) Actual Week of delivery began Monday:

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YYYY	MM	DD

(b)	Sixth	week	before	actual	date	of	delivery	began	Monday:
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	-	YY	/Y	IVIVI	D	D	_		

# TABLE IA WEEKLY RATE OF PAY

State weekly Rates of Pay for the 13 week period BEFORE the week indicated as the actual Date of Delivery in Section 5(b).

(a) WK	) (	b) ATE ,		(c) ACTUAL EAR	NINGS
NO.	YYYY	YYY MM DD		\$	С
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2					
3					
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9					
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11					
12					
13					
		To	otal		

FOR OFFICIA	L USE ONLY
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4/NI 13
SECTION "C" - TO BE COMPLETED BY APPLICANT'S EMPLOYER (Cont'd)
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
POSITION:
COMPANY STAMP
SIGNATURE (If any) DATE:
SECTION "D" - TO BE COMPLETED BY THE FATHER OF THE CHILD
1. NAME: SURNAME OTHER NAME
2. HOME ADDRESS: (STREET)
(CITY/DISTRICT/COUNTY)
3. *POSTAL ADDRESS (if
different from above):  (CITY/DISTRICT/COUNTY)
4. NATIONAL INSURANCE NO.:  5. DATE OF BIRTH: YYYY MIM DD
6. VALID IDENTIFICATION:  BELECTORAL ID PASSPORT DRIVER'S PERMIT NUMBER:
7. TELEPHONE NUMBERS: (OFFICE/WORK) (CELLULAR)
8. MARITAL STATUS: SINGLE MARRIED DIVORCED  If married, submit marriage certificate, otherwise see Notes.
9. ARE YOU THE LAWFUL SPOUSE OF THE APPLICANT? YES NO
10. OCCUPATION:
11. EMPLOYER'S NAME:
12. *EMPLOYER'S ADDRESS: (STREET)

<sup>\*</sup>EXAMPLE: Light Pole No. 8, Southern Main Road, Couva OR Near Bertie's Parlour, Industry Lane, Belmont. 01/2008

## SECTION "E" - TO BE COMPLETED BY FATHER'S EMPLOYER

### INSTRUCTIONS FOR COMPLETION OF QUESTIONS 5(a) TO 6

- (i) (a) In completing Question 5(a) refer to actual date of delivery in SECTION "B".
  - (b) Check 6 weeks before the week of delivery and enter date at 5 (b).
  - (c) Complete item 6, Table IA, columns (a),(b),(c) for the 13 week period prior to the week established at 5 (b).
- (ii) In completingTable IA determine weekly earnings as follows:
  - (a) Where pay frequency is monthly:

Monthly Earnings x 3 e.g. \$800 x 3

= \$184.62 (weekly) OR;

(a) Where pay frequency is fortnightly:

Fortnightly Earnings e.g. \$200

= \$100.00 (weekly)

1. EMPLOYER'S NAME:										
2. *EMPLOYER'S ADDRESS:					18	TRE	ETV			

6.

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4.	REGISTRATION	MOMBER:


(a) Actual week of delivery begins Monday:

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	 15/15

(b)	Sixth	week	before	actual	date of	delivery	begins	Monday:
		LI	1	1				
	_	YY	YY	IVIVI	DD	-37		

### TABLE IA WEEKLY RATE OF PAY

State weekly Rates of Pay for the 13 week period BEFORE the week indicated as the actual Date of Delivery in

(a) WK	0	b) ATE		(c) ACTUAL EA	ARNINGS
NO.	YYYY	MM	DD	\$	С
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3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
	***************************************	0	Total		

FOR OFFICIA	L USE ONLY
WEEK	CLASS
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6	
7	
8	
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11	
12	
13	

# SECTION "E" - TO BE COMPLETED BY FATHER'S EMPLOYER (Cont'd) 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: OTHER NAME(S) POSITION COMPANY STAMP (If any) DATE: SIGNATURE SECTION "F" - FOR OFFICIAL USE APPLICATION RECEIVED BY: NAME: SURNAME OTHER NAME(S) SERVICE CENTRE DATE: STAMP SIGNATURE OF SERVICE CENTRE STAFF MM DD

### INSTRUCTIONS TO APPLICANT

- Use BLOCK/CAPITALS to complete this Form.
- The Special Maternity Grant is payable to the mother of the child/children using the father's contributions.
- Where the mother does not satisfy the contribution requirements for Maternity Benefit in her own right or where the mother is unemployed, the father's contribution will be used to qualify her for the Special Maternity Grant.
- 4. Only one (1) Special Maternity Grant is allowed every twenty-four (24) consecutive months.
- The Special Maternity Grant is a lumpsum payment equivalent to the Maternity Grant of \$2,500.00 per child.
- 6. Your form must be accompanied by:
  - (a) NI 4 if applicant does not have a National Insurance Number.
  - (b) Marriage Certificate if applicant is legally married.

OR

- (b) Where both mother and father are in a common-law union, evidence of:
  - (1) co-habitation at the time of delivery of the child/children and
  - (2) marital status of both mother and father,
- (c) Birth certificate(s) of child/children and supporting statutory declaration(s) (if necessary).