CARICOM AGREEMENT ON SOCIAL SECURITY

APPLICATION FOR INDUSTRIAL DISABLEMENT/
OCCUPATIONAL DISEASE PENSION

Warning: Any person who knowingly makes a false statement or false representation for the purpose of obtaining any payment for himself or for some other person, or produces or furnishes any document or information which he knows to be false in a material particular, renders himself liable to prosecution.

Please **NOTE** the Documentary Evidence Requirements at the back of this form.

SECTION "A" - PARTICULARS OF CLAIMANT

1. COUNTRY OF PERMANENT RESIDENCE: _____

2. NAME: _____
            (SURNAME)   OTHER NAME(S)

3. NAME AT BIRTH IF DIFFERENT: _____
                                      (SURNAME)   OTHER NAME(S)

_____
                                        (STREET)

_____
              (CITY/DISTRICT/COUNTY)   (COUNTRY)

5a. NATIONAL INSURANCE/SOCIAL SECURITY NUMBER *

5b. COUNTRY

6. COUNTRY OF BIRTH: _____

7. DATE OF BIRTH:

YYYY   MM   DD

5c. NATIONAL REGISTRATION NUMBER *(WHERE APPLICABLE)*

8. TELEPHONE NUMBER

5d. WORKS NUMBER *(WHERE APPLICABLE)*

9. SEX: ☐ MALE ☐ FEMALE

10. FATHER'S NAME: _____
                        SURNAME   OTHER NAME (S)

11. MOTHER'S MAIDEN NAME _____
                          SURNAME   OTHER NAME (S)

12. MARITAL STATUS: (TICK APPROPRIATE BOX)

12.1 ☐ SINGLE   12.2 ☐ MARRIED   12.3 ☐ WIDOWED

12.4 ☐ DIVORCED   12.5 ☐ COMMON-LAW

13. OCCUPATION _____

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* NOTE: Applicants must submit additional information on a separate sheet if necessary.

SECTION "B" - DETAILS OF ACCIDENT/OCCUPATIONAL DISEASE

14a. Date of Accident

| | | | | | | | |

YYYY   MM   DD

14b. Date of development of occupational diseases

14c. Time of Accident ─────────────── A.M./P.M.

15. What was the person engaged in at the time of the Accident? _____

_____

16. Was person duly authorised to perform such duties?   Yes ☐   No ☐

17. What caused the Accident? _____

18. State how the Accident occurred _____

_____

_____

19. What is the nature of the injury/disease.

_____

SECTION "C" - PARTICULARS OF EMPLOYER

20. Name of Employer _____

21. Address of Employer _____
(STREET)

_____
(CITY/DISTRICT/COUNTY)   (CITY)

22. Nature of Business _____

SECTION "D" PARTICULARS OF INCAPACITY

23. Period of incapacity for work | | | | | | | | to | | | | | | | |
YYYY   MM   DD   YYYY   MM   DD

24. Was person hospitalised?   Yes ☐   No ☐

25. If answer to 24. is Yes, please state:

26a. Name and address of hospital _____

_____

26b. Period of hospitalisation | | | | | | | to | | | | | | |
YYYY   MM   DD   YYYY   MM   DD

26c. Period of constant care and attention | | | | | | | to | | | | | | |
YYYY   MM   DD   YYYY   MM   DD

27. Was person paid injury during period of incapacity?   Yes ☐   No ☐

SECTION "E" - DETAILS OF WORK DONE IN OTHER CARICOM COUNTRIES

28a. EMPLOYMENT RECORD IN CARICOM COUNTRIES. (Use additional sheets if necessary).

NAME OF EMPLOYER	ADDRESS	EMPLOYER REGISTRATION NUMBER (If known)	PERIOD OF EMPLOYMENT FROM			TO		
			YYYY	MM	DD	YYYY	MM	DD

28b. AS A SELF EMPLOYED PERSON

TYPE OF EMPLOYMENT	PERIOD WORKED FROM			TO			COUNTRY
	YYYY	MM	DD	YYYY	MM	DD	

29. DECLARATION OF APPLICANT

I hereby declare that to the best of my knowledge and belief the information given is true and correct, and I undertake to notify the National Insurance System of any change that might affect my entitlement to this benefit.

29.1 SIGNATURE OF CLAIMANT

_____

DATE: | | | | | | | |
      YYYY   MM   DD

30. DECLARATION OF WITNESS

(Where Claimant Cannot Sign)

I have read this application to the applicant, who appears to understand the contents and has affixed his/her mark. To be witnessed by Minister of Religion, J.P., Notary Public, Lawyer, Permanent Secretary, Bank Manager, Senior Official of Social Security Scheme, with accompanying stamp.

30.1 NAME OF WITNESS:

_____
SURNAME   OTHER NAME(S)

30.2 ADDRESS OF WITNESS: _____

_____

_____

_____

30.3 SIGNATURE OF WITNESS: _____

DATE: | | | | | | | |
      YYYY   MM   DD

31. (FOR OFFICIAL USE)

31.1   I hereby declare that I have examined and certified the documents submitted by the claimant with the application form.

NAME OF RECEIVING OFFICER   _____
                            SURNAME   OTHER NAME(S)

Signature of Receiving Officer

_____

DATE: | | | | | | | |
      YYYY   MM   DD

DOCUMENTARY EVIDENCE REQUIRED

1. Medical Certificates

2. National Insurance/Social Security Card

3. Identification Card

4. Notice of Accident

ACKNOWLEDGEMENT OF CLAIM

Dear Sir/Madam,

Acknowledgement is made of your claim for _____ dated _____ which has

been accepted. Kindly look forward in the near future for further communication with regard to your claim.

12/99