



MONTERRAT Social Security Act, 1985 APPLICATION FOR SICKNESS BENEFIT / EMPLOYMENT INJURY

Warning : Any person who knowingly makes a false representation for the purpose of obtaining a benefit commits an offence punishable by fine or imprisonment or both.

SECTION A - To be completed by the Employee

To: Director Social Security

Social Security Reg. No. [ ] [ ] [ ] [ ] [ ] [ ] Date of Birth [ ] [ ] [ ] [ ] [ ] [ ] dd mm yy

I, Mr. / Mrs. / Miss. ....

Address .....

Tel. No. .... Email .....

hereby state that I have been medically certified as incapable of being gainfully

employed and I claim Sickness Benefit / Employment Injury from [ ] [ ] [ ] [ ] [ ] [ ] dd mm yy

Attached is a Medical Certificate in support of my claim.

I was last employed as a/an .....at

.....and ceased work there on [ ] [ ] [ ] [ ] [ ] [ ] dd mm yy

My other employers during the last thirteen (13) weeks were :

1. Name..... Address.....

2. Name..... Address.....

My incapacity [is] [is not] as a result of injury or disease arising out of my employment.

I declare that the information given above is true and accurate to the best of my knowledge and belief. I also authorize the disclosure of my diagnosis for the purpose of the Montserrat Social Security Benefit.

Signature..... Date [ ] [ ] [ ] [ ] [ ] [ ] dd mm yy

Claim must be made NOT later than fifteen (15) days from the date on which the doctor examined you.

FOR OFFICIAL USE ONLY

CL No. [ ] [ ] [ ] [ ] [ ] [ ]

NIMS No. [ ] [ ] [ ] [ ] [ ] [ ]

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EMPLOYEE'S AUTHORIZATION

Section B - To be completed by the Employee

I, Mr/Mrs/ Miss ..... Full Name

in keeping with the Labour Code 20 of 2012, hereby authorize the Montserrat Social Security Office to disclose to my Employer - ..... the amount due / paid to me as Sickness Benefit.

Employee's signature..... Date [ ] [ ] [ ] [ ] [ ] [ ] dd mm yy

EMPLOYER'S CERTIFICATE

Section C : To be completed by Employer

I certify that Mr. / Mrs. / Miss ..... Full Name

is making a claim for Sickness Benefit to the Montserrat Social Security Fund for the period [ ] [ ] [ ] [ ] [ ] [ ] dd mm yy to [ ] [ ] [ ] [ ] [ ] [ ] dd mm yy

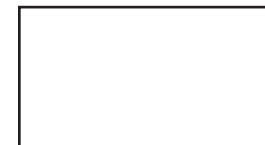
and he / she ceased work on [ ] [ ] [ ] [ ] [ ] [ ] dd mm yy

I declare that the information given above is true and accurate to the best of my knowledge and belief.

..... Name of Business

Authorized Person's Name

Authorized Person's Signature ..... Date [ ] [ ] [ ] [ ] [ ] [ ] dd mm yy



Official Stamp