



**MONTserrat**  
**Social Security Act, 1985**  
**APPLICATION FOR INVALIDITY BENEFIT**

Form IB\_1

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

To: Director  
 Social Security Fund

Social Security Reg. No.

Date of Birth   
 dd mm yy

Surname Mr./ Mrs. / Miss .....

First Name ..... Middle Name .....

Address .....

.....

Telephone No. .... Email .....

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

and claim Invalidation Benefit from   
 dd mm yy

Overleaf is a medical certificate in support of my claim along with an attached detailed doctor's report.

***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 the diagnosis overleaf for the purpose of the Montserrat Social Security Fund.***

Signature..... Date   
 dd mm yy

***Claim must be made NOT later than three (3) months from the date on which, apart from satisfying the condition of making a claim.***

**FOR OFFICIAL USE ONLY**

Claim No.

NIMS No.

**MEDICAL CERTIFICATE  
 OF INVALIDITY**

Form MC\_3

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

**TO BE COMPLETED BY A MEDICAL PRACTITIONER**

**NOTE: For the purpose of "BENEFIT REGULATIONS" INVALID means a person incapable of work as the result of a specific disease or bodily or mental disablement other than employment injury, BEING SUCH A DISEASE OR DISABLEMENT AS IS LIKELY TO REMAIN PERMANENT, and invalidity shall be construed accordingly.**

Mr. / Mrs. / Miss.....  
 Full Name

I hereby certify that on  I examined the above  
 dd mm yy

named person and he / she is suffering from .....

.....

and his / her condition is such that he / she is :

Is permanently incapable of being gainfully employed as a result, of his/her medical condition.

Any other remarks .....

.....

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

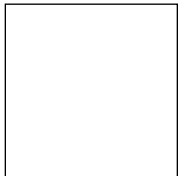
Medical Practitioner's Name .....

Address .....

.....

.....

Signature ..... Date   
 dd mm yy



Doctor's stamp /  
 Registration No.