Form IB_1

MONTSERRAT
Social Security Act, 1985
APPLICATION FOR INVALIDITY BENEFIT

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 Invalidity 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. _____

Form MC_3

MEDICAL CERTIFICATE OF INVALIDITY

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 .....

.....

.....

Doctor's stamp / Registration No.

Signature ..... Date | | | | | | |
dd mm yy