



MONTSERRAT

Social Security Act, 1985

Form MB_2

CLAIM FOR MATERNITY BENEFIT (Grant only)

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

To be completed by an Insured woman or the spouse of Insured Man

To : Director
Social Security

Soc. Sec. Reg. No.
Date of Birth
dd mm yy

I, Mrs, Miss.....
Full name of claimant

residing at hereby claim
Address

Maternity Grant in respect of my confinement on
dd mm yy

I am the wife of Mr
of
Address

an Insured Person whose Social Security Reg No. is
who is employed by.....

Attached is a copy of my Marriage Certificate.

*Overleaf is a medical certificate of confinement in support of my claim.
Claim must be made NOT later than four (4) weeks after the date of confinement.*

Claimant's signature Date
dd mm yy



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MATERNITY BENEFIT MEDICAL CERTIFICATE

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

MEDICAL CERTIFICATE OF CONFINEMENT

To be completed by a Medical Practitioner or Registered Midwife in respect of a claim for benefit AFTER confinement

Social Security Reg. No.

Date of Birth
dd mm yy

Mrs / Miss
Full Name

I certify that I attended the above named person at her confinement involving the birth of of one child or children which took place at on
dd mm yy

Print name of Medical Practitioner or Registered Midwife
.....

Signature..... Date
Medical Practitioner or Registered Midwife dd mm yy



Doctor's Stamp



Registration No. of Midwife

Please submit this certificate within four (4) weeks of date of confinement.