

## **INVALIDITY CERTIFICATE**

Form MC\_5

Registration No.

To be completed by Medical Practitioner

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
	<b>Montserrat Social Security</b>

					Date of Birth					
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Full Name Mr. / Mrs. / M	1SS					•••••		•••••	•••••	••••
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she is suffering from and his / her condition is				•••••		•••••	•••••		•••••	
Please tick appropriate bo	X									
Can be gainfull	y emplo	yed at	this po	oint i	n time					
Cannot be gain	fully em	ploye	d at this	s poi	nt in time					
Any other remarks										
It is my opinion he / she v										
I declare that the foregoi knowledge and belief.	ng info	rmatio	n give	n abo	ove is true and accurate	e to the	best (	of m	y	
Name of Medical Practition	oner						•••••			
Signature of Medical Prac	ctitioner	·							•••••	••••
Addresss										
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NOTE: For the purpose of Benefit Regulations "INVALID" means the person is incapable of being gainfully employed as a result of a specific disease or bodily or mental disablement. Gainfully employed in this instance means Insured Person is capable of performing work for which renumeration is or would ordinarily be payable.

## HONTSERRAN SOLITION

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Date of Birth

Го:	Director
	<b>Montserrat Social Security</b>

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