MONTSERRAT
SOCIAL SECURITY ACT 1985
APPLICATION FOR MEDICAL EXPENSES INCURRED AS A RESULT OF EMPLOYMENT INJURY

Form ME_EI_1

CL No. ☐☐☐☐☐☐ NIMS No. ☐☐☐☐☐☐

To : Director
: Social Security

Surname Mr / Mrs / Miss.....

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

Address.....

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

Address of Employer.....

I suffered accident / illness at..... Date ☐☐ ☐☐ ☐☐ Time ☐☐ ☐☐ am / pm

Place *dd mm yy* *hh mm*

I reported it to my employer on ☐☐ ☐☐ ☐☐ Describe briefly what injury you sustained as a result of the accident / illness.

dd mm yy

.....

.....

.....

To obtain a refund of your portion of medical expenses incurred, please complete the followng :

1. I hereby claim refund of my medical expenses in the amount of $.....
2. I hereby claim refund of my air fare in the amount of $.....
3. My receipt(s) in support of this claim is / are attached Yes ☐ No ☐
4. Please indicate if any expenses were met by your employer Yes ☐ No ☐

   If Yes, please state the amount $.....

I hereby authorize the disclosure to the Social Security Board of the doctor's diagnosis for the purposeof the Montserrat Social Security Act 1985 and Regulations made thereunder.

I hereby declare the information given in this claim is true to the best of my knowledge and belief.

Claimant's signature ..... Date ☐☐ ☐☐ ☐☐

dd mm yy

Note: Please submit to the Social Security Office no later than 15 days from the date of medical examination or the date when the expenses were paid.

FOR OFFICAL USE ONLY

Date Received ☐☐ ☐☐ ☐☐ No. of receipts received ☐☐☐☐ Amount $.....

dd mm yy

Name of Receiving Officer ..... Signature of Receiving Officer .....

Name of Verification Officer ..... Signature of Verification Officer .....