



MONTERRAT
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 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.

**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 :

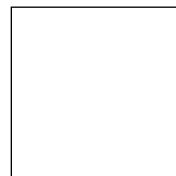
☐ Is permanently incapable of being gainfully employed as a result, of his/her medical condition.

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



Doctor's stamp /
Registration No.

Signature Date
dd mm yy