

SECTION "B" - PARTICULARS OF DECEASED (CONT'D)

25. Cause of Death: _____
(Diagnosis)

26. What was person engaged in at time of Accident? _____

27. Was person duly authorised to perform such functions: YES NO

28. Name of employer at time of Accident. _____

29. Address of last employer _____
SURNAME OTHER NAME (S)

(STREET) (CITY/DISTRICT/COUNTY)

(COUNTRY)

SECTION "C" - PARTICULARS OF WIDOW

30. DATE OF MARRIAGE:

--	--	--	--	--	--	--	--	--	--

YYYY MM .DD

31. Has the widow the care of child/children of the deceased? Yes No

32. If answer to question 31 is yes, please give the following details.

NAME OF CHILD	DATE OF BIRTH	RELATIONSHIP TO DECEASED	AT SCHOOL	
			YES	NO

33a. Do you have a source of income? Yes No

33b. Amount of income
\$

34. Was the widow pregnant for the deceased? Yes No

SECTION "D" - PARTICULARS OF WIDOWER

35. Date of Marriage

YYYY				MM		DD		

36. Has widower a source of income?

Yes No

37 If answer to 36 is yes, please state of income

\$

AMOUNT

38. Is widower incapacitated for work?

Yes No

If answer to 38 is yes, please state nature of incapacity and submit medical certificates.

INCAPACITY

SECTION "E" - PARTICULARS OF CHILD

39. Has child a surviving parent?

Yes No

40. Was child wholly or partially maintained by deceased?

Yes No

41. Has child a step parent with a prior claim to the benefit?

Yes No

SECTION "F" - PARTICULARS OF PARENT

42. Is parent capable of self support?

Yes No

43. Date of Birth

YYYY				MM		DD		

44. Was dependent wholly or partially maintained by the deceased?

Yes No

SECTION "G" - PARTICULARS OF OTHER DEPENDENTS

45. Is dependent permanently incapaable of self support?

Yes No

46. Date of Birth

YYYY				MM		DD		

47. Was dependent wholly or partially maintained by the deceased?

Yes No

SECTION "H" -DETAILS OF WORK DONE IN CARICOM COUNTRIES

48. Employment record in Caricom Countries. (Use additional sheets if necessary)

NAME OF EMPLOYER	PERIOD WORKED						NATIONAL INSURANCE/ SOCIAL SECURITY NUMBER	ADDRESS OF EMPLOYER
	FROM				TO			
	YY	MM	DD	YY	MM	DD		

49. **DECLARATION OF APPLICANT**

I hereby declare that to the best of my knowledge and belief the information given is true and correct, and I undertake to notify the National Insurance System of any change that might affect my entitlement to this benefit.

49.1 SIGNATURE OF CLAIMANT

DATE:

YYYY				MM		DD	

50. **DECLARATION OF WITNESS**

(Where Claimant Cannot Sign)

I have read this application to the applicant, who appears to understand the contents and has affixed his/her mark. To be witnessed by Minister of Religion, J.P, Notary Public, Lawyeer, Permanent Secretary, Bank Manager, Senior Official of Social Security Scheme, with accompanying stamp.

50.1 NAME OF WITNESS: _____

50.2 ADDRESS OF WITNESS: _____

50.3 SIGNATURE OF WITNESS:

DATE:

YYYY				MM		DD	

51. **(FOR OFFICIAL USE)**

51.1 I hereby declare that I have examined and certified the documents submitted by the claimant with the application form.

NAME OF RECEIVING OFFICER: _____

SURNAME

OTHER NAME (S)

Signature of Receiving Officer

DATE

YYYY				MM		DD	

DOCUMENTARY EVIDENCE REQUIRED

1. Birth Certificate
2. Death Certificate
3. Marriage Certificate
4. Identification Card
5. Declaration of Maintenance
6. Letter of Co-habitation
7. Evidence of Full-time Education if child is over 16 years of age.

This form should be submitted to the National Insurance/Social Security Office in the country in which you are residing.

ACKNOWLEDGEMENT OF CLAIM

Dear Sir/Madam,

Acknowledgement is made of your claim for _____ dated _____

which has been accepted. Kindly look forward in the near future for further communication with regard to your claim.

**APPLICATION FOR INDUSTRIAL DISABLEMENT/
OCCUPATIONAL DISEASE PENSION**

Warning: Any person who knowingly makes a false statement or false representation for the purpose of obtaining any payment for himself or for some other person, or produces or furnishes any document or information which he knows to be false in a material particular, renders himself liable to prosecution.

Please **NOTE** the Documentary Evidence Requirements at the back of this form.

SECTION "A" - PARTICULARS OF CLAIMANT

1. COUNTRY OF PERMANENT RESIDENCE: _____

2. NAME: _____
(SURNAME) OTHER NAME(S)

3. NAME AT BIRTH IF DIFFERENT: _____
(SURNAME) OTHER NAME(S)

(STREET)

(CITY/DISTRICT/COUNTY)

(COUNTRY)

5a. NATIONAL INSURANCE/SOCIAL SECURITY NUMBER *

5b. COUNTRY

6. COUNTRY OF BIRTH:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

7. DATE OF BIRTH:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

YYYY MM DD

5c. NATIONAL REGISTRATION NUMBER (WHERE APPLICABLE)

8. TELEPHONE NUMBER

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

	-																		
--	---	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

5d. WORKS NUMBER (WHERE APPLICABLE)

9. SEX: MALE FEMALE

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

10. FATHER'S NAME: _____
SURNAME OTHER NAME (S)

11. MOTHER'S MAIDEN NAME _____
SURNAME OTHER NAME (S)

12. MARITAL STATUS: (TICK APPROPRIATE BOX)

- 12.1 SINGLE 12.2 MARRIED 12.3 WIDOWED
12.4 DIVORCED 12.5 COMMON-LAW

13. OCCUPATION _____

* NOTE: Applicants must submit additional information on a separate sheet if necessary.

SECTION "B" - DETAILS OF ACCIDENT/OCCUPATIONAL DISEASE

14a. Date of Accident

YYYY				MM		DD	

14b. Date of development of occupational diseases

14c. Time of Accident _____ A.M./P.M.

15. What was the person engaged in at the time of the Accident? _____

16. Was person duly authorised to perform such duties? Yes No

17. What caused the Accident? _____

18. State how the Accident occurred _____

19. What is the nature of the injury/disease. _____

SECTION "C" - PARTICULARS OF EMPLOYER

20. Name of Employer _____

21. Address of Employer _____
 (STREET)

 (CITY/DISTRICT/COUNTY) (CITY)

22. Nature of Business _____

SECTION "D" PARTICULARS OF INCAPACITY

23. Period of incapacity for work

YYYY				MM		DD	

 to

YYYY				MM		DD	

24. Was person hospitalised? Yes No

25. If answer to 24. is Yes, please state:

26a. Name and address of hospital _____

26b. Period of hospitalisation

YYYY				MM		DD	

 to

YYYY				MM		DD	

26c. Period of constant care and attention

YYYY				MM		DD	

 to

YYYY				MM		DD	

27. Was person paid injury during period of incapacity? Yes No

SECTION "E" - DETAILS OF WORK DONE IN OTHER CARICOM COUNTRIES

28a. EMPLOYMENT RECORD IN CARICOM COUNTRIES. (Use additional sheets if necessary).

NAME OF EMPLOYER	ADDRESS	EMPLOYER REGISTRATION NUMBER (If known)	PERIOD OF EMPLOYMENT					
			FROM			TO		
			YYYY	MM	DD	YYYY	MM	DD

28b. AS A SELF EMPLOYED PERSON

TYPE OF EMPLOYMENT	PERIOD WORKED						COUNTRY
	FROM			TO			
	YYYY	MM	DD	YYYY	MM	DD	

29. **DECLARATION OF APPLICANT**

I hereby declare that to the best of my knowledge and belief the information given is true and correct, and I undertake to notify the National Insurance System of any change that might affect my entitlement to this benefit.

30. **DECLARATION OF WITNESS**

(Where Claimant Cannot Sign)

I have read this application to the applicant, who appears to understand the contents and has affixed his/her mark. To be witnessed by Minister of Religion, J.P., Notary Public, Lawyer, Permanent Secretary, Bank Manager, Senior Official of Social Security Scheme, with accompanying stamp.

30.1 NAME OF WITNESS:

SURNAME OTHER NAME(S)

30.2 ADDRESS OF WITNESS: _____

30.3 SIGNATURE OF WITNESS: _____

29.1 SIGNATURE OF CLAIMANT

DATE:

YYYY				MM		DD

DATE:

YYYY				MM		DD

31. **(FOR OFFICIAL USE)**

31.1 I hereby declare that I have examined and certified the documents submitted by the claimant with the application form.

NAME OF RECEIVING OFFICER _____
SURNAME OTHER NAME(S)

Signature of Receiving Officer

DATE:

YYYY				MM		DD

DOCUMENTARY EVIDENCE REQUIRED

1. Medical Certificates
2. National Insurance/Social Security Card
3. Identification Card
4. Notice of Accident

ACKNOWLEDGEMENT OF CLAIM

Dear Sir/Madam,

Acknowledgement is made of your claim for _____ dated _____ which has been accepted. Kindly look forward in the near future for further communication with regard to your claim.

SECTION "C" - PARTICULARS OF ILLNESS

15. Are you in receipt of sickness or other benefits? Yes No

16a. If answer to question 15 is yes, please state type of benefit. _____

16b. Date of commencement

YYYY				MM		DD			

SECTION: "D" - DETAILS OF WORK DONE IN CARICOM COUNTRIES

17. EMPLOYMENT RECORD IN CARICOM COUNTRIES. (Use additional sheets if necessary).

NAME OF EMPLOYER	ADDRESS	EMPLOYER REGISTRATION NUMBER (If known)	PERIOD OF EMPLOYMENT					
			FROM			TO		
			YYYY	MM	DD	YYYY	MM	DD

18. DECLARATION OF APPLICANT

I hereby declare that to the best of my knowledge and belief the information given is true and correct, and I undertake to notify the National Insurance System of any change that might affect my entitlement to this benefit.

18.1 SIGNATURE OF CLAIMANT

DATE:

YYYY				MM		DD	

19. DECLARATION OF WITNESS

(Where Claimant Cannot Sign)

I have read this application to the applicant, who appears to understand the contents and has affixed his/her mark. To be witnessed by Minister of Religion, J.P, Notary Public, Lawyer, Permanent Secretary, Bank Manager, Senior Official of Social Security Scheme, with accompanying stamp.

19.1 NAME OF WITNESS:

_____ SURNAME OTHER NAME(S)

19.2 ADDRESS OF WITNESS: _____

19.3 SIGNATURE OF WITNESS: _____

DATE:

YYYY				MM		DD	

20. (FOR OFFICIAL USE)

20.1 I hereby declare that I have examined and certified the documents submitted by the claimant with the application form.

NAME OF RECEIVING OFFICER _____ SURNAME OTHER NAME(S)

Signature of Receiving Officer

DATE:

YYYY				MM		DD	

**CARICOM AGREEMENT ON SOCIAL SECURITY
ACKNOWLEDGEMENT OF CLAIM**

Dear Sir/Madam

Acknowledgement is made of your claim for _____ dated _____ which has been accepted. Kindly look forward in the near future for further communication with regard to your claim.

SIGNATURE:

DOCUMENTARY EVIDENCE REQUIRED

PROOF OF AGE

- a) Certified Birth Certificate and Affidavit if applicant's name does not appear on the Birth Certificate or
- b) Valid Passport or;
- c) Electoral Identification Card

Where applicable.

CHANGE OF NAME

- a) Marriage Certificate or
- b) Deed Poll

OTHER

- a) Medical Certificate

This form should be submitted to the National Insurance Office in the country in which you reside.

SECTION "B" - PARTICULARS OF SPOUSE (CONT'D)

15a. NATIONAL INSURANCE/SOCIAL SECURITY NUMBER *

15b. COUNTRY

15c. NATIONAL REGISTRATION NUMBER (WHERE APPLICABLE)

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

15d. WORKS NUMBER (WHERE APPLICABLE)

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

16. DATE OF MARRIAGE/ CO-HABITATION:

YYYY MM DD

17. DATE OF BIRTH OF SPOUSE:

YYYY MM DD

SECTION "C" - DETAILS OF WORK DONE IN CARICOM COUNTRIES

18a. EMPLOYMENT RECORD IN CARICOM COUNTRIES. (Use additional sheets if necessary).

NAME OF EMPLOYER	ADDRESS	EMPLOYER REGISTRATION NUMBER (If known)	PERIOD OF EMPLOYMENT					
			FROM			TO		
			YYYY	MM	DD	YYYY	MM	

18b. AS A SELF EMPLOYED PERSON

TYPE OF EMPLOYMENT	PERIOD WORKED						COUNTRY
	FROM			TO			
	YYYY	MM	DD	YYYY	MM	DD	

* NOTE: Applicants may submit additional information on a separate sheet if necessary.

SECTION "C" - DETAILS OF WORK DONE IN CARICOM COUNTRIES (CONT'D)

19. Are you still employed?

YES NO

Please state the name and address of your employer/last employer:

20. EMPLOYER'S NAME: _____

21. EMPLOYER'S ADDRESS: _____
(STREET)

(CITY/DISTRICT/COUNTY)

(COUNTRY)

22. Have you ever applied for a Retirement Benefit from a Caricom country? YES NO

23. If "yes" please state country(ies) _____

24. Are you in receipt of any Benefit listed below? (Please tick)

25. COUNTRY

24.1 TYPE OF BENEFIT

24.2 INVALIDITY BENEFIT

24.3 SICKNESS BENEFIT

24.4 EMPLOYMENT INJURY BENEFIT

24.5 SURVIVORS BENEFIT

26. Are you a Voluntary Contributor?

27. COUNTRY

YES

NO

28. DETAILS OF DEPENDENTS:

NAME	RELATIONSHIP TO APPLICANT	DATE OF BIRTH	ADDRESS	COUNTRY

SECTION "C" DETAILS OF WORK DONE IN CARICOM COUNTRIES (CONT'D)

29. AUTHORISATION TO TRANSMIT PERSONAL INFORMATION

For the purpose of this application made under the Caricom Agreement on Social Security, I authorise the social security organisations to furnish to this National Insurance System any information in its possession which relates or could relate, to this application for benefits.

30. DECLARATION OF APPLICANT

I hereby declare that to the best of my knowledge and belief the information given is true and correct, and I undertake to notify the National Insurance System of any change that might affect my entitlement to this benefit.

30.1 SIGNATURE OF CLAIMANT

DATE:

YYYY				MM		DD

31. DECLARATION OF WITNESS

(Where Claimant Cannot Sign)

I have read this application to the applicant, who appears to understand the contents and has affixed his/her mark. To be witnessed by Minister of Religion, J.P, Notary Public, Lawyer, Permanent Secretary, Bank Manager, Senior Official of Social Security Scheme, with accompanying stamp.

31.1 NAME OF WITNESS:

_____ SURNAME OTHER NAME

31.2 ADDRESS OF WITNESS: _____

31.3 SIGNATURE OF WITNESS: _____

DATE:

YYYY				MM		DD

32. (FOR OFFICIAL USE)

32.1 I hereby declare that I have examined and certified the documents submitted by the claimant with the application form.

NAME OF RECEIVING _____ SURNAME OTHER NAME

Signature of Receiving Officer

DATE:

YYYY				MM		DD

DOCUMENTARY EVIDENCE REQUIRED

PROOF OF AGE

- a) Certified Birth Certificate and Affidavit if applicant's name does not appear on the Birth Certificate or
- b) Valid Passport or;
- c) Electoral Identification Card

Where applicable.

CHANGE OF NAME

- a) Marriage Certificate
- b) Deed Poll

OTHER

- a) Letter of Co-habitation

This form should be submitted to the National Insurance Office in the country in which you reside.

ACKNOWLEDGEMENT OF CLAIM

Dear Sir/Madam

Acknowledgement is made of your claim for _____ dated _____

which has been accepted. Kindly look forward in the near future for further communication with regard to your claim.

SECTION "C" - PARTICULARS OF WIDOW

25. DATE OF MARRIAGE:

YYYY				MM		DD	

26. Has the widow the care of child/children of the deceased?

Yes No

27. If answer to question 26 is yes, please give the details.

NAME OF CHILD	DATE OF BIRTH			RELATIONSHIP TO DECEASED	AT SCHOOL	
	YYYY	MM	DD		YES	NO

28. Has child surviving parent?

Yes No

29. Was child wholly or partially maintained by the deceased?

Yes No

30. Has child a step parent with a prior claim to the benefit?

Yes No

31. Is child mentally or physically challenged? (handicapped)

Yes No

32. Is child receiving full-time education?

Yes No

33. If answer to 31 and 32 is "Yes", attach medical/school report.

34. Do you have a source of income?

Yes No

35. Amount of income

\$

36. Was the widow pregnant for the deceased?

Yes No

37. Is widow incapacitated for work?

Yes No

Submit medical certificate(s) if yes.

SECTION "D" - PARTICULARS OF WIDOWER

38. Date of Marriage:

YYYY				MM		DD	

39. Has widower a source of income?

Yes No

SECTION "D" - PARTICULARS OF WIDOWER (CONT'D)

If answer to 39 is yes, please state source of income _____

\$

40. Is widower incapacitated for work? Yes No

AMOUNT

If answer to 40 is yes, please state nature of incapacity _____

INCAPACITY

SECTION "E" - PARTICULARS OF OTHER DEPENDENTS

41. State relationship to deceased. _____

42. Date of Birth

--	--	--	--	--	--	--	--

YYYY MM DD

43. Is dependent permanently incapable of self support?

Yes No

44. Was dependent wholly or partially maintained by the deceased?

Yes No

SECTION "F" - DETAILS OF WORK DONE IN CARICOM COUNTRIES

45. Employment record in Caricom Countries. (Use additional sheets if necessary)

NAME OF EMPLOYER	ADDRESS	EMPLOYER REGISTRATION NUMBER (If known)						PERIOD OF EMPLOYMENT

46. DECLARATION OF APPLICANT

I hereby declare that to the best of my knowledge and belief the information given is true and correct, and I undertake to notify the National Insurance System of any change that might affect my entitlement to this benefit.

46.1 SIGNATURE OF CLAIMANT

DATE:

YYYY				MM		DD	

47. DECLARATION OF WITNESS

(Where Claimant Cannot Sign)

I have read this application to the applicant, who appears to understand the contents and has affixed his/her mark. To be witnessed by Minister of Religion, J.P, Notary Public, Lawyer, Permanent Secretary, Bank Manager, Senior Official of Social Security Scheme, with accompanying stamp.

47.1 NAME OF WITNESS: _____
SURNAME OTHER NAME (S)

47.2 ADDRESS OF WITNESS: _____

47.3 SIGNATURE OF WITNESS: _____

DATE:

YYYY				MM		DD	

48. (FOR OFFICIAL USE)

48.1 I hereby declare that I have examined and certified the documents submitted by the claimant with the application form.

NAME OF RECEIVING OFFICER _____
SURNAME OTHER NAME(S)

Signature of Receiving Officer

DATE:

YYYY				MM		DD	

DOCUMENTARY EVIDENCE REQUIRED

1. Birth Certificates of surviving spouse and other dependents
2. Death Certificate
3. Marriage Certificate
4. Identification Card/National Registration Card/Valid Passport
5. Medical Reports of Applicants
6. Evidence of Full Time Education
7. Declaration of Maintenance
8. Evidence of Co-habitation

ACKNOWLEDGEMENT OF CLAIM

Dear Sir/Madam,

Acknowledgement is made of your claim for _____ dated _____ which
has

been accepted. Kindly look forward in the near future for further communication with regard to your claim.