CARICOM AGREEMENT ON SOCIAL SECURITY

DETAILS OF INSURANCE PERIODS COMPLETED BY CLAIMANT/DECEASED PERSON

(In Accordance with Article 39 of the Agreement)

For Applicants to the Barbados Scheme Only[1]

CARICOM 8A

1. NAME OF EXAMINING _____
2. ADDRESS OF EXAMINING _____
3. DETAILS OF PERIODS WORKED BY CLAIMANT/DECEASED _____

1 COUNTRY	2 SOCIAL SECURITY NUMBER	3 PERIODS WORKED (YEARS) FROM	TO	4 NUMBER OF WEEKS WORKED	5 INSURABLE EARNINGS	6 NOTIONAL AMOUNT	7 ACTUAL AMOUNT	8 REMARKS (OFFICIAL STAMP)
	TOTAL							

Notes: [1] **Barbados requires breakdown of No. of weeks worked and Insurable Earnings on an annual basis.**
Please complete page 2 if Claimant/Deceased Person worked more than one (1) year in your country.

This form should be completed and returned to the Examining Institution within one month of the date of receipt.

OFFICIAL STAMP

Prepared by:
Name: _____
Signature: _____
Designation: _____
Date: ____ ____ ____ (YYYY) ____ (MM) ____ (DD)

Certified by:
Name: _____
Signature: _____
Designation: _____
Date: ____ ____ ____ (YYYY) ____ (MM) ____ (DD)

CARICOM AGREEMENT ON SOCIAL SECURITY

DETAILS OF INSURANCE PERIODS COMPLETED BY CLAIMANT/DECEASED PERSON

(In accordance with Article 39 of the Agreement)

For Applicants to the Barbados Scheme Only

YEAR	NUMBER OF WEEKS WORKED	INSURABLE EARNINGS
TOTAL		

CARICOM AGREEMENT ON SOCIAL SECURITY

CARICOM 6

CERTIFICATE OF DEPENDENCY

(In Accordance with Article 36 of the Agreement)

1. NAME OF CERTIFYING INSTITUTION: ______________________________

2. NAME OF CLAIMANT: ______________________________
   SURNAME OTHER NAME(S)

3. ADDRESS OF CLAIMANT: ______________________________

   ____

4. DETAILS OF DEPENDANTS RESIDING IN THE TERRITORY OF ANOTHER CONTRACTING PARTY

NAME OF DEPENDENT	RESIDENTIAL ADDRESS	DATE OF BIRTH			REMARKS (NAME OF SCHOOL ATTENDING)
		YYYY	MM	DD	

OFFICIAL STAMP

OFFICIAL STAMP

OFFICIAL STAMP

5. PREPARED BY:

NAME: ______________________________

SIGNATURE: ______________________________

DESIGNATION: ______________________________

DATE: | | | | | | | | |
YYYY MM DD

6. CERTIFIED BY:

NAME: ______________________________

SIGNATURE: ______________________________

DESIGNATION: ______________________________

DATE: | | | | | | | | |
YYYY MM DD

CARICOM AGREEMENT ON SOCIAL SECURITY

APPLICATION FOR INDUSTRIAL DEATH BENEFIT

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 Requirement 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)

4. ADDRESS: _____
(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)*

5d. WORKS NUMBER *(WHERE APPLICABLE)*

8. TELEPHONE NUMBER:

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

10. MOTHER'S MAIDEN NAME: _____
SURNAME OTHER NAME(S)

11. MARITAL STATUS: (TICK APPROPRIATE BOX)

11.1 ☐ SINGLE 11.2 ☐ MARRIED 11.3 ☐ WIDOWED

11.4 ☐ DIVORCED 11.5 ☐ COMMON-LAW

12. RELATIONSHIIP TO

12.1 ☐ WIDOW 12.2 ☐ WIDOWER

12.3 ☐ CHILD 12.4 ☐ PARENT

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

SECTION "A" PARTICULARS OF DECEASED

13. COUNTRY OF PERMANENT RESIDENCE: _____

14. NAME: _____
SURNAME OTHER NAME(S)

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

16. ADDRESS: _____
(STREET)

_____
(CITY/DISTRICT/COUNTY) (COUNTRY)

17a .NATIONAL INSURANCE/ SOCIAL SECURITY NUMBER*

17b. COUNTRY: _____

18. COUNTRY OF BIRTH: _____

17c. NATIONAL REGISTRATION NUMBER *(WHERE APPLICABLE)*

17d. WORKS NUMBER *(WHERE APPLICABLE)*

19. DATE OF BIRTH:
YYYY MM DD

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

21. MOTHER'S NAME: _____
SURNAME OTHER NAME(S)

22. DATE OF DEATH:
YYYY MM DD

23. MARITAL STATUS OF DECEASED:
TICK APPROPRIATE BOX

23.1 SINGLE ☐

23.2 MARRIED ☐ YYYY MM DD

23.3 WIDOWED ☐ YYYY MM DD

23.4 DIVORCED ☐ YYYY MM DD

23.5 COMMON-LAW ☐ YYYY MM DD

24. DATE OF ACCIDENT:
YYYY MM DD

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

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	AT SCHOOL 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 FROM YY	MM	DD	TO YY	MM	DD	NATIONAL INSURANCE/ SOCIAL SECURITY NUMBER	ADDRESS OF EMPLOYER

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 coiuntry in which you are residlng.

ACKNOWLEDGEMENT OF CLAIM

Dear Sir/Madam,

Acknowqledgement 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.

10/99

CARICOM AGREEMENT ON SOCIAL SECURITY

CARICOM 4

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 YYYY	MM	DD	TO YYYY	MM	DD

28b. AS A SELF EMPLOYED PERSON

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

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.

29.1 SIGNATURE OF CLAIMANT

_____

DATE: | | | | | | | | |
YYYY MM DD

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: _____

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.

12/99

CARICOM AGREEMENT ON SOCIAL SECURITY

CARICOM 2

APPLICATION FOR INVALIDITY 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)

4. ADDRESS: _____

_____

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: ☐ FEMALE ☐ MALE

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

SECTION "B" - PARTICULARS OF LAST EMPLOYMENT

13. NAME OF LAST EMPLOYER: _____

14. ADDRESS OF LAST EMPLOYER: _____
(STREET)

_____
(CITY/DISTRICT/COUNTY) (COUNTRY)

DATE

YYYY MM DD

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

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.

08/01

CARICOM AGREEMENT ON SOCIAL SECURITY

CARICOM 7

NOTIFICATION OF CLAIM RECEIVED

(In Accordance with Article 38 of the Agreement)

1. NAME OF CLAIMANT: _____
   SURNAME OTHER NAME(S)

2. NATIONAL INSURANCE/SOCIAL SECURITY NUMBER* | | | | | | | | | | | | |

   NATIONAL REGISTRATION NUMBER *(WHERE APPLICABLE)* | | | | | | | | | | | | |

   WORKS NUMBER *(WHERE APPLICABLE)* | | | | | | |

3. RESIDENTIAL ADDRESS : _____

   _____

4. PERIOD WORKED IN YOUR COUNTRY

   FROM: | | | | | | | | TO | | | | | | | |
   YYYY MM DD YYYY MM DD

5. NAME OF EMPLOYER: _____

6. EMPLOYER REGISTRATION NUMBER: _____

7. TYPE OF CLAIM RECEIVED: _____

8. DATE CLAIM RECEIVED: | | | | | | | |
   YYYY MM DD

9. CLAIMANT WAS IN RECEIPT OF: _____

   Please indicate period of receipt | | | | | | | | to | | | | | | | |
   YYYY MM DD YYYY MM DD

PREPARED BY:

NAME: _____

SIGNATURE: _____

DESIGNATION: _____

DATE: | | | | | | | |
YYYY MM DD

CERTIFIED BY:

NAME: _____

SIGNATURE: _____

DESIGNATION: _____

DATE: | | | | | | | |
YYYY MM DD

OFFICIAL STAMP

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

10/99

CARICOM AGREEMENT ON SOCIAL SECURITY

CARICOM 1

APPLICATION FOR RETIREMENT/AGE 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)

4. ADDRESS: _____

_____

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: ☐ FEMALE ☐ MALE

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

SECTION "B" - PARTICULARS OF SPOUSE

13. NAME OF SPOUSE: _____
SURNAME OTHER NAME(S)

14. ADDRESS: _____
(STREET)

_____
(CITY/DISTRICT/COUNTY) (COUNTRY)

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

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 YYYY MM DD	TO YYYY MM DD

18b. **AS A SELF EMPLOYED PERSON**

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

* 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.

12/99

CARICOM AGREEMENT ON SOCIAL SECURITY

CARICOM 3

APPLICATION FOR SURVIVORS' 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)

4. ADDRESS: _____
(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. FATHER'S NAME: _____
SURNAME OTHER NAME(S)

10. MOTHER'S MAIDEN NAME: _____
SURNAME OTHER NAME(S)

11. MARITAL STATUS:
(TICK APPROPRIATE BOX)

11.1 SINGLE ☐

11.2 MARRIED ☐ YYYY MM DD

11.3 WIDOWED ☐ YYYY MM DD

11.4 DIVORCED ☐ YYYY MM DD

11.5 COMMON-LAW ☐ YYYY MM DD

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

SECTION "A" - PARTICULARS OF CLAIMANT (CONT'D)

12. RELATIONSHIP TO DECEASED: 12.1 ☐ WIDOW 12.2 ☐ WIDOWER

12.3 ☐ CHILD 12.4 ☐ PARENT

SECTION "B"- PARTICULARS OF DECEASED

13. COUNTRY OF PERMANENT RESIDENCE: _____

14. NAME: _____
SURNAME OTHER NAME(S)

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

16. ADDRESS: _____
(STREET)

_____
(CITY/DISTRICT/COUNTY) (COUNTRY)

17a .NATIONAL INSURANCE/ SOCIAL SECURITY NUMBER *

17b. COUNTRY: _____

18. COUNTRY OF BIRTH: _____

17c. NATIONAL REGISTRATION NUMBER *(WHERE APPLICABLE)*

17d. WORKS NUMBER *(WHERE APPLICABLE)*

19. DATE OF BIRTH:
YYYY MM DD

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

21. MOTHER'S NAME: _____
SURNAME OTHER NAME(S)

22. DATE OF DEATH:
YYYY MM DD

23. MARITAL STATUS OF DECEASED:
(TICK APPROPRIATE BOX)

23.1 SINGLE ☐

23.2 MARRIED ☐ YYYY MM DD

23.3 WIDOWED ☐ YYYY MM DD

23.4 DIVORCED ☐ YYYY MM DD

23.5 COMMON-LAW ☐ YYYY MM DD

24. Type of benefit deceased received or was entitled to prior to death _____

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

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 YYYY	MM	DD	RELATIONSHIP TO DECEASED	AT SCHOOL 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 _____ $ AMOUNT

40. Is widower incapacitated for work? ☐ Yes ☐ No

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.