National Insurance Scheme

CLAIM FOR SURVIVOR'S BENEFIT

Fill In The Information Below

Deceased Information

Surname

First Name

Other Names

N.I.S #

Date of Death YYYY MM DD

Address

Street

Parish / State

Country

Gender [ ] Male [ ] Female

Claimant Information - Widow / Widower

Surname

First Name

Other Names

N.I.S #

Date of Birth YYYY MM DD

Address

Street

Parish / State

Country

Telephone Number

Home

Mobile

Work

Date of Marriage YYYY MM DD

Please state:

Were you living with the deceased at the time of death? [ ] Yes [ ] No

If yes, state for how long [ ] Years [ ] Months

Are you married to someone else? [ ] Yes [ ] No

Did the deceased have a surviving wife/husband? [ ] Yes [ ] No

Are You an Invalid? [ ] Yes [ ] No

If Yes please attach a Certificate from a Registered Medical Practitioner

Are you receiving a benefit presently? [ ] Yes [ ] No

(if yes, please state which one).....

FORM SUR 1 REVISED 2008

National Insurance Scheme, P.O. Box 322, Melville Street, St. George's
Telephone Nos.: (473) 440-3309/3375 Fax: (473) 440-6636
Email: cservice@nisgrenada.org - Web address: www.nisgrenada.org

Give a list of all employers for whom the deceased worked since April 1983:

NAME OF EMPLOYER	YEAR OR PERIOD WORKED

If applicable, please state name and address of estates worked on from 1970 to 1983

NAME OF ESTATE	ADDRESS	PERIOD WORKED

If the deceased worked in any other country, please state:

NAME OF COUNTRY	NIS/S.S. NUMBER	PERIOD WORKED

Banking Information

Name of Bank | | | | | | | | | | | PARISH | | | | | | | | | | |

Account Number | | | | | | | | | | |

I hereby declare that the information given is true and correct.

Claimant's Signature or Mark..... Date: .....

Signature of Witness to Mark..... Date: .....

(where claimant cannot sign)

Please note that if any person claiming this benefit is physically or mentally challenged (an Invalid), it must be accompanied by a Doctor's Certificate.

If there are any children up to age 16 or still in school up to age 18, please fill the other side of this form.

CLAIM FOR SURVIVORS BENEFIT: CHILDREN

This Benefit is Payable to all children, including those who have been legally adopted.

1. How many children are being claimed for?
2. Are you the legal guardian? [ ] Yes [ ] No, if no state who……..
3. The child/children are: [ ] Legitimate [ ] Step[ ] Adopted
4. Are both parents deceased? [ ] Yes [ ] No
5. Please give the status of children being claimed for, e.g. Legitimate, Step or Adopted. **In the case of Adopted children, the supporting document must be submitted. In all cases, Birth Certificates must be submitted.**
6. (continued on next page)

NAME	SCHOOL	GENDER		DATE OF BIRTH	CLAIM NO.
		Male	Female		

Other than the child/children stated previously, did the deceased person have any other child/children who may be entitled to claim? [ ]Yes [ ] No

If yes, please state Name(s) and Address:

_____

_____

_____

Name (PRINT)……. Relationship:……

Address:……...

Signature of person making the claim:……..……..

Witness: ……

Date: ……

CLAIM FOR SURVIVORS BENEFIT: DEPENDANT PARENT(S)

INFORMATION ABOUT DEPENDANT PARENT(S) OF THE DECEASED INSURED PERSON

Name of person making claim:……

Address:……

Date of Birth:…….. Relationship to Deceased:……..

At the time of death were you residing at his/her home? Yes [ ] No [ ]

Were you wholly/mainly maintained by the deceased? Yes [ ] No [ ]

Are you in receipt of income from any other source?.....

Please state:……..……

I declare that I am a dependant parent of the deceased.

Signature of Claimant_____ Date_____

Signature of Witness_____ Date_____

Warning: Any person who knowingly makes any false statement or representation for the purpose of obtaining benefit commits a criminal offence punishable by fine or imprisonment or both.