NATIONAL INSURANCE SCHEME
P.O. Box 322, Melville Street, St. George's, Grenada W.I.
Telephone Nos.: (473) 440-3309/6647 Fax: (473) 440-6636
Email: cservice@nisgrenada.org - Web address: www.nisgrenada.org
National Insurance Act Chapter 205 of 1990

Claim for Disablement Benefit Form

To be completed by Applicant

PART A - Personal information

Insured name (Surname, First Name, Middle Initials) …….	……..-…… NIS Number
Address: ……... ……... Tel # …… SEX ……... e-mail address:……..…… [ ] Male [ ] Female Marital Status [ ] Separated [ ] Common Law [ ] Divorced [ ] Married [ ] Single	

In support of my application, I attach hereto the original of my Birth Certificate/Passport as proof of age:

Date of Birth: _____/_____/_____
D M Y
Also attached is the original or Certified Copy of my marriage certificate as proof of marriage.

Answer the following questions:

1. What is the date of the accident or the development of the prescribed disease in respect of which you are claiming disablement benefit?……..
2. State in what way you are disabled as a result of the accident/disease:……..
   ……
3. Are you fit enough to travel if you are required to attend for medical examination? YES [ ] NO [ ]
4. Have you attended a hospital for treatment of the injury/disease? YES [ ] NO [ ]
   If YES, please complete the following:

Name of Hospital	**State whether as In-patient or Out-patient**	**Hospital admission #**	**Period of Treatment**	
			From	**To**

Were any X-rays taken? YES [ ] NO [ ]

I declare that to the best of my knowledge and belief, the information given above is true and complete. I claim disablement benefit accordingly.

Signature:……. Date:……

I hereby authorize the above named institution to provide the Executive Director of National Insurance with my medical records in respect of my claim.

……
Signature or mark of Claimant

If you have worked in any other country, please state:……NIS/SS Number……
If you qualify for this benefit, it will be paid into your bank account. Please state:
Name of Bank……Parish …… Account No……..……

(WARNING: TO GIVE FALSE INFORMATION MAY RESULT IN PROSECUTION)

Witness to mark where the claimant cannot sign

Name: ……

Address: ……

……

Occupation: ……

Signature: …… Date……./……./……

Report Of Medical Assessment For Disablement Benefit
To Be Completed By A Registered Medical Practitioner

Examination for Disablement benefit should be performed after the end of the Injury Benefit period in accordance with National Insurance Employment Injury benefit Regulations SRO. 7 of 1998, second schedule for prescribed degrees of disablement. A provisional assessment for a period not less that thirteen (13) weeks is allowed, to be followed by a final assessment. If the space for the description of the injury/disease is not adequate you may submit a report attached to this form.

To: Mrs./Ms./Mr……

I certify that I have examined you today and that in my opinion you have suffered (please state the percentage) …….% loss or mental/physical faculty by reason of Employment Injury/Occupational Disease) described medically as……..……

……..……

……..……

……..……

……..……

……..……

……..……

and are expected to suffer relevant loss of faculty for (please select) ……. Weeks/Months/Years/Life which is my provisional/final assessment.

Name of Medical Practitioner ……..…
(in BLOCK LETTERS)

Signature and Stamp …… Date ……

Any other remarks ……

……..……

……..……

……..…

……..

For Official Use Only

Application No: ……..…..

Date Received: ……...

Benefit Type: ……...

National Insurance Scheme
P.O. Box 322, Melville Street, St. George's, W.I.
Tel # (473) 440 3309 Fax # (473) 440 6636