The National Insurance Board of Trinidad and Tobago

F-IOP-NI12

Maternity Benefit Application

INSTRUCTIONS

1. Please complete in CAPITAL letters.
2. Please complete in black or blue ink. The use of correction fluid is prohibited
3. The Application must be submitted within three (3) months of the date of Delivery.

FOR OFFICIAL USE

Local Office No.

Claim No.

SECTION "A" - TO BE COMPLETED BY APPLICANT

1. NAME: SURNAME OTHER NAME(S)

2. HOME ADDRESS: STREET

CITY/DISTRICT/COUNTY

3. *POSTAL ADDRESS (If different from above): STREET

CITY/DISTRICT/COUNTY

4. VALID IDENTIFICATION DOCUMENT: (Tick appropriate box) (Present original and copy of ID)

☐ ELECTORAL IDENTIFICATION CARD ☐ PASSPORT ☐ DRIVER'S PERMIT NUMBER:

5. NATIONAL INSURANCE NO.: 6. DATE OF BIRTH : y y y y m m d d

7. EMAIL ADDRESS: _____

8. WAS EVIDENCE OF DATE OF BIRTH PREVIOUSLY SUBMITTED? ☐ YES ☐ NO
(If "No", submit Birth Certificate, Passport or Affidavit with this application.)

9. TELEPHONE NO.: – (Home) – (Office/Work) – (Cellular)

10. HAVE YOU CHANGED YOUR NAME OR MARITAL STATUS SINCE REGISTRATION?: ☐ YES ☐ NO
(If "Yes", submit Marriage Certificate or Deed Poll.)

11. OCCUPATION:

12. BUSINESS NAME OF EMPLOYER:

13. *EMPLOYER'S ADDRESS: STREET

CITY/DISTRICT/COUNTY

14. NAME OF ACTUAL PLACE OF WORK:
(e.g. School/Department/Division)

15. ADDRESS OF ACTUAL PLACE OF WORK: STREET

CITY/DISTRICT/COUNTY

16. ARE YOU CURRENTLY EMPLOYED ELSEWHERE?: ☐ YES ☐ NO
(If "YES", state Business Name and Address of other employer.)

BUSINESS NAME OF EMPLOYER:

EMPLOYER'S ADDRESS : STREET

CITY/DISTRICT/COUNTY

*EXAMPLE: Light Pole No. 8, Southern Main Road, Couva or Near Bertie's Parlour, Industry Lane, Belmont

SECTION "A" - TO BE COMPLETED BY APPLICANT (Cont'd)

17. LAST DATE WORKED: | | | | | | | | | | y y y y m m d d

PERIOD OF ABSENCE: | | | | | | | | | | y y y y m m d d **TO** | | | | | | | | | | y y y y m m d d

18. PLEASE INDICATE THE METHOD OF PAYMENT OF BENEFIT:

MAIL TO: ☐ **POSTAL ADDRESS** **DEPOSIT TO:** ☐ **FINANCIAL INSTITUTION**

FINANCIAL INFORMATION

(If method of payment is "Financial Institution", complete below.)

The NIBTT considers the foregoing information as instructions from you regarding the deposit of your benefit payment to the financial institution of your choice.

The NIBTT is not liable for any payment issued to an inaccurate financial institution or account based on these instructions.

NAME OF FINANCIAL INSTITUTION:

ADDRESS OF FINANCIAL INSTITUTION:

STREET

CITY/DISTRICT/COUNTY

ACCOUNT NUMBER:

National Insurance (Benefits) Regulation 23 states an insured person shall be disqualified from receiving maternity benefit, if during the period when such benefit is payable she engages in any work for which remuneration is or would ordinarily be payable.

DECLARATION

I declare that to the best of my knowledge and belief the information given by me is true and correct and I am aware that if there is any statement in this declaration which is false in fact or which I know or believe to be false or do not believe to be true, I am liable on summary conviction to a fine of three thousand dollars ($3,000.00) and to imprisonment for two years in accordance with Sect 33, NI Act Chap 32:01.

I hereby give permission to The National Insurance Board of Trinidad & Tobago to update my registration information from this form.

SIGNATURE OF WITNESS TO CLAIMANT

DATE : | | | | | | | | | y y y y m m d d

APPLICATION SUBMITTED BY THIRD PARTY (Person other than Claimant)

I **CLAIMANT'S SURNAME** **CLAIMANT'S OTHER NAME(S)** ***hereby authorize***

SURNAME **OTHER NAME(S)** ***to submit this claim***

on my behalf.

Third Party must present a valid form of National Identification and provide contact information in order to submit claim (Present original and copy of ID)

VALID IDENTIFICATION DOCUMENT: (Tick appropriate box)

☐ **ELECTORAL IDENTIFICATION CARD** ☐ **PASSPORT** ☐ **DRIVER'S PERMIT** **NUMBER:**

TELEPHONE NO.: | | | | – | | | | | **(HOME)** | | | | – | | | | | **(OFFICE/WORK)** | | | | – | | | | | **(CELLULAR)**

RELATIONSHIP TO CLAIMANT:

SIGNATURE OF WITNESS TO CLAIMANT

DATE : | | | | | | | | | y y y y m m d d

SIGNATURE OF WITNESS TO THIRD PARTY

DATE : | | | | | | | | | y y y y m m d d

PARTICULARS OF WITNESS TO MARK (Where Claimant/Third Party Cannot Sign)

NAME: SURNAME OTHER NAME(S)

ADDRESS: STREET

CITY/DISTRICT/COUNTY

OCCUPATION:

VALID IDENTIFICATION DOCUMENT: (Tick appropriate box) (Present original and copy of ID)

☐ ELECTORAL IDENTIFICATION CARD ☐ PASSPORT ☐ DRIVER'S PERMIT NUMBER:

SIGNATURE OF WITNESS TO MARK

DATE : y y y y m m d d

SECTION "B" - TO BE COMPLETED BY A REGISTERED MEDICAL PRACTITIONER OR MIDWIFE

CERTIFICATE OF EXPECTED/ACTUAL DELIVERY

To be completed not earlier than the 11th week prior to the expected date of delivery.

I hereby certify that Miss/Mrs. SURNAME OTHER NAME(S)

was examined by me on y y y y m m d d Expected/Actual date of delivery is/was y y y y m m d d

Is Pregnancy at least 26 weeks old at the Date of Examination? ☐ Yes ☐ No

OR

Did Delivery result in the birth of a living child or children ☐ Yes ☐ No

If "Yes"

(i) State number of children _____
Words and Figures

NAME OF MEDICAL PRACTITIONER/MIDWIFE: SURNAME OTHER NAME(S)

OFFICE ADDRESS OF MEDICAL PRACTITIONER/MIDWIFE: STREET

CITY/DISTRICT/COUNTY

REGISTRATION NUMBER OF MEDICAL PRACTITIONER/ MIDWIFE: TELEPHONE NO.: –

I declare that to the best of my knowledge and belief the information given by me is true and correct and I am aware that if there is any statement in this declaration which is false in fact or which I know or believe to be false or do not believe to be true, I am liable on summary conviction to a fine of three thousand dollars ($3,000.00) and to imprisonment for two years in accordance with Sect 33, NI Act Chap 32:01.

STAMP

SIGNATURE OF MEDICAL PRACTITIONER/MIDWIFE

DATE: y y y y m m d d

INSTRUCTIONS FOR COMPLETION OF QUESTIONS 4(a) TO 6

(i) (a) In completing Question 4(a) refer to expected/actual date of delivery in SECTION "B".

(b) Check 6 weeks before the expected/actual week of delivery and enter date at 4 (b).

(c) Complete item 5, Table IA, colums (a), (b), (c) for the 13 weeks period prior to the week established at 4 (b).

(ii) In completing Table IA determine weekly earnings as follows:

(a) Where pay frequency is monthly: $\frac{\text{Monthly Earnings x 3}}{13}$ $\frac{\text{e.g. \$800 x 3}}{13}$ = \$184.62 (weekly) OR;

(b) Where pay frequency is fortnightly: $\frac{\text{Fortnightly Earnings}}{2}$ $\frac{\text{e.g. \$200}}{2}$ = \$100.00 (weekly)

SECTION "C" - TO BE COMPLETED BY EMPLOYER

1. EMPLOYER'S NAME:

REGISTRATION NO.: **TELEPHONE NO.:** –

***2. THIS IS TO CERTIFY THAT MISS/MRS:**

SURNAME OTHER NAME(S)

HAS BEEN ABESNT FROM WORK EFFEVTIVE **TO** **ON MATERNITY LEAVE.**

y y y y m m d d y y y y m m d d

(*Please refer to Table of Absence, IB, at question (6).)

3. APPLICANT IS: ☐ **Still Employed** ☐ **No Longer Employed**

Date of Separation

y y y y m m d d

If "No Longer Employed" state reason(s). _____

_____

4. (a) EXPECTED WEEK OF DELIVERY BEGINS MONDAY:

y y y y m m d d

(b) SIXTH WEEK BEFORE EXPECTED DATE OF DELIVERY BEGINS MONDAY.

y y y y m m d d

6.

TABLE IB

PERIOD OF ABSENCE						
TYPE OF LEAVE	FROM			TO		
	yyyy	mm	dd	yyyy	mm	dd

TABLE IA
5. WEEKLY RATE OF PAY

State Weekly Rates of Pay for the 13 week period BEFORE the week as calculated at 4(b) in section C.

(a) WK NO.	(b) Date			(c) Actual Earnings	
	yyyy	mm	dd	$	¢
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
Total					

SECTION "C" - TO BE COMPLETED BY EMPLOYER (Cont'd)

EMPLOYER'S DECLARATION

I declare that to the best of my knowledge and belief the information given by me is true and correct and I am aware that if there is any statement in this declaration which is false in fact or which I know or believe to be false or do not believe to be true, I am liable on summary conviction to a fine of three thousand dollars ($3,000.00) and to imprisonment for two years in accordance with Sect 33, NI Act Chap 32:01.

NAME: SURNAME OTHER NAME(S)

POSITION:

SIGNATURE

COMPANY STAMP (If any)

DATE : y y y y m m d d

SECTION "D" - FOR OFFICIAL USE

APPLICATION RECEIVED BY:

NAME: SURNAME OTHER NAME(S)

SIGNATURE OF SERVICE CENTRE STAFF

SERVICE CENTRE STAMP

DATE : y y y y m m d d

PART I - CUSTOMER SERVICE REPRESENTATIVE

1. Name, N.I. No. and Date of Birth Confirmed and Updated (If Necessary) On I.A. System? ☐ Yes ☐ No
2. Registration Record Compl ete? (If "No" complete forms NI 165/NI 182 as applicable) ☐ Yes ☐ No
3. Check for Duplicate Registration (SIRF file included)? (Record Result on Minute Sheet) ☐ Yes ☐ No
4. Claim History Viewed? ☐ Yes ☐ No
   (If yes, record findings here.) _____
   (Use minute sheet if this space is inadequate.)
5. Application Completed and Accepted for Processing? ☐ Yes ☐ No
6. Application Recorded? (Print and attach Claim Profile) ☐ Yes ☐ No
7. Contribution Recorded and Transferred? (Print and attach Audit Report) ☐ Yes ☐ No
8. Application Processed? ☐ Yes ☐ No

CUSTOMER SERVICE REPRESENTATIVE

DATE : y y y y m m d d