NI 12

THE NATIONAL INSURANCE BOARD
MATERNITY BENEFIT APPLICATION

(PLEASE USE BLOCK/CAPITALS)

(FOR OFFICIAL USE)
CLAIM NO:
SERVICE CENTRE CODE:

NOTE: **The Application must be submitted within three (3) months of the date of Delivery.**

SECTION "A" - TO BE COMPLETED BY APPLICANT

1. NAME: SURNAME OTHER NAME

2. HOME ADDRESS: (STREET) (CITY/DISTRICT/COUNTY)

3. *POSTAL ADDRESS (if different from above): (STREET) (CITY/DISTRICT/COUNTY)

4. NATIONAL INSURANCE NO.:

5. DATE OF BIRTH: YYYY MM DD

6. WAS EVIDENCE OF DATE OF BIRTH PREVIOUSLY SUBMITTED? ☐ YES ☐ NO
If "NO", submit Birth Certificate or Passport with this application.

7. TELEPHONE NUMBERS: (HOME) (OFFICE/WORK) (CELLULAR)

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

9. OCCUPATION:

10. EMPLOYER'S NAME:

11. *EMPLOYER'S ADDRESS: (STREET) (CITY/DISTRICT/COUNTY)

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

13. ADDRESS OF ACTUAL PLACE OF WORK: (STREET) (CITY/DISTRICT/COUNTY)

14. 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)

15. LAST DATE WORKED: YYYY MM DD

PERIOD OF ABSENCE: YYYY MM DD TO YYYY MM DD

16. 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) Regulations 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 NIBTT to update the information from this form.

SIGNATURE OR MARK OF CLAIMANT

DATE: YYYY MM DD

PARTICULARS OF WITNESS TO MARK (Where Claimant Cannot Sign)

NAME: SURNAME OTHER NAME(S)

ADDRESS: (STREET)

(CITY/DISTRICT/COUNTY)

VALID IDENTIFICATION: (Tick appropriate box)

☐ PASSPORT

☐ DRIVER'S PERMIT

☐ ELECTORAL I.D.

OCCUPATION:

NUMBER:

SIGNATURE OF WITNESS TO MARK

DATE: YYYY MM DD

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 _____ . Expected/Actual date of delivery is/was _____
YYYY MM DD YYYY MM DD

Is Pregnancy at least 26 weeks old at the Date of Examination? ☐ YES ☐ NO

OR

Did Delivery result in the birth of living 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: _____ TELEPHONE NUMBER: _____

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: _____
YYYY MM DD

SECTION "C" - TO BE COMPLETED BY THE EMPLOYER

INSTRUCTIONS FOR COMPLETION OF QUESTIONS 4(a) TO 5(c)

(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, columns (a),(b),(c) for the 13 week period prior to the week established at 4 (b).

(ii) In completingTable 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;

(a) 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 THE EMPLOYER (CONT'D)

1. EMPLOYER'S NAME:

REGISTRATION NO: -- TELEPHONE NUMBER --

*2. This is to certify that Miss/Mrs SURNAME OTHER NAME(S)

has been absent from work effective YYYY MM DD to YYYY MM DD on maternity leave.

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

3. Applicant is ☐ still employed ☐ no longer employed.

DATE OF SEPARATION YYYY MM DD

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

4. (a) Expected Week of delivery begins Monday: YYYY MM DD

(b) Sixth week before expected date of delivery begins Monday: YYYY MM DD

6. **TABLE IB**

PERIOD OF ABSENCE						
TYPE OF LEAVE	FROM			TO		
	YYYY	MM	DD	YYYY	MM	DD

5. **TABLE IA**
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	$	c
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
Total					

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:

COMPANY STAMP (If any)

SIGNATURE

DATE: YYYY MM DD

SECTION "D" - FOR OFFICIAL USE

APPLICATION RECEIVED BY:

NAME: ________________ ________________

SURNAME OTHER NAME(S)

SIGNATURE OF SERVICE CENTRE STAFF

SERVICE CENTRE STAMP

DATE: YYYY MM DD

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 COMPLETE? (If "NO" complete forms NI 165/NI 182 as applicable) ☐ YES ☐ NO
3. CHECK FOR DUPLICATE REGISTRATION (SIRF file included)? (Record Results 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: YYYY MM DD