THE NATIONAL INSURANCE BOARD

NI 117

APPLICATION FOR DEATH BENEFIT

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

NOTE: 1. Please read instructions on Page 7 carefully before completing this form.

2. This Application must be submitted within twelve (12) months of the Date of Death of the Insured Person.

SECTION "A" - PARTICULARS OF DECEASED INSURED PERSON

1. NAME: SURNAME / OTHER NAME(S)

2. *LAST ADDRESS: (STREET) / (CITY/DISTRICT/COUNTY)

3. NATIONAL INSURANCE NO.:

4. SEX: ☐ MALE ☐ FEMALE

5. DATE OF BIRTH YYYY MM DD

6. DATE OF DEATH YYYY MM DD

7. DATE OF ACCIDENT: YYYY MM DD

8. LAST DATE WORKED: YYYY MM DD

9. TIME OF ACCIDENT ____________ am/pm

10. NAME AND ADDRESS OF LAST EMPLOYER:
(State exact location e.g. School/Division/Department):
(STREET)
(CITY/DISTRICT/COUNTY)

11. WAS DECEASED IN RECEIPT OF ANY BENEFIT AT THE DATE OF DEATH? ☐ YES ☐ NO ☐ NOT KNOWN
If "YES", please state the type of benefit and the Service Centre at which claimed:
BENEFIT TYPE: ____________ SERVICE CENTRE: ____________

SECTION "B" - PARTICULARS OF APPLICANT

1. NAME: SURNAME / OTHER NAME(S)

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

3. NATIONAL INSURANCE NO.

4. POSTAL ADDRESS: (STREET) / (CITY/DISTRICT/COUNTY)

5. TELEPHONE NO. ____ - ____

6. DATE OF BIRTH: YYYY MM DD

7. PRESENT MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

8. INDENTIFICATION:
☐ PASSPORT ☐ DRIVER'S PERMIT ☐ ELECTORAL I.D. I.D. NO.:

9. RELATIONSHIP TO DECEASED INSURED PERSON: ____________

10. PLEASE INDICATE THE BENEFIT(S) FOR WHICH YOU ARE APPLYING:
☐ WIDOW'S BENEFIT ☐ WIDOWER'S BENEFIT ☐ CHILD ALLOWANCE
☐ DEPENDENT PARENT'S PENSION

11. WAS AN APPLICATION FOR FUNERAL GRANT SUBMITTED? ☐ YES ☐ NO
If "NO", please submit Death Certificate with this form.

***Exact location, e.g. Light Pole No. 8, Southern Main Road, Couva or Near Bertie's Parlour, Industry Lane, Belmont.**

SECTION "B" - PARTICULARS OF APPLICANT CONT'D

12. Are you receiving a Survivor's or Death Benefit now? ☐ YES ☐ NO

If "YES", please provide the following information:

NAME OF DECEASED: ____________ SURNAME ____________ OTHER NAME(S)

NATIONAL INSURANCE NO. ____________

ADDRESS OF DECEASED WHILE ALIVE:

____________ (STREET)

____________ (CITY/DISTRICT/COUNTY)

RELATIONSHIP TO DECEASED: ____________

SERVICE CENTRE AT WHICH BENEFIT WAS CLAIMED? ____________

13. Please make Payment to: ☐ POSTAL ADDRESS ☐ FINANCIAL INSTITUTION

If Financial Institution is selected, what is:

ACCOUNT NUMBER: ____________

NAME OF FINANCIAL INSTITUTION: ____________

ADDRESS: ____________ (STREET)

____________ (CITY/DISTRICT/COUNTY)

SECTION "C" - PARTICULARS OF WIDOWS/WIDOWERS

N.B. THE NATIONAL INSURANCE ACT PROVIDES FOR THE PAYMENT OF BENEFIT TO COMMON-LAW SPOUSES OF DECEASED INSURED PERSONS.

1. Are you the Lawful spouse of the deceased? ☐ YES ☐ NO

   If "YES",please state the date of Marriage: ____ YYYY ____ MM ____ DD

2. If you were not married to the deceased insured please answer 2(a) to 2(e).

   (a) Please state your Marital Status (tick appropriate box)

   ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

   (b) Have you been nominated as the beneficiary by the deceased person? ☐ YES ☐ NO

   (c) How long have you lived together in the common-law union? ____________

   (d) Were the both of you living together in the relationship up to the time of his death? ☐ YES ☐ NO

   (e) Have you been nominated as the beneficiary by any other person? ☐ YES ☐ NO

   If "YES", please state the name and NI Number of that person.

   ____________ SURNAME ____________ OTHER NAME(S)

   NATIONAL INSURANCE NO. ____________

3. Were you pregnant at the date of your spouse's death? ☐ YES ☐ NO

   If "YES", please submit medical certificate.

* 4. Were you mentally or physically disabled at the date of your spouse's death? (Widowers only) ☐ YES ☐ NO

   If "YES", please submit NI 34 - Widow/Widower Benefit - Medical Report.

* 5. Were you wholly/mainly maintained by the deceased? ☐ YES ☐ NO

   (Applicable to widowers only)

   If "YES", please provide evidence of maintenance.

*** Applicable where date of death is prior to 01/03/2004.**

SECTION "D" - PARTICULARS OF CHILD/ORPHAN

1. Is/Are Child/Children in respect of whom Allowance is claimed?

   (a) The Child/Children of the deceased? ☐ YES ☐ NO

   (b) Maintained by you? ☐ YES ☐ NO

   (c) Living in your home? ☐ YES ☐ NO

   If the answer to (b) or (c) is "NO", give details of the Guardian/Institution responsible for their care.

   NAME OF GUARDIAN /INSTITUTION:

   ADDRESS OF GUARDIAN /INSTITUTION:

   (STREET)

   (CITY/DISTRICT/COUNTY)

2. Please indicate below, the particulars of the unmarried child/children. (Use additional sheets if necessary.)

   Where children are over the age of 16 years a letter from the named school must be provided.

NAME OF CHILD/ORPHAN		RELATIONSHIP TO DECEASED			DATE OF BIRTH			PLACE OF LEARNING	DISABLED
SURNAME	OTHER NAME(S)	CHILD	STEP CHILD	ADOPTED	YYYY	MM	DD		YES/NO

3. Are letter(s) from the place of learning attached? ☐ YES ☐ NO

   FOR PERSONS CLAIMING DEPENDENT PARENT BENEFIT ONLY.

   Were you wholly or mainly maintained by the deceased? ☐ YES ☐ NO

DECLARATION

I DECLARE THAT THE INFORMATION GIVEN ON THIS FORM IS TRUE AND CORRECT.

SIGNATURE OF CLAIMANT: ____________________ DATE: YYYY MM DD

WITNESS TO MARK WHERE CLAIMANT CANNOT SIGN:

NAME OF WITNESS: SURNAME OTHER NAME(S)

ADDRESS OF WITNESS:

(STREET)

(CITY/DISTRICT/COUNTY)

OCCUPATION OF WITNESS:

DATE: YYYY MM DD

SIGNATURE OF WITNESS: ____________________

I.D. NUMBER:

IDENTIFICATION TYPE: (Tick Appropriate Box)

☐ DRIVER PERMIT ☐ PASSPORT ☐ ELECTORAL I.D CARD

WARNING! It is an offence punishable by law to give false information.

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SECTION "E" - PARTICULARS OF EMPLOYER

This Section must be completed by the Employer before the application can be submitted to the Board.

1. NAME OF EMPLOYER:

2. TYPE OF BUSINESS:

3. EMPLOYER REG. NO.

4. TELEPHONE NO. -

5. This is to certify that Mr/Mrs/Miss ______ SURNAME ______ OTHER NAME(S)

was injured in a work related accident on ______ YYYY MM DD and died as a result of that accident on ______ YYYY MM DD.

6. Was deceased an unpaid apprentice? ☐ YES ☐ NO

7. State below the wages paid or payable in:

   (a) Week/Month prior to the week of the accident $

   (b) Week/Month in which the accident occured $

8. (a) Did accident occur during working hours? ☐ YES ☐ NO

   (b) Was employee engaged in his/her duties at the time of the accident? ☐ YES ☐ NO

   If "NO" to either (a) or (b), give details

9. Give details of the cause of the accident.

10. If accident took place while travelling, please complete the following:

    (a) Place of embarkation

    (b) Destination

    (c) Purpose of presence on the vehicle?

    (d) Was vehicle owned/rented by employer? ☐ YES ☐ NO

    If "NO", was the vehicle used by an arrangement with the employer? ☐ YES ☐ NO

11. Name and addresses of any witnesses to the accident.

12. Has the accident been recorded in the employer's accident book? ☐ YES ☐ NO

COMPANY STAMP (If any)

SIGNATURE OF EMPLOYER

DATE

YYYY MM DD

SECTION "F" - PROCESSING OF APPLICATION - (FOR OFFICIAL USE)

PART I - CUSTOMER SERVICE REPRESENTATIVE

1. Name, N.I. No. and Date of Birth of Deceased Insured person confirmed and updated on I.A. System? ☐ YES ☐ NO
2. Is Insured Person's Registration Record complete? (If "NO", complete Forms NI 4, NI 165 and NI 182 as applicable). ☐ YES ☐ NO
3. Check for Duplicate Registration completed? (SIRF included). (Please record your finding on minute sheet) ☐ YES ☐ NO
4. Registration Records updated? (If "NO", state reason). ☐ YES ☐ NO

____

5. Name of Person nominated as Beneficiary:

SURNAME | OTHER NAME(S)

6. I.A. System updated with Date of Death? ☐ YES ☐ NO
7. Claims history viewed? (Please record findings on minute sheet) ☐ YES ☐ NO
8. Application complete and acceptable for processing? ☐ YES ☐ NO
9. Application recorded? (Print and attach Claim Profile) ☐ YES ☐ NO

SIGNATURE OF CUSTOMER SERVICE REP.

DATE
YYYY MM DD

PART II -MANAGER SERVICE CENTRE

1. (a) If applicant is the Legal Widow, Widower, Child, Orphan, Dependent Parent proceed to Part V.

   (b) If applicant is the Common-Law Spouse and alternative evidence of nomination is received, forward to Manager Service Centre for acceptance.

   (c) If applicant is the nominated Common-Law Spouse forward to the Supervisor for further action at 2 below.

2. Forward Benefit Unit to Manager Corporate Communications for press publication.

   Date Benefit Unit forwarded: YYYY MM DD

   SIGNATURE OF MANAGER

3. If applicant is a Widower or a Disabled Widow/Child refer the Benefit Unit to the Medical Adviser.

   Date Benefit Unit forwarded: YYYY MM DD

   SIGNATURE OF MANAGER

SECTION "F" - PROCESSING OF APPLICATION - (FOR OFFICIAL USE) (Cont'd)

PART III - CORPORATE COMMUNICATIONS

1. Date of Final Press Publication [YYYY | MM | DD]

2. Forward the Benefit Unit to the Executive Director u.f.s. Executive Manager Insurance Operations after confirmation of the Final Press Publication.

Date Benefit Unit forwarded [YYYY | MM | DD]

____
SIGNATURE OF MANAGER
CORPORATE COMMUNICATIONS

PART IV - EXECUTIVE DIRECTOR

For the purpose of Death benefit I deem ______________________________ the Spouse of
CLAIMANT

______________________________ in accordance with Section 2 Sub Section 2 of the National Insurance Act
DECEASED INSURED PERSON

____
SIGNATURE OF EXECUTIVE DIRECTOR

DATE [YYYY | MM | DD]

PART V - SERVICE CENTRE - VALIDATION OF CLAIM

1. Claim Profile(s) verified? ☐ YES ☐ NO

2. Claim Validated? ☐ YES ☐ NO

____
SUPERVISOR/CLERICAL OFFICER II

DATE [YYYY | MM | DD]

NOTES

Documentary evidence required to support claim.

Boxes are to be ticked by Service Centre staff upon receipt of documentary evidence.

FOR OFFICIAL USE

1. LAWFUL SPOUSE - WIDOW

☐ (a) Death Certificate if not previously submitted.

☐ (b) Marriage Certificate.

☐ (c) Medical Certificate if pregnant at time of husband's death and child's Birth Certificate after delivery or Medical Report if child is still-born.

2. LAWFUL SPOUSE - WIDOWER

☐ (a) Marriage Certificate.

☐ * (b) Medical evidence to show the date from which inability to work due to illness commenced.

☐ * (c) Affidavit to show dependence on deceased.

3. COMMON-LAW UNION - WIDOW/WIDOWER

☐ (a) Evidence of period of co-habitation up to time of death of deceased and marital status of claimant.

☐ (b) Evidence of nomination.

☐ * (c) Medical Certificate if disabled. (Applicable to Widower only.)

☐ (d) Decree Absolute of Divorce where applicable.

☐ (e) Death Certificate of lawful spouse, if applicable.

☐ (f) Medical Certificate if pregnant at time of husband's death and child's birth certificate after delivery.

4. CHILD

☐ (a) Birth Certificate and supporting Affidavit where necessary.

☐ * (b) Evidence of education if child is between 16 - 19 yrs, i.e. letter signed by School Principal or Head of Organisation indicating the education and employment status of child.

☐ (c) Medical evidence if child is disabled to show date the disability commenced.

☐ (d) Statutory Declaration re step-child giving parents name, residence and dependence on deceased insured person.

☐ (e) Evidence of Adoption.

5. DEPENDENT PARENT

☐ (a) Birth Certificate of Deceased Insured Person.

☐ (b) Evidence of support e.g. Deed of Covenant, Affidavit or other acceptable evidence.

*** Applicable where date of death is prior to 01/03/2004.**