THE NATIONAL INSURANCE BOARD SPECIAL MATERNITY GRANT BENEFIT APPLICATION

(PLEASE USE BLOCK/CAPITALS)

Please read the notes at the back of this form CAREFULLY.

NOTE: This application must be submitted within three (3) months of the Date of Delivery.

This application must be completed on/after the date of delivery.

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

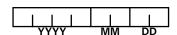
(
SECTION "A" - TO BE COMPLETED BY APPLICANT (MOTHER)
1. NAME: SURNAME OTHER NAME
2. HOME ADDRESS:
(STREET) (CITY/DISTRICT/COUNTY)
3. *POSTAL ADDRESS (if different from (STREET)
above): (CITY/DISTRICT/COUNTY)
4. NATIONAL INSURANCE NO.: 5. DATE OF BIRTH: YYYY MM DD
6. VALID IDENTIFICATION: BELECTORAL ID PASSPORT DRIVER'S PERMIT NUMBER:
7. MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED
If married, submit marriage certificate, otherwise see Notes.
8. TELEPHONE NUMBERS:
9. NAME OF FATHER OF CHILD: SURNAME OTHER NAME(S)
10. PLEASE INDICATE THE METHOD OF PAYMENT OF BENEFIT:
MAIL TO: 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:
(STREET)
(CITY/DISTRICT/COUNTY)
ACCOUNT NUMBER:

SECTION "A" - TO BE COMPLETED BY APPLICANT (MOTHER) (Cont'd)
11. ARE YOU PRESENTLY EMPLOYED? YES NO
(IF "YES", HAVE YOUR EMPLOYER COMPLETE SECTION C)
EMPLOYER'S NAME
EMPLOYER'S ADDRESS: (STREET)
(CITY/DISTRICT/COUNTY)
DECLARATION OF APPLICANT
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 APPLICANT DATE:
PARTICULARS OF WITNESS TO MARK (Where applicant cannot sign)
NAME:
SURNAME OTHER NAME(S)
ADDRESS: PASSPORT PASSPORT
VALID IDENTIFICATION: DRIVER'S PERMIT
(CITY/DISTRICT/COUNTY) (Tick appropriate box) ELECTORAL I.D.
OCCUPATION: NUMBER:
SIGNATURE OF WITNESS TO MARK DATE:

SECTION "B" - TO BE COMPLETED BY A REGISTERED MEDICAL PRACTITIONER OR MIDWIFE
CERTIFICATE OF ACTUAL DELIVERY
To be completed after delivery.
I hereby certify that Miss/Mrs.
SURNAME OTHER NAME(S)
was under my care for the delivery of her child/children. Her actual date of delivery was YYYY MM DD .
Did pregnancy last at least 26 weeks at the date of delivery?
Did Delivery result in the birth of a living child/children? If "YES" NO
(i) State number of children : —————
(Words and figures) NAME OF MEDICAL
PRACTITIONER /MIDWIFE: SURNAME OTHER NAME(S)
OFFICE
ADDRESS: LA
(CITY/DISTRICT/COUNTY)
REGISTRATION NUMBER OF TELEPHONE NUMBER: 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
DATE:
SIGNATURE OF MEDICAL PRACTITIONER /MIDWIFE YYYY MM DD
SECTION "C" - TO BE COMPLETED BY APPLICANT'S EMPLOYER
SECTION C - TO BE CONTILETED BY ATTEICANT S LIVII ESTEN
INSTRUCTIONS FOR COMPLETION OF QUESTIONS 5(a) TO 6
(i) (a) In completing Question 5(a) refer to actual date of delivery in SECTION "B".
(b) Check 6 weeks before the week of delivery and enter date at 5 (b).
(c) Complete item 6, Table IA, columns (a),(b),(c) for the 13 week period prior to the week established at 5 (b).
(ii) In completingTable IA determine weekly earnings as follows:
(a) Where pay frequency is monthly: Monthly Earnings x 3 e.g. \$800 x 3 = \$184.62 (weekly) OR;
(a) Where now frequency is fortnightly: Fortnightly Formings a.g. \$200
2 2 = \$100.00 (weekly)
1. EMPLOYER'S
NAME:
ADDRESS:
2. *EMPLOYER'S (STREET)
(CITY/DISTRICT/COUNTY)
3. TELEPHONE NUMBER: 4. REGISTRATION NUMBER:

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

5. (a) Actual Week of delivery began Monday:



(b) Sixth week before actual date of delivery began Monday:

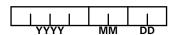


TABLE IA

State weekly Rates of Pay for the 13 week period BEFORE

6. WEEKLY RATE OF PAY

the week indicated as the actual Date of Delivery in Section 5(b).										
(a) WK		b) ATE		(c) ACTUAL EARNINGS						
NO.	YYYY	ММ	DD	\$	С					
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
Total										

FOR OFFICIAL USE ONLY							
WEEK	CLASS						
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							

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:		SURNAM	ΛE				ОТНІ	ER NA	ME			
POSITION:]							
				S	MPANY TAMP If any)	Y						
SIGNATURI	E						DAT	E: [I VYY	Y	MM] DD

SECTION "D" - TO BE COMPLETED BY THE FATHER OF THE CHILD
1. NAME: SURNAME OTHER NAME
2. HOME
ADDRESS: (STREET)
(CITY/DISTRICT/COUNTY)
3. *POSTAL ADDRESS (if
different from above):
(CITY/DISTRICT/COUNTY)
4. NATIONAL INSURANCE NO.: 5. DATE OF BIRTH: YYYY MM DD
6. VALID IDENTIFICATION: BELECTORAL ID PASSPORT DRIVER'S PERMIT NUMBER:
7. TELEPHONE NUMBERS:
(HOME) (OFFICE/WORK) (CELLULAR) 8. MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED
If married, submit marriage certificate, otherwise see Notes.
9. ARE YOU THE LAWFUL SPOUSE OF THE APPLICANT?
10. OCCUPATION:
11. EMPLOYER'S NAME:
12. *EMPLOYER'S ADDRESS:
(STREET)
(CITY/DISTRICT/COUNTY)
13. NAME OF ACTUAL PLACE OF WORK:
14. ADDRESS OF ACTUAL
PLACE OF WORK: e.g. School/Department
Division
15. 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. 08/2011

SECTION "D" - TO BE COMPLETED BY THE FATHER OF THE CHILD (Cont'd)									
DECLARATION OF FATHER									
SURNAME OTHER NAME(S) authorize usage of my									
contributions for the purpose of determining Special Maternity Grant on behalf of my spouse, SURNAME OTHER NAME(S)									
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.									
SIGNATURE OR MARK OF FATHER DATE:									
PARTICULARS OF WITNESS TO MARK (Where Father Cannot Sign)									
NAME: SURNAME OTHER NAME(S) ADDRESS:									
(STREET) (CITY/DISTRICT/COUNTRY) (CITY/DISTRICT/COUNTRY) (CITY/DISTRICT/COUNTRY) (Tick One Box) NUMBER: NUMBER:									
SIGNATURE OF WITNESS TO MARK DATE:									
SECTION "E" - TO BE COMPLETED BY FATHER'S EMPLOYER									
INSTRUCTIONS FOR COMPLETION OF QUESTIONS 5(a) TO 6									
(i) (a) In completing Question 5(a) refer to actual date of delivery in SECTION "B".									
(b) Check 6 weeks before the week of delivery and enter date at 5 (b).									
(c) Complete item 6, Table IA, columns (a),(b),(c) for the 13 week period prior to the week established at 5 (b).									
(ii) In completingTable IA determine weekly earnings as follows:									
(a) Where pay frequency is monthly: $\frac{\text{Monthly Earnings x 3}}{13} = \$184.62 \text{ (weekly)} \frac{\text{OR}}{3};$									
(a) Where pay frequency is fortnightly: $\frac{\text{Fortnightly Earnings}}{2} = \100.00 (weekly)									

S	SECTION "E" - TO BE COMPLETED BY FATHER'S EMPLOYER (Cont'd)												
	1. EMPLOYER'S												
	NAME:	-											
2.	2. *EMPLOYER'S ADDRESS: (STREET)												
	(CITY/DISTRICT/COUNTY)												
3.	3. TELEPHONE NUMBER: 4. REGISTRATION NUMBER: 4. REGISTRATION NUMBER:												
5.	5. (a) Actual week of delivery begins Monday: (b) Sixth week before actual date of delivery begins Monday:												
	YYYY MM DD YYYY MM DD												
6.	TABLE IA 6. WEEKLY RATE OF PAY												
	the wee	eekly Rate	es of Pa	y for th	e 13 week peri Date of Delive			FOR OFFICIA	L USE ONLY				
	Section (a)		(b)		(c)			WEEK	CLASS				
	WK NO.		PATE	l _{DD}	ACTUAL EA	ARNINGS C		1					
	1	11111	IVIIVI	DD	Ψ			2					
	2							3					
	3							4					
	4							5					
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	11							12					
	12							13					
	13												
			7	otal									
						EMPLO	YER'S DECLAR	<u>ATION</u>					
	l declare	that to	the bes	st of m	y knowledge	and belief	the information given	by me is true and	correct and I am aware that if e false or do not believe to be				
	true, I aı	m liable c	n sum	mary c	onviction to a control of the contro	a fine of thi	ee thousand dollars ((\$3,000.00) and to	imprisonment for two years in				
	NAME:				SURNAME			OTHER NAM	IE(S)				
	POSITIO	N			JOHNAME			OTHER INAIN	12.07				
		<u> </u>		-									
							COMPANY						
-						.	STAMP (If any)	DA	TE:				
	SIGNATU	IRE					. , , , ,		YYYY MM DD				

SECTION "F" - FOR OFFICIAL USE										
APPLICATION R	ECEIVED BY:									
NAME:		SURNAME				OTHER NAME(S)				
SIGNATURE OF SI	ERVICE CENTRE STAFF			SERVICE CENTRE STAMP		DATE: YYYY				
				÷						

INSTRUCTIONS TO APPLICANT

- 1. Use BLOCK/CAPITALS to complete this Form.
- 2. The Special Maternity Grant is payable to the mother of the child/children using the father's contributions.
- 3. Where the mother does not satisfy the contribution requirements for Maternity Benefit in her own right or where the mother is unemployed, the father's contribution will be used to qualify her for the Special Maternity Grant.
- 4. Only one (1) Special Maternity Grant is allowed every twenty-four (24) consecutive months.
- 5. The Special Maternity Grant is a lumpsum payment equivalent to the Maternity Grant of \$2,500.00 per child.
- Your form must be accompanied by:
 - (a) NI 4 if applicant does not have a National Insurance Number.
 - (b) Marriage Certificate if applicant is legally married.

OR

- (b) Where both mother and father are in a common-law union, evidence of:
 - (1) co-habitation at the time of delivery of the child/children and
 - (2) marital status of both mother and father,
- (c) Birth certificate(s) of child/children and supporting statutory declaration(s) (if necessary).