NI 15A

THE NATIONAL INSURANCE BOARD
SICKNESS BENEFIT FOLLOW-UP MEDICAL CERTIFICATE

(Please use Block Capitals)

WARNING! Pursuant to Section 33 of the National Insurance Act, a person who makes any false statement is liable on summary conviction to a fine of $3,000.00 and to imprisonment for two years.

FOR OFFICIAL USE

CLAIM NO.:

SERVICE CENTRE CODE:

SECTION "A" - PARTICULARS OF APPLICANT

I, _____ _____ hereby consent to the
SURNAME OTHER NAME(S)

follow-up Medical Certificate at Section "B" being submitted to the National Insurance Board.

NATIONAL INSURANCE NO.

I declare that I am losing earnings, have not worked as a result of my illness and that the information given is true and correct.

_____
SIGNATURE OR MARK OF APPLICANT

DATE: _____
Y Y Y Y M M D D

PARTICULARS OF WITNESS TO MARK (WHERE CLAIMANT CANNOT SIGN)

NAME: _____ OCCUPATION: _____

ADDRESS: _____

IDENTIFICATION (Tick Appropriate Box):

☐ PASSPORT ☐ DRIVER'S PERMIT ☐ ELECTORAL I.D.

NUMBER:

_____
SIGNATURE OF WITNESS TO MARK

DATE: _____
Y Y Y Y M M D D

SECTION "B" - FOR USE BY MEDICAL PRACTITIONER

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

was examined by me on _____ and in my opinion was at the time suffering from
Y Y Y Y M M D D

_____

_____

In my opinion this patient will remain incapable of work for a period of _____ days starting from
(In Words and Figures)

_____
Y Y Y Y M M D D

Confidential information has/has not been sent to the Board's Medical Adviser.

NAME IN BLOCK LETTERS OR STAMP OF DOCTOR: _____

TELEPHONE NO.: ___ - ____

ADDRESS: _____

_____

_____
SIGNATURE OF DOCTOR

DATE: _____
Y Y Y Y M M D D

NOTE: In the case of a FIRST or SECOND CERTIFICATE the period entered must not exceed 14 DAYS including Sundays and Public Holidays. In the case of a THIRD OR SUBSEQUENT CERTIFICATE THE PERIOD entered must not exceed 28 DAYS including Sundays and Public Holidays.

NOTE: National Insurance Legislation 1980 provides that Sickness Benefit will be paid, if there is a loss of earnings, for a period of 26 WEEKS. At the end of this period, if the recipient is still ill, he must be medically re-examined to determine further benefit eligibility. Where invalidity cannot be determined, but the doctor certifies continued illness, the recipient may be paid Sickness Benefit for a further period not exceeding 26 WEEKS, providing other qualifying conditions are met. In effect therefore, it is now possible to qualify for Sickness Benefit for a maximum period of 52 weeks.

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SECTION "C" - FOR USE BY EMPLOYER

INSTRUCTIONS FOR COMPLETION

(i) This Section must be completed by the Employer before the Application is submitted to the Board.

(ii) In completing Column 4(c), 5(d) and 5(e) below proceed as follows:

(a) Weekly Earnings = $\frac{\text{Monthly Earnings x 3}}{13}$ (e.g. $\frac{\$800.00 \times 3}{13}$ = $184.62) OR

(b) Weekly Earnings = $\frac{\text{Fortnightly Earnings}}{2}$ (e.g. $\frac{\$200.00}{2}$ = $100.00) OR

(c) Daily Earnings = $\frac{\text{Weekly Earnings}}{7}$ (e.g. $\frac{\$100.00}{7}$ = $14.28)

(iii) Earnings and Loss of Earnings must be calculated at the daily rate.

1. EMPLOYER'S NAME:

REGISTRATION NO: TELEPHONE NO: -

2. This is to certify that during the period recorded at Section "B" of this form Mr/Mrs/Ms

SURNAME

OTHER NAME(S) has been absent from work.

Sickness ☐ is/ ☐ is not as a result of an accident on the job.

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

If "NO LONGER EMPLOYED", state reason(s):

DATE OF SEPARATION:

YYYY MM DD

4. **DAILY EARNINGS DURING SICKNESS**

(a) NO.	(b) PERIOD OF ABSENCE FROM YYYY MM DD	TO YYYY MM DD	(c) TOTAL NO. OF DAYS	(d) DAILY EARNINGS DURING SICKNESS $	c
1					
2					
3					
4					
5					

5. Was Loss of Earnings caused by sickness?

(a) ☐ Yes (b) ☐ No

If "No", please state reason for Loss of Earnings:

DECLARATION

WARNING! Pursuant to Section 33 of the National Insurance Act, a person who makes any false statement is liable on summary conviction to a fine of $3,000.00 and to imprisonment for two (2) years.

I declare that the information given is true and correct.

NAME: _____ SIGNATURE: _____

SURNAME OTHER NAME(S)

POSITION: _____ COMPANY STAMP (If any) DATE:

YYYY MM DD

SECTION "D" - FOR OFFICIAL USE

DETERMINATION

1. (a) Weekly Rate of Benefit in Class = [ ] $ [ ]

(b) Daily Rate of Benefit in Class [ ] 1(a) / 7 = $ [ ]

(c) Payment is recommended for the Period [ ] [ ] [ ] (Y Y Y Y M M D D) to [ ] [ ] [ ] (Y Y Y Y M M D D) in

Class _____ at the Rate of $ [ ] per Day/Week.

[See Medical Adviser's response at Minute ( ) and parent claim at folio ( )]

2. Payment is NOT recommended on the grounds that:

_____

_____

_____
SIGNATURE OF PROCESSING OFFICER

DATE: [ ] [ ] [ ] (Y Y Y Y M M D D)

DECISION/AUTHORISATION

(a) Payment authorised as detailed at (1) above.

(b) Payment is not authorised on the grounds stated at (2) above. [ ] [ ] [ ] (Y Y Y Y M M D D)

(c) Applicant notified of decision on Form NI 44/NI 53 dated [ ] [ ] [ ] (Y Y Y Y M M D D)

_____
SIGNATURE OF MGR./SUPERVISOR/C.O. II

DATE: [ ] [ ] [ ] (Y Y Y Y M M D D)