

THE NATIONAL INSURANCE BOARD
EMPLOYMENT INJURY BENEFIT APPLICATION

NI 19

FOR OFFICIAL USE

CLAIM NO.:

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SERVICE CENTRE CODE:

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(Please Use Block Capitals)

NOTE: This Application must be submitted within 3 months of the date of the Accident/Development of the Prescribed Industrial Disease.

SECTION "A" - TO BE COMPLETED BY APPLICANT

1. NAME:

SURNAME OTHER NAME (S)

3. POSTAL ADDRESS:

(STREET) 2. NATIONAL INSURANCE NO.

(CITY/DISTRICT/COUNTY) 4. TELEPHONE NUMBER

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5. DATE OF BIRTH:

YYYY MM DD 6. SEX: MALE FEMALE

7. OCCUPATION:

8. EMPLOYER'S NAME:

9. *EMPLOYER'S ADDRESS:

(STREET)

(CITY/DISTRICT/COUNTY)

10. NAME AND ADDRESS OF ACTUAL PLACE OF WORK:

(STREET)

(CITY/DISTRICT/COUNTY)

11. 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)

12. DATE AND TIME ACCIDENT OCCURRED:

YYYY MM DD TIME: _____ am/pm.

13. LAST DATE WORKED:

YYYY MM DD

14. DATE RESUMED WORK:

YYYY MM DD

15. EXACT PLACE/LOCATION WHERE ACCIDENT OCCURRED: _____

16. DID ACCIDENT OCCUR WHILE TRAVELLING IN EMPLOYER'S TRANSPORT?: YES NO
 (If "YES" give details).

(i) Place of Embarkation:

(ii) Destination:

*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)

25. METHOD OF PAYMENT OF CHEQUE:

MAIL TO: POSTAL ADDRESS

DEPOSIT TO: BANK CREDIT UNION

(If Method of Payment is "BANK" or "CREDIT UNION", Complete Below).

NAME OF BANK/
CREDIT UNION

ACCOUNT NUMBER

ADDRESS:
(STREET)

(CITY/DISTRICT/COUNTY)

DECLARATION

I DECLARE THAT THE INFORMATION GIVEN IS TRUE AND CORRECT.

I hereby give consent for the Medical Report at Section "B" to be sent to the National Insurance Board in support of my Application for Employment Injury Benefit.

SIGNATURE OR MARK OF APPLICANT

DATE:
YYYY MM DD

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.

PARTICULARS OF WITNESS TO MARK (WHERE APPLICANT CANNOT SIGN)

NAME:
SURNAME

OCCUPATION:

OTHER NAME(S)

IDENTIFICATION:
(Tick (✓) One Box)
 PASSPORT
 DRIVER'S PERMIT
 ELECTORAL I.D.

ADDRESS:
(STREET)

(CITY/DISTRICT/COUNTY)

NUMBER:

SIGNATURE OF WITNESS TO MARK

DATE:
YYYY MM DD

SECTION "B" - TO BE COMPLETED BY MEDICAL PRACTITIONER

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

was examined by me on as a result of an accident sustained/disease developed at work on

YYYY MM DD

I found the following injuries/industrial disease: _____

My findings are/are not consistent with the description of the accident/disease. I hereby recommend that the patient be granted

(In words and figures) _____ days/weeks leave with effect from
YYYY MM DD

SECTION "D"

(FOR OFFICIAL USE)

PART I - CUSTOMER SERVICE REPRESENTATIVE

- 1. NAME, N.I. AND DATE OF BIRTH CONFIRMED ON I.A. SYSTEM? YES NO
- 2. REGISTRATION (1.A) RECORD COMPLETE?
(If "NO" complete forms NI 4/NI 165/NI 182 as applicable). YES NO
- 3. SYSTEM CHECK FOR DUPLICATE REGISTRATION COMPLETED. (SIRF file included)? YES NO
- 4. REGISTRATION RECORD UPDATED?
(If "NO" state reason) _____ YES NO
- 5. CLAIM HISTORY GENERATED?. YES NO
- 6. HAS THIS INSURED PERSON APPLIED FOR A BENEFIT PREVIOUSLY?
(If "YES", request Benefit Unit) YES NO
- 7. APPLICATION COMPLETE AND ACCEPTED FOR PROCESSING? YES NO

CUSTOMER SERVICE REPRESENTATIVE

DATE:

YYYY				MM		DD	

PART II - DETERMINATION OF APPLICATION

Ensure that the following conditions are satisfied. If answer to any is "NO", refer to Clerical Officer II/Supervisor. Clerical Officer II/Supervisor must indicate action on Minute Sheet.

- 1.. WAS APPLICANT IN INSURABLE EMPLOYMENT AT THE TIME OF THE ACCIDENT? YES NO
- 2. (i) DID ACCIDENT/DISEASE ARISE IN THE COURSE OF EMPLOYMENT? YES NO
- (ii) DID ACCIDENT/DISEASE ARISE OUT OF EMPLOYMENT? YES NO
- 3..AGE OF APPLICANT AT THE TIME OF THE ACCIDENT?
 UNDER 16 YEARS 16 - 65 YEARS OVER 65 YEARS
- 4.. IS APPLICANT AN UNPAID APPRENTICE? YES NO

DETERMINATION OF EARNINGS CLASS

- 5.. APPLICANT'S EARNINGS IN WEEK OF INJURY/DISCOVERY OF DISEASE? \$ EARNINGS CLASS:
- 6.. APPLICANT'S EARNINGS IN WEEK PRIOR TO INJURY/DISCOVERY OF DISEASE? \$ EARNINGS CLASS:
- 7.. (a) APPLICATION APPROVED FOR PAYMENT IN EARNINGS CLASS AT THE WEEKLY RATE OF \$

FOR THE PERIOD

YYYY				MM		DD	

 TO

YYYY				MM		DD	

(Use the higher of 5 or 6 above)

(b) APPLICATION RECOMMENDED FOR DISALLOWANCE ON THE GROUNDS THAT:

NAME

SIGNATURE

DATE:

PROCESSING OFFICER

YYYY				MM		DD	

SECTION "D"

(FOR OFFICIAL USE)

8. DECISION/AUTHORISATION

(a) PAYMENT AUTHORISED FOR THE PERIOD AND RATE STATED AT 7(a).

(b) APPLICATION DISALLOWED ON THE GROUNDS STATED AT 7(b).

(c) APPLICANT NOTIFIED OF DECISION ON FORM NI 44/NI 53:

YYYY				MM		DD	

9. DECISION RECORDED ON I.A. SYSTEM:

YYYY				MM		DD	

NAME

SIGNATURE

DATE

(MANAGER/SUPERVISOR/CLERICAL OFFICER II)

YYYY				MM		DD	