THE NATIONAL INSURANCE BOARD
INVALIDITY BENEFIT APPLICATION

NI 38

(PLEASE USE BLOCK CAPITALS)

NOTE: (1) This application must be submitted within three (3) months of the first day of being certified an invalid.
(2) Birth Certificate and Affidavit (if necessary) must be submitted with claim form.

FOR OFFICIAL USE
CLAIM NO.:
SERVICE CENTRE CODE:

SECTION - "A" TO BE COMPLETED BY APPLICANT

I hereby apply for Invalidity Benefit and furnish herewith a Medical Report.

1. NAME: SURNAME OTHER NAME(S)

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

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

4. TELEPHONE NUMBER (for daytime contact): --

5. NATIONAL INSURANCE NUMBER

6. TELEPHONE NUMBER --

7. SEX: ☐ MALE ☐ FEMALE

8. DATE OF BIRTH: Y Y Y Y M M D D

9. LAST DATE WORKED: Y Y Y Y M M D D

10. LAST OCCUPATION:

11. EMPLOYMENT HISTORY:

NAME OF EMPLOYER	ADDRESS OF EMPLOYER	PERIOD OF EMPLOYMENT	
		FROM	TO

12. I am able ☐ unable ☐ to travel to a Medical Centre for Medical re-examination.

13. Did you work or live in Canada or any of the CARICOM countries? ☐ YES ☐ NO

If "YES", please provide:

(i) SOCIAL SECURITY NO.

(ii) NAME OF COUNTRY

* Please give mailing address.
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)

14. Please make payment to the undermentioned Financial Institution.

NAME OF FINANCIAL: INSTITUTION:

ADDRESS:

(STREET)

(CITY/DISTRICT/COUNTY)

ACCOUNT NUMBER:

NOTE: National Insurance Legislation (1999) provides for payment of Invalidity Benefit to an insured person who is medically examined and declared permanently incapable of work for a period not less than 12 months. An insured person who qualifies for Invalidity Benefit may be medically re-examined from time to time. A recipient of Invalidity Benefit must inform the Board when he/she resumes working at any job, including self-employment.

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.

(1) I declare that the information given above is true and correct.
(2) I hereby give permission for the NIBTT to update the address information from this form.

SIGNATURE OR MARK OF CLAIMANT

DATE: Y Y Y Y M M D D

PARTICULARS OF WITNESS TO MARK (WHERE APPLICANT CANNOT SIGN)

NAME: SURNAME OTHER NAME(S)

ADDRESS:

(STREET)

(CITY/DISTRICT/COUNTY)

OCCUPATION:

IDENTIFICATION: TYPE: ☐ PASSPORT ☐ DRIVER'S PERMIT ☐ ELECT. IDENTIFICATION CARD

NUMBER:

SIGNATURE OF WITNESS

DATE: Y Y Y Y M M D D

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SECTION - "B" TO BE COMPLETED BY A REGISTERED MEDICAL PRACTITIONER

(MEDICAL PRACTITIONER'S REPORT)

NOTE: **National Insurance Legislation (1999) provides for the payment of Invalidity Benefit to an insured person who was medically examined and declared to be incapable of work for a period not less than twelve (12) months.**

1. I certify that I examined Mr/Mrs/Miss. _____

SURNAME

_____ **on** _____ . **In my opinion this patient**

OTHER NAME(S) **Y Y Y Y M M D D**

is incapable of work* for a period of _____ ****months/years starting**

(words and figures)

_____ .

Y Y Y Y M M D D

***PLEASE CIRCLE OR UNDERLINE THE RELEVANT INFORMATION.**

***The term "incapable of work" means incapacity to do any kind of work, not necessarily the work which the person performed before his incapacity.**

****Please avoid use of the term "indefinitely". The term"permanently" is permissible.**

2. Please describe findings that contribute to Insured Person's incapacity for work.

_____

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_____

DOCTOR'S ADDRESS: _____

(STREET)

_____

(CITY/DISTRICT/COUNTY)

DATE: _____

Y Y Y Y M M D D

NAME OF DOCTOR IN BLOCK CAPITALS AND STAMP

TELEPHONE NUMBER: _____ - _____

_____

(SIGNATURE OF DOCTOR)

REGISTERED NUMBER: _____

(FOR OFFICIAL USE)

PART "I" - SERVICE CENTRE

1. Name, National Insurance Number and Date of Birth confirmed and updated, if necessary on IA System. ☐ Yes ☐ No
2. Registration Record Complete? (If No, complete NI 14, NI 165 & NI 182 application form) ☐ Yes ☐ No
3. Check for duplicate registration (SIRF file included). (Record results on minute sheet) ☐ Yes ☐ No
4. Claim history viewed? (Record results on Minute Sheet) ☐ Yes ☐ No
5. (a) Contribution Record Generated? ☐ Yes ☐ No

   (b) Outstanding contribution Records captured? ☐ Yes ☐ No
6. Application Recorded? (Print and attach claim Profile) ☐ Yes ☐ No

NAME _____ SIGNATURE _____ DATE Y Y Y Y MM DD

CUSTOMER SERVICE REPRESENTATIVE

PART "II" - REFERRAL TO MEDICAL ADVISER

1. Details on claims profile verified? ☐ Yes ☐ No
2. Claim referred to Medical Adviser. ☐ Yes ☐ No DATE Y Y Y Y MM DD

CLERICAL OFFICER I DATE Y Y Y Y MM DD

PART "III" - INSURANCE OPERATIONS

1. (a) Application is allowed. Review date: DATE Y Y Y Y MM DD
2. (b) Application disallowed on the grounds that: _____

NAME _____ SIGNATURE _____ DATE

MANAGER INSURANCE OPERATIONS Y Y Y Y MM DD

PART "IV" - VALIDATION OF CLAIM

1. Claim validated? ☐ Yes ☐ No
2. Claim results key entered? ☐ Yes ☐ No
3. Claim authorised and stop recorded created? ☐ Yes ☐ No

SUPERVISOR/CLERICAL OFFICER II Y Y Y Y MM DD