NI 114

THE NATIONAL INSURANCE BOARD
EMPLOYMENT INJURY BENEFIT
APPLICATION FOR MEDICAL EXPENSES

NOTE: Please read instructions on Page 6 **carefully** before completing this form.

WARNING: **IT IS AN OFFENCE PUNISHABLE BY LAW TO GIVE FALSE INFORMATION.**

FOR OFFICIAL USE

CLAIM NO: | | | | | | | | | |

LOCAL OFFICE CODE: | | | | | | |

SECTION "A" - TO BE COMPLETED BY APPLICANT

1. NAME: _____ (SURNAME) _____ (OTHER NAME(S))
2. NATIONAL INSURANCE NO. | | | | | | | | | | |
3. *POSTAL ADDRESS: _____
4. TELEPHONE NO. | | | | - | | | | | |
5. DATE OF BIRTH: | | | | | | | | (YYYY) (MM) (DD)
6. SEX: *(Tick (✓) Appropriate Box)* ☐ MALE ☐ FEMALE
7. EMPLOYER'S NAME: _____
8. EMPLOYER REGISTRATION NO. | | | | | | |
9. *EMPLOYER'S ADDRESS: _____
10. LOCAL OFFICE AT WHICH EMPLOYMENT INJURY BENEFIT WAS CLAIMED/PAID: _____
11. DATE OF ACCIDENT/DEVELOPMENT OF INDUSTRIAL DISEASE: | | | | | | | | (YYYY) (MM) (DD)
12. TIME OF ACCIDENT: _____ a.m./p.m.
13. PERIOD FOR WHICH MEDICAL EXPENSES ARE CLAIMED: | | | | | | | | (YYYY) (MM) (DD) TO | | | | | | | | (YYYY) (MM) (DD)
14. STATEMENT/BILLS FOR THE FOLLOWING EXPENSES ARE ATTACHED IN SUPPORT OF MY CLAIM:

☐ HOSPITALISATION	☐ SPECIALIST CONSULTATION
☐ SURGERY	☐ DRUGS/X-RAY/LAB. TEST
☐ DOCTOR'S VISITS (OFFICE/HOME/HOSPITAL)	☐ TRAVELLING
☐ CONSTANT CARE	☐ PARAMEDICAL TREATMENT/ EQUIPMENT

15. NAME AND ADDRESS OF FIRST DOCTOR WHO ATTENDED TO YOU AS A RESULT OF THE INJURY/DISEASE.

NAME: _____ ADDRESS: _____

DATE SEEN: | | | | | | | | (YYYY) (MM) (DD)

16. MAIL TO: ☐ POSTAL ADDRESS PLEASE MAKE PAYMENTS TO: ☐ BANK ☐ CREDIT UNION

NAME OF BANK/ CREDIT UNION: _____ ACCOUNT NUMBER: | | | | | | | | | | | | |

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*

DETAILS OF CLAIM

(a) DOCTOR'S VISITS (Office Visits **ONLY**).

NAME OF DOCTOR	OFFICE ADDRESS OF DOCTOR	DATES OF VISITS YYYY MM DD	FEES PAID $	FOR OFFICIAL USE AMOUNT APPROVED $
		TOTAL		

(b) DOCTOR'S VISITS (At Home **OR** Hospital).

NAME OF DOCTOR	HOME/HOSPITAL ADDRESS VISITED	DATE(S) OF VISIT(S) YYYY MM DD	TIME am/pm	FEES PAID $	FOR OFFICIAL USE AMOUNT APPROVED $
			TOTAL		

(c) HOSPITALISATION (To include the Cost of Investigations, Drugs, X-Rays, etc.).

NAME OF HOSPITAL/ NURSING HOME	HOME/HOSPITAL ADDRESS	PERIOD OF STAY FROM YYYY MM DD	PERIOD OF STAY TO YYYY MM DD	PARTICULARS OF ITEMS CLAIMED	COST $	FOR OFFICIAL USE AMOUNT APPROVED $
				TOTAL		

SECTION "A" - TO BE COMPLETED BY APPLICANT *Cont'd*

(d) SURGERY/OPERATIONS (Enclose Doctor's description of surgery).

NAME OF DOCTOR	DATE(S) OF SURGERY YYYY	MM	DD	TYPE OF SURGERY	COST $	FOR OFFICIAL USE AMOUNT APPROVED $
				TOTAL		

(e) DRUGS, DRESSINGS, X-RAYS (As Prescribed for Persons **NOT** Hospitalised)

NAME OF PHARMACY/ INSTITUTION	ADDRESS OF PHARMACY/ INSTITUTION	DATE PRESCRIPTION FILLED/TEST CONT'D YYYY	MM	DD	COST $	FOR OFFICIAL USE AMOUNT APPROVED $
				TOTAL		

(f) PARAMEDICAL TREATMENT/EQUIPMENT/APPLIANCE (To be Certified by the Attending Doctor)
- List here any Therapeutical Treatment received.

NAME OF PARAMEDIC/ SUPPLIER	ADDRESS OF PARAMEDIC/ SUPPLIER	REFERRED BY (Name of Doctor)	TYPE OF APPLIANCE/ EQUIPMENT FITTED/ TREATMENT RECEIVED	COST $	FOR OFFICIAL USE AMOUNT APPROVED $
			TOTAL		

(g) CONSTANT CARE AND ATTENDANCE
(Provide Statement from Doctor Certifying the need for Constant Care).

NAME OF ATTENDANT	ADDRESS	NO. OF DAYS ATTENDED	COST $	FOR OFFICIAL USE AMOUNT APPROVED $
		TOTAL		

SECTION "A" - TO BE COMPLETED BY APPLICANT *Cont'd*

(h) TRAVELLING EXPENSES (Provide Evidence of All Visits).

DATE OF TRAVEL YYYY	MM	DD	POINTS OF TRAVEL FROM	TO	MODE OF TRANSPORT	COST $	FOR OFFICIAL USE AMOUNT APPROVED $
					TOTAL		
					GRAND TOTAL OF EXPENSES		

DECLARATION

I declare that the information given in respect of the Medical Expenses incurred 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: _____

OCCUPATION OF WITNESS: _____

IDENTIFICATION TYPE:

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

NUMBER:

SIGNATURE OF WITNESS: _____ DATE: YYYY MM DD

SECTION "B" - TO BE COMPLETED BY LOCAL OFFICE

FOR OFFICIAL USE

PART I - CUSTOMER SERVICE REPRESENTITIVES

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

_____ DATE: YYYY MM DD
SIGNATURE OF CUSTOMER SERVICE REP.

SECTION "B" - TO BE COMPLETED BY LOCAL OFFICE *Cont'd* FOR OFFICIAL USE

PART II - DETERMINATION OF APPLICATION

1. Application recommended for allowance as detailed below:

EXPENSE TYPE	AMOUNT APPROVED $
(a) Doctor's visits (Office visits only)	
(b) Doctor's visits (At home or hospital)	
(c) Hospitalisation	
(d) Surgery/Operation	
(e) Drugs, Dressings, X-Ray	
(f) Paramedical treatment Equipment/Appliances	
(g) Constant care and attendance	
(h) Travelling	
TOTAL	

2. Application recommended for Disallowance on the grounds that:

_____

_____

_____

_____

_____
PROCESSING OFFICER

DATE: ____ ____ ____ (YYYY MM DD)

3. Decision/Authorisation:

☐ (a) Application Allowed and Payment Authorised for the Expenses and Amount at (1) above.

☐ (b) Aplication Disallowed on the grounds stated at (2) above.

☐ (c) Benefit details and decision recorded on IA system? ☐ YES ☐ NO

(d) Payment details recorded on STB system? ☐ YES ☐ NO

(e) Applicant notified of decision by letter (NI 53/NI 44) dated ____ ____ ____ (YYYY MM DD)

_____
C.O. II/SUPERVISOR/MANAGER

DATE: ____ ____ ____ (YYYY MM DD)

INSTRUCTIONS TO APPLICANT

1. Use BLOCK/CAPITALS to complete this Form.

2. Ensure that all bills and receipts for medical attention, drugs and dressings, hospital treatment and operation are clearly detailed in respect of the treatment obtained. Information on these bills/receipts must indicate the:

   (a) Dates and times of visits to the doctor. In respect of time state the actual hour of visit, e.g. 3:45 p.m.;

   (b) Letter of referral from the first doctor to any other doctor visited;

   (c) Date(s) of hospitalisation, if applicable;

   (d) Particulars of treatment (for both in-patient and out-patient) received at the hospital;

   (e) Submission of bills/receipts from pharmacy in support of a claim for drugs/dressings;

   (f) Travelling expenses with respect to visits to the doctor or hospitalisation, which must be supported by some evidence from the attending doctor/ hospital.

   (g) The total amount of funds expended.

3. Where it was necessary for you to have constant care and attendance as certified by the attending doctor, state the name and address of the person who attended to you and the period for which such attendance extended should be stated and you should submit your doctor's certification of same.

4. If a claim for treatment outside of Trinidad and Tobago has been made you must produce evidence that such treatment was not available in Trinidad and Tobago.

5. Where it was necessary for you to have Paramedical Treatment/Equipment/ Appliance as certified by the attending doctor, you should submit your doctor's certification of the same.

6. Kindly date and sign Section "A" of the form. Where you are unable to write, place your mark in the space provided and have it witnessed.