

THE NATIONAL INSURANCE BOARD
FUNERAL GRANT APPLICATION

NI 8

(PLEASE USE BLOCK/CAPITALS)

FOR OFFICIAL USE
CLAIM NO.

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SERVICE CENTRE CODE

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NOTE: This claim must be submitted within 3 months of the Date of Death of the Insured Person.

SECTION "A" - PARTICULARS OF APPLICANT

1. NAME:

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 SURNAME

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 OTHER NAME (S)

2. POSTAL ADDRESS:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

 (STREET)

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 (CITY/DISTRICT/COUNTY)
TELEPHONE NUMBER

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

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4. RELATIONSHIP TO DECEASED:

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5. DOCUMENTS TO ATTACH IN RESPECT OF DECEASED PERSON: a) DEATH CERTIFICATE b) BIRTH CERTIFICATE AND SUPPORTING AFFIDAVIT(S)
 c) BILLS AND RECEIPTS OF FUNERAL EXPENSES d) NATIONAL INSURANCE REGISTRATION CARD

SECTION "B" - PARTICULARS OF DECEASED INSURED PERSON

1. NAME OF DECEASED:

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 SURNAME

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 OTHER NAME (S)

2. LAST ADDRESS:

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 (STREET)

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 (CITY/DISTRICT/COUNTY)

3. N.I. NO.:

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4. SEX: Male Female

5. DATE OF BIRTH:

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 YYYY MM DD

6. DATE OF DEATH:

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 YYYY MM DD

7. DID DEATH OCCUR AS A RESULT OF ACCIDENT/INDUSTRIAL DISEASE ARISING FROM EMPLOYMENT? YES NO
If "yes", please state date of accident/development of disease

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 and have employer complete
Section "E" of this form. YYYY MM DD

8. NAME OF LAST EMPLOYER:

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9. ADDRESS OF LAST EMPLOYER:

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 (STREET)

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 (CITY/DISTRICT/COUNTY)

SECTION "C" METHOD OF PAYMENT

COLLECT AT SERVICE CENTRE MAIL TO POSTAL ADDRESS

PLEASE ENQUIRE FROM YOUR SERVICE CENTRE ABOUT THE SURVIVOR/DEATH BENEFIT WHERE APPLICABLE.

SECTION "D" DECLARATION

I hereby declare that the information given overleaf is true and correct.

SIGNATURE OR MARK OF APPLICANT DATE: YYYY MM DD

NAME OF WITNESS TO MARK: SURNAME OTHER NAME (S)

ADDRESS OF WITNESS TO MARK: (STREET) (CITY/DISTRICT/COUNTY)

SIGNATURE OF WITNESS TO MARK PROFESSION OR RANK 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.

SECTION "E" - ACCIDENT DETAILS To be completed by the employer when the worker died as a result of an accident/disease which arose out of and in the course of employment

1. Date of accident/development of disease YYYY MM DD Time of accident am/pm

2. Exact place of accident.....

3. Did accident occur while travelling in employer's transport? YES NO (If "yes", give details)

i. Place of embarkation

ii. Destination.....

iii. Purpose of presence on vehicle:

iv. Was vehicle owned/rented by employer? YES NO If "no", was vehicle used through arrangement with employer? (describe)

4. State clear details of the cause of the accident.....

.....

5. State clear details of injury sustained.....

.....

6. Was accident reported to you? YES NO If "yes" state date of report YYYY MM DD

7. (i) Did accident occur while travelling in employer's transport? YES NO

(ii) Was employee engaged in his/her duties at the time of accident? YES NO If "no" to either (i) or (ii) give details:

8. Did employee die at time of accident? YES NO

If "no", please state of death. YYYY MM DD

EMPLOYER DECLARATION

I declare that the information given is true and correct.

NAME _____
SURNAME OTHER NAMES



POSITION _____

SIGNATURE

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.

FOR OFFICIAL USE

PART I SECTION "F" - SERVICE CENTRE

- 1. Deceased Insured Record confirmed and status updated if necessary on I.A System? YES NO
- 2. Registration Records of Deceased Insured complete? (If no complete NI 4/165) YES NO
- 3. Claim History viewed? (Please record findings on the minute sheet) YES NO
- 4. Information Received from the Records Department? (Where Necessary) YES NO
- 5. Was the Claim Recorded? (Print and attach claim profile) YES NO
- 6. Contribution Record Entered? (Print and attach Audit Report) YES NO
- 7. Was claim validated and processed? YES NO

CUSTOMER SERVICE REPRESENTATIVE

DATE:

YYYY			MM		DD	

PART II

- 1. Details of Claim Profile Verified? YES NO
- 2. Contribution Audit Report Checked? YES NO
- 3. Contribution Record Transferred? YES NO
- 4. Claim Authorised? YES NO
- 5. Voucher Generated and Authorised? YES NO

SUPERVISOR/CLERICAL OFFICER II

DATE:

YYYY			MM		DD	

PART III

- 1. Cheque Issued YES NO
- 2. Cheque Number

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- 3. Date Cheque Issued

DATE:

YYYY			MM		DD	