THE NATIONAL INSURANCE BOARD OF TRINIDAD AND TOBAGO

GUIDELINES AND CHECKLIST

Application / Benefit:	**Application**
Form Name:	**Medical Expenses**
Form Number:	**NI 114**

Section A

Description	**To be completed by Insured Person**		
Question #	**No.**	**Questions on form**	**What should be inserted**
	1	Name	Surname followed by First name and middle name (if applicable)
	2	Home Address	Your current address showing the house or lot number, Street Name(s) and City or Borough
	3	Postal Address	**If different from your Home Address:** State your postal address showing the house or lot number, Street Name(s) and City or Borough
	4	National Insurance No.	Your National Insurance Number (if known)
	5	Date of Birth	Your Date of Birth in the format year, month, day
	6	Gender	Tick Female or Male based on your gender
	7	Telephone Number	Your current telephone contact numbers (Mobile, Home, Work)
	8	Employer's Name	The Business/Trading name of your employer
	9	Employer's Address	The current address of your employer showing the house or lot number, Street Name(s) and City or Borough
	10	Employer Registration No.	Your employer's registration number (if known)
	11	Date of Accident/ Development of Disease	The date of the Accident/ Development of Disease in the format year, month, day
	12	Time of Accident	The time of the accident in the 12-hour format. Indicate whether time was am or pm
	13	Period for which Medical Expenses are claim	The period of incapacity which you are claiming for, in the format year, month, day
	14	Did you meet total costs of Medical Expenses	Tick Yes or No to indicate whether or not you paid the total cost of your medical expenses. If Yes, complete questions 15 to 17
	15	Statement/ Bills for the following expenses are attached in support of my claim	Tick the expenses for which you have Statements and/or Bills to support your claim
	16	Date Seen	Date seen by medical practitioner highlighted in Question 17

	17	Name and Address of the first Medical Practitioner who attended to you as a result of the injury/disease	The Surname, Other Name(s) and the current address of the first Medical Practitioner who attended to you when you were injured/ contracted the disease showing the house or lot number, Street Name(s) and City or Borough (if known)
	18	Please indicate the method of payment of Benefit	Tick Postal, if you would like your payment posted to your home address or Financial Institution if you would like your payment deposited to your account in the Financial Institution of your choice. If you ticked Financial Institution, you must state the Name of your Financial Institution, the Branch Address and your Account Number in the boxes provided
Section A – Details of Claim:	**Complete the table for the expenses as indicated in Question 15**		
	No.	**Options on form**	**What should be inserted**
	(a)	Medical Practitioner's Visit	The Medical Practitioner's name, Office Address, Date of Visit in the format year, month, day, Time visited, and Fee paid for each Doctor Visit
	(b)	Hospitalization	The Name of Hospital/ Nursing Home, Address of Hospital/Home, Period of Stay in the format year, month, day, Particulars of Items Claimed and amount paid of each period of hospitalization for each hospital visit
	(c)	Surgery/ Operations	The name of the Medical Practitioner, Date of Surgery in the format year, month, day, Type of Surgery (Minor, Major, Intermediate), Amount Paid for each surgery
	(d)	Drugs, Dressings, X-Rays	The Name of the Pharmacy/ Supplier, Address of Pharmacy/ Supplier, Name of Medical Practitioner who gave prescription, Date Prescription was filled in the format, year, month, day, Amount paid for each Prescription
	(e)	Paramedical Treatment/ Equipment/ Appliance	The Name of Paramedic/ Supplier, Address of Paramedic/ Supplier, Name of Medical Practitioner who gave referral, Type of Appliance/ Equipment Fitted/ Treatment Received, and Amount Paid for each referred treatment
	(f)	Constant Attendance and Care	The Name of Attendant/ Caretaker, Address of Attendant/ Caretaker, No. of Days attended, and amount paid for each attendant/ caretaker
	(g)	Travelling Expenses	The date of Travel in the format year, month, day, the point of travel To and From, Mode of transport and amount paid for each date of travel
	(h)	Magnetic Resonance Imaging (MRI)	The Name of Medical Institution, Address of Medical Institution, Name of Medical Practitioner who gave referral, Date of Visit in the format Year, month, day and the Cost for each MRI visit

Description	Applicant's Declaration	
	Information needed	**What should be inserted**
	Signature or Mark of Claimant	The signature of the insured person or the thumb print of the insured person where they are unable to sign. Indicate if it is the right thumb or the left thumb.
	Date	The date in the format year, month, day
	Information needed	**What should be inserted**
	Name	Your Surname followed by Other Name
	Address	The date in the format year, month, day
	Valid Identification	Tick **one** form of Identification and state the number in the boxes provided
	Occupation	The Occupation of the Witness
	Signature of Witness	The Signature of the Witness
	Date	The date in the format year, month, day

Section B

Description	For Official Use
	The Customer Service Representative completes the section of the form

What you should know about this claim
1. Time frame for the submission of claim - 3 months from the expense was incurred
2. Where the claim is submitted by a third party, valid ID and letter of authorization to conduct business
3 . Who can sign as witness -

Supporting Documents
Original Bills/ Statements
Identification (Electoral ID, Drivers Permit, Passport)

List of Errors	No.	Questions on form	Possible Errors
	1		
	2		
	3		

CHECKLIST

- Claim Form – **N.I. 114**. This form is completed when the insured has suffered a personal injury due to a job-related incident and pays his own medical expenses.

- **ALL** fields must be completed. **ALL** changes **MUST** be initialed.

- Identification Card of Insured.

- Original & Copy of the Birth Certificate / Affidavit / Deed Poll where there is a change to the insured's name.

- **ALL** original or certified copies of receipts to support the expense being claimed **MUST** be submitted. The receipts **MUST** relate to the injury claimed. The insured's name and date of the accident **MUST** be stated on the receipt.

- If the method of payment is **Financial**, the bank statement reflecting the name of the bank, the account number and the branch should be submitted. If the method of payment is **Postal** a utility bill, no older than three (3) months should be submitted.

- If the claim is being submitted by a third party, the Identification Card of the third party **MUST** be presented.

- The claim **MUST** be submitted within three (3) months from the date the expense was incurred, if not a letter **MUST** be written with an explanation for the late submission.