THE NATIONAL INSURANCE BOARD OF TRINIDAD AND TOBAGO

Application / Benefit:	Application				
Form Name:	CONTINUATION CLAIM TO SICKNESS BENEFIT				
Form Number:	NI 15A				
	<u> </u>	Section A	N N N N N N N N N N N N N N N N N N N		
Description	Particulars of Applicant - (This is person who is making the application)				
Question #	No.	Questions on form	What should be inserted		
	1	Name	Surname followed by First name and middle name (if applicable)		
		National Insurance No.	What is your National Insurance Number		
Section A - Description	Declaration				
		Information needed	What should be inserted		
	Signature or Mark of Claimant		Sign name or affix thumb print		
		Date	Date when the form was completed by applicant		
Section A - Description		Particulars of witness to Mark (where applicant cannot sign)			
		Information needed	What should be inserted		
	Nam	e	The witness surname and other name		
		ess	The address of the witness		
	Valid Identification		Tick the box which ID used - Identification should be a valid form of one of the following: Passport, Driver's Permit or Electoral Identification Card.		
	Occupation		What position does witness hold		
	Number		Place number from valid Identification		
		ature of Witness to mark	The signture of the witness		
	Date		Date the form was completed by the witness		

Mr/Mrs/Ms applicable) Was examined by me on Date you were seen by Medical Practitioner In my opinion was at the Medical Practitioner to insert name and/or type of illness The patient will remain incapable of work for a period of Medical Practitioner to insert in words and figures number of days incapable of work Start date of illness Medical Practitioner to insert the continuation date of the illness period Confidential information has been sent to Board's Medical Medical Practitioner to Tick Yes or No Name of Medical Sumame followed by First name and middle name (if Practitioner Name of Medical Sumame followed by First name and middle name (if Practitioner Registration Number of Medical Practitioner Registration Number as issued by the Medical Board of Trinidad and Tobago Telephone Numbers Telephone contact - home, office/work or cellular Description Medical Practitioner to sign Medical Practitioner Stamp Medical Practitioner to sign Medical Practitioner Stamp Date Date Date State of Medical Practitioner to sign Medical Practitioner Stamp Medical Practitioner to sign Medical Practitioner Stamp Medical Practitioner to sign Medical Practitioner Stamp Date form was completed by Medical Practiti	Section B					
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1 Employer's Name What is the employer's name, National Insurance	Section C - Description	To be completed by the Employer				
	Question #	No.	Questions on form	What should be inserted		
Telephone No		1	Registration No	What is the employer's name, National Insurance Registration number and Telephone Number		

	2	This is to certify that during the period recorded at Section B of this form Mr/Mrs/Ms	Surname followed by First name and middle name (if applicable) of employee	
	2	Is Sickness as a result of an accident on the job	Tick Is or Is Not	
	3	Is the Applicant still employed?	Tick Yes or No. If "No" the employer must stated the reason why you are no longer employed and the Date of Separation	
	4	Daily Earnings During Sickness	 (a) Number order to insert information (b) Employer must insert the period for which the employee would have been absent from work (c) Total number of days employee was absent from work including Saturday, Sunday and Public Holidays (d) Employer must state what the employee's daily earnings would have been if they were paid or insert "Nil" if the employee was not paid during their period of sickness. 	
	5	Was loss of Earnings Caused by Sickness	Tick Yes or No. If "No" the employer must stated the reason for the loss of earning	
Description	Employer's Declaration			
	I	nformation needed	What should be inserted	
1	Name Surname and other name of the person who completed the form on behalf of the employer			
F	Positi	on	The position/ job title of the employer/employer's representative	
	Signature of Employer		The signature of the employer/ employer's representative	
		any Stamp	Stamp of the employer	
[[Date		Date the form was completed by the employer	
Section D				
Section D - Description	For Offical Use			
Part I	The Customer Service Representative completes this section of the form			
	W	/hat you should know al	pout this claim	
1. Where illness persists afer the initial claim, a continuation or subsequent medical may be submitted				

2. Application must be submitted within three months of the loss of earnings

Supporting Documents

Medical Certificate from a certified medical practitioner

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