# THE NATIONAL INSURANCE BOARD OF TRINIDAD AND TOBAGO

| Application / Benefit: | Application | | |
|---|---|---|---|
| Form Name: | CONTINUATION CLAIM TO SICKNESS BENEFIT | | |
| Form Number: | NI 15A | | |
| Section A | | | |
| 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 |
| | Name | | The witness surname and other name |
| | Address | | The address of the witness |
| | Valid Identification | | Tick the box which ID used - Identification should be a valid form of one of the following:<br>Passport, Driver's Permit or Electoral Identification Card. |
| | Occupation | | What position does witness hold |
| | Number | | Place number from valid Identification |
| | Signature of Witness to mark | | The signture of the witness |
| | Date | | Date the form was completed by the witness |

| Section B | | | |
| --- | --- | --- | --- |
| **Section B - Description** | **Subsequent Medical Certificate<br>To be Completed by Medical Practitioner** | | |
| **Question #** | **No.** | **Information needed** | **What should be inserted** |
| | | I herey certify that Mr/Mrs/Ms | Surname followed by First name and middle name (if applicable) |
| | | Was examined by me on | Date you were seen by Medical Practitioner |
| | | In my opinion was at the time suffering from | 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 Practitioner | Medical Practitioner to Tick Yes or No |
| | | Name of Medical Practitioner | Surname followed by First name and middle name (if applicable) |
| | | Office Address | Address of Medical 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 Doctor Declaration** | |
| --- | --- | --- |
| | **Information needed** | **What should be inserted** |
| | Signature of Medical | Medical Practitioner to sign |
| | Medical Practitioner Stamp | Medical Practitioner to affix stamp |
| | Date | Date form was completed by Medical Practitioner |

| Section C | | | |
| --- | --- | --- | --- |
| **Section C - Description** | **To be completed by the Employer** | | |
| **Question #** | **No.** | **Questions on form** | **What should be inserted** |
| | 1 | Employer's Name<br>Registration No<br>Telephone 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.<br>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<br>(b) Employer must insert the period for which the employee would have been absent from work<br>(c) Total number of days employee was absent from work including Saturday, Sunday and Public Holidays<br>(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.<br>If "No" the employer must stated the reason for the loss of earning |

| **Description** | **Employer's Declaration** | |
|---|---|---|
| | **Information needed** | **What should be inserted** |
| | Name | Surname and other name of the person who completed the form on behalf of the employer |
| | Position | The position/ job title of the employer/employer's representative |
| | Signature of Employer | The signature of the employer/ employer's representative |
| | Company 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** |

**What you should know about 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 | | | |
| | | | |
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| **List of Errors** | **No.** | **Questions on form** | **Possible Errors** |
| | 1 | | |
| | 2 | | |
| | 3 | | |
| | | | |