Incapacity is due to an injury received while working for an employer

1. The accident happened on _____ **at**
Date

_____ **am/pm**
Place **Time**

2. Nature of accident (describe) _____

_____

_____

3. State briefly how the accident happened.

_____

_____

_____

_____

4. Did you report the accident to your employer?

Yes [ ] No [ ]

5. If so, when? _____

6. How long have you been employed with this employer?

_____

7. Names and addresses of other employers for whom you worked during the last 9 months:

_____

_____

_____

_____

Signature: _____

Date: _____

WARNING: Any person who knowingly makes any false statement or false representation for the purpose of obtaining benefit commits a criminal offence punishable by fine or imprisonment or both.

NATIONAL INSURANCE ACT No. 33 of 1986
CLAIM FOR SICKNESS/INJURY BENEFIT
To be completed by insured person

1. **Name in Full** _____
2. **Postal Address** _____
3. **National Insurance No:** |___|___|___|___|___|___|___|
4. **Date of Birth** |___|___|___| **Phone** _____
5. **Occupation** _____
6. **Are you incapable of work as a result of an accident at work? Yes [ ] No [ ]**

   If the answer to this question is "yes", please complete page 3 of this form.
7. **When you became incapable of work, were you employed [ ] or self-employed [ ]?**
8. **I am/was last employed by** _____

_____
(Name and address of employer)

And worked there until _____ **am pm on** _____ **(Date)**

I am incapable of work and I claim benefit from

_____ **I have not worked since then.**
Date

My Bank Account # _____ **at** _____

I declare that the information given in this claim is true to the best of my knowledge and belief, and that I will NOT receive benefit in respect of a period during which I was at work.

Signature of Claimant: _____

Date: _____

Please ensure that this claim is signed.

This claim must be submitted to the NIS Office within 15 days of the date of the Doctor's visit.

If this claim is late, you should submit a letter stating reasons for its lateness.

MEDICAL CERTIFICATE OF INCAPACITY FOR WORK

To be Completed by a Registered Medical Practitioner

I certify that I have examined Mr/Mrs/Miss _____

_____ **today** _____/_____/_____

and that in my opinion he/she is incapable of work by reason of

_____

_____

_____

_____

I recommend that he/she be granted _____ **calendar days sick leave from** _____/ _____/ _____ **to** _____/ _____/ _____

In my opinion he/she should be fit to return to work on _____/ _____/ _____.

Name of Medical Practitioner:

_____
(IN BLOCK LETTERS)

Signature: _____

Date: _____

Any other remarks:

_____

_____

_____

_____

_____