SAINT LUCIA

STATUTORY INSTRUMENT, 2025, No. 8

ARRANGEMENT OF REGULATIONS

Regulation

SAINT LUCIA

STATUTORY INSTRUMENT, 2025, No. 8

[20th January, 2025]

In exercise of the power conferred under section 91(1)(k) and (p) of the National Insurance Corporation Act, Cap. 16.01, the Minister responsible for the National Insurance Corporation makes these Regulations:

Citation

1. These Regulations may be cited as the National Insurance Corporation (Amendment) Regulations, 2025.

Interpretation

2. In these Regulations, "principal Regulations" means the National Insurance Corporation Regulations, Cap. 16.01.

Replacement of regulation 5

3. The principal Regulations are amended by deleting regulation 5 and by substituting the following —

"**Manner of payment of contribution**

5. All payments of contributions to the Fund must be paid —

(a) in cash, to an officer of the Corporation authorized by the Director to receive such payment;

(b) by money order, postal order sent by post to an office of the Corporation;

(c) by a bank draft or a cheque drawn on a financial institution in Saint Lucia; or

(d) by any other form of payments, including electronic payments made at such place and by a method authorized by the Director.".

Insertion of new Division L in Part 7

4. The principal Regulations are amended in Part 7 by inserting immediately after regulation 110 the following new Division L —

"L. NON-CONTRIBUTORS

Authority to pay non-contributors

110A. A payment from the Fund to an aged person, a person with disability or a needy person who is not a contributor must be made under section 3(2)(g) of the Act.

Payment to non-contributors

110B.—(1) The Corporation may pay a fixed sum directly to a charitable organization for the purpose of assisting an aged person, a person with disability or a needy person.

(2) A payment made under subregulation (1) may be made on a one-time, quarterly or annual basis or any other basis determined by the Director.

(3) In this regulation —

"aged" means an individual who is over the age of sixty-five years;

"disabled" means a person who is unable to undertake the ordinary activities of life as a result of a physical or mental incapacity;

"needy" means an individual who lacks the necessities of life, is poor or disadvantaged.

Sector and purpose of payment

110C.—(1) The Board may determine the sector of the community and the purpose and application for which the funds may be used.

(2) Notwithstanding the generality of subregulation (1), where funds are paid to the National Community Foundation, the Board shall appoint an internal auditor to undertake an internal audit review in accordance with International Internal Auditing Standards to provide —

(a) independent assurance to the Board and the management of the National Insurance Corporation on the adequacy and effectiveness of governance, risk management and control processes of the National Community Foundation;

(b) advisory services to the Board; and

(c) any other service requested by the Board.

(3) For the purpose of this regulation, "National Community Foundation" means the entity established under section 3 of the National Community Foundation Act, Cap. 17.16.

Assessment of the payment

110D.—(1) The Board may establish a committee to consider and assess a request for the funds under regulation 110B.

(2) A committee established under subregulation (1) shall provide the Director with written recommendations on the impact and effectiveness of the funds paid.".

Amendment of Schedule 1

5.—(1) Schedule 1 of the principal Regulations is amended —

(a) in the list of forms, by deleting —

(i) Form SB2, Claim for Sickness Benefit and by replacing with Form SB2, Sickness Benefit Claim Form,

(ii) Form MB1, Claim for Maternity Allowance and Grant and by replacing with Form MB1, Maternity Benefit Claim Form,

(iii) Form FB1, Claim for Funeral Benefit and by replacing with Form FB1, Funeral Grant Claim Form,

(iv) Form EIB2, Claim for Employment Injury Benefit and by replacing with Form EIB2, Employment Injury Benefit Claim Form;

(b) by replacing —

(i) Form SB 2, Claim for Sickness Benefit, Reg. 31 with the following Form SB 2, Sickness Benefit Claim Form —

Form SB2 (Reg. 31)

(FOR OFFICIAL USE)
CLAIM NO:
BRANCH OFFICE CODE:

NATIONAL INSURANCE CORPORATION
SICKNESS BENEFIT CLAIM FORM

SECTION "A" – TO BE COMPLETED BY CLAIMANT

1. NAME: _____ 2. NATIONAL INSURANCE NUMBER: _____
3. DATE OF BIRTH: _____ (dd/mm/yy) 4. EMAIL ADDRESS: _____ 5. GENDER: MALE ◯ FEMALE ◯
6. HOME ADDRESS: _____ 7. POSTAL ADDRESS: _____ (if different from above)
8. MARTIAL STATUS: MARRIED ◯ SINGLE ◯ WIDOWED ◯ DIVORCED ◯
9. TELEPHONE: _____ (HOME) _____ (WORK) _____ (CELL)
10. OCCUPATION: _____ 11. EMPLOYER'S NAME: _____
12. EMPLOYER'S ADDRESS: _____
13. NAME OF ACTUAL PLACE OF WORK: _____
14. ADDRESS OF ACTUAL PLACE OF WORK: _____
15. ARE YOU CURRENTLY EMPLOYED ELSEWHERE? YES ◯ NO ◯
(If "YES" state Name and Address of other employer.)
NAME OF EMPLOYER: _____
EMPLOYER'S ADDRESS: _____
16. IS SICKNESS AS A RESULT OF INJURY ON THE JOB? YES ◯ NO ◯
17. LAST DATE WORKED IMMEDIATELY BEFORE ILLNESS: _____ (dd/mm/yy)

SECTION "B" (OPTIONAL) – ASSIGNMENT TO EMPLOYER

ONLY COMPLETE IF YOU WILL BE PAID 100% OF YOUR EARNINGS BY YOUR EMPLOYER FOR THE PERIOD OF ILLNESS WITH THE UNDERSTANDING THAT YOU WILL AUTHORIZE THE NIC TO REIMBURSE YOUR EMPLOYER FOR THIS BENEFIT PAYMENT(S)

I _____ authorize the Director of the National Insurance Corporation to pay to my employer the benefit payment resulting from this claim.

SIGNATURE OR MARK OF CLAIMANT: _____ DATE: _____ (dd/mm/yy)

GOVERNMENT-ISSUED PHOTO IDENTIFICATION OF CLAIMANT TO BE SUBMITTED WITH CLAIM

SECTION "C" – YOUR FINANCIAL INFORMATION

ONLY COMPLETE IF YOUR BENEFIT PAYMENT IS NOT ASSIGNED TO YOUR EMPLOYER

FINANCIAL INFORMATION

By providing your account information for the purposes of payment of a benefit to you via direct deposit you agree that the National Insurance Corporation (the Corporation) will rely on the information which you provide for the processing of each payment of the benefit transmitted to you. You are responsible for providing the Corporation with accurate information including; the account number; the name of the Financial Institution; the Branch of the Financial Institution and any other information determined by the Financial Institution, since the payment to you will be processed based on said information.

NAME OF FINANCIAL INSTITUTION: _____ ADDRESS: _____

ACCOUNT NUMBER: _____ ROUTING NUMBER: _____

TYPE OF ACCOUNT: CHEQUING ◯ SAVINGS ◯ BRANCH: _____

Sickness Benefit will be paid in full for a maximum period of 26 WEEKS if there is a loss of earnings.

SECTION "D" – MUST BE COMPLETED BY CLAIMANT

I understand that a false statement or misrepresentation makes me liable to a penalty under the National Insurance Corporation Act, Cap. 16. 01 of the Revised Laws of Saint Lucia. I hereby certify that the above-captioned statements are true to the best of my knowledge and belief, and I assume full responsibility as to their correctness. I declare that I am losing earnings and have not worked for the period claimed as a result of my illness. I hereby give permission for NIC to update my contact information from this form. I hereby give consent for the Medical Certificate at Section "E" to be sent to the National Insurance Corporation.

I understand that I am solely responsible for any losses arising from the National Insurance Corporation's reliance on the information provided, including but not limited to losses associated with funds being incorrectly credited to the wrong beneficiary.

_____ _____

Date *dd/mm/yy* Signature or Mark of Claimant

PARTICULARS OF WITNESS (Lawyer, Notary Royal/Notary Public, Commissioner of Oaths) TO MARK OR SIGNATURE (Where Claimant Cannot Sign or Claimant is Overseas)

NAME: _____

ADDRESS: _____

EMAIL: _____

OCCUPATION: _____

STAMP OF WITNESS

SIGNATURE OF WITNESS: _____ DATE: _____ *dd/mm/yy*

SECTION "E" – TO BE COMPLETED BY MEDICAL PRACTITIONER

I hereby certify that Mr./Mrs./Ms._____

was examined by me on _____ and in my opinion was at the time suffering from _____ .

This patient will remain incapable of work for a period of _____days starting from _____ and will be fit to resume work
dd/mm/yy

on _____
dd/mm/yy

NAME OF MEDICAL PRACTITIONER: _____

OFFICE ADDRESS: _____

MEDICAL PRACTITIONER
CERTIFICATE LICENSE NUMBER: _____

LICENSE EXPIRATION
DATE: _____
dd/mm/yy

TELEPHONE NUMBER: _____

I hereby certify that the above-captioned statements are true to the best of my knowledge and belief and I assume full responsibility as to their correctness.

_____
SIGNATURE OF MEDICAL PRACTITIONER

_____
DATE
dd/mm/yy

MEDICAL/DENTAL PRACTITIONER'S STAMP

NOTE: In case of a FIRST or SECOND CERTIFICATE the period of certified incapacity must not exceed 14 DAYS including Sundays and Public Holidays.

In case of a THIRD OR SUBSEQUENT CERTIFICATE, the PERIOD entered must not exceed 28 DAYS including Sundays and Public Holidays.

OTHER REMARKS BY DOCTOR

SECTION "F" – TO BE COMPLETED BY EMPLOYER

EMPLOYER'S NAME: _____ **REGISTRATION NUMBER:** _____

TELEPHONE NUMBER: _____ **EMAIL ADDRESS:** _____

1. The following information is with reference to Mr./Mrs./Ms.: _____

2. Employee National Insurance Number: _____

3. The Employee has been absent from work on account of sickness continuously from: _____
dd/mm/yy

4. The employee is expected to return to work on (*exact date*): _____
dd/mm/yy

5. The employee is scheduled for vacation leave during period of sick leave. YES ◯ NO ◯

If "YES" state exact period, from _____ to _____
dd/mm/yy *dd/mm/yy*

6. How much will employee be paid during the period of illness? **(Select the appropriate response below)**

(a) ◯ 100% of earnings with NO requirement for assignment of the NIC benefit to the employer

State the exact period that the employee will be receiving full pay:

From: _____ to _____
dd/mm/yy *dd/mm/yy*

(b) ◯ 100% of earnings with the expectation of assignment of NIC Benefit Payment to Employer
Note: if selected please provide your financial information via our website (stlucianic.org) to facilitate reimbursement.

State the exact period that the employee will be receiving full pay:

From: _____ to _____
dd/mm/yy *dd/mm/yy*

(c) ◯ 35% of earnings (d) ◯ No Payment (e) ◯ Other: _____
Please specify

7. Is the Sickness as a result of an accident on the job? YES ◯ NO ◯
(If Yes Please Complete Form EIB(1) (Employment Injury Form))

8. Is applicant still employed? YES ◯ NO ◯

If "NO" please state last date of employment: _____
dd/mm/yy

NAME OF EMPLOYER'S REPRESENTATIVE: _____

POSITION OF EMPLOYER'S REPRESENTATIVE: _____

I hereby certify that the above-captioned statements are true to the best of my knowledge and belief, and I assume full responsibility as to their correctness.

_____ _____
SIGNATURE OF EMPLOYER'S REPRESENTATIVE DATE

EMPLOYER'S STAMP

SECTION "G" OPTIONAL – REASON(S) FOR LATE CLAIM
TO BE COMPLETED BY CLAIMANT OR EMPLOYER

NOTE: * To be completed and signed by the Claimant if the delay is as a result of the claimant's late submission to the employer.

OR

To be completed and signed by the employer if the delay is as a result of the employer's late submission to the NIC.

IMPORTANT: A Sickness Benefit Claim must be submitted to the National Insurance Corporation within 3 months from the date of expiration of sick leave. Late claims may mean loss of the benefit. If this Sickness Benefit claim is late, please provide details of the reason(s) for lateness.

Please note that completion of this section does not guarantee payment of a claim which has been submitted late.

_____

_____

_____

_____

_____

_____
NAME OF EMPLOYER REPRESENTATIVE

_____
POSITION OF EMPLOYER REPRESENTATIVE

_____
SIGNATURE OF EMPLOYER REPRESENTATIVE

_____
NAME OF CLAIMANT

_____
SIGNATURE OR MARK OF CLAIMANT

Warning: Any person who knowingly makes a false statement or misrepresentation for the purpose of obtaining benefit for himself or herself or some other person commits a criminal offence punishable by a fine or imprisonment or both pursuant to the National Insurance Corporation Act Cap. 16.01 of the Revised Laws of Saint Lucia.

(ii) Form MB 1, Claim for Maternity Allowance and Grant, Reg. 44(1) with the following Form MB 1, Maternity Benefit Claim Form, Reg. 44(1) —

NATIONAL INSURANCE CORPORATION
MATERNITY BENEFIT CLAIM FORM

Form MB1 (Reg. 44 – (1))

SECTION "A" – TO BE COMPLETED BY CLAIMANT

1. **NAME:** _____ 2. **NATIONAL INSURANCE NUMBER:** _____
3. **DATE OF BIRTH:** _____ *dd/mm/yy* 4. **EMAIL ADDRESS:** _____
5. **HOME ADDRESS:** _____ 6. **POSTAL ADDRESS:** _____ *(if different from above)*
7. **MARITAL STATUS:** **MARRIED** ◯ **SINGLE** ◯ **WIDOWED** ◯ **DIVORCED** ◯
8. **TELEPHONE:** _____ **(HOME)** _____ **(WORK)** _____ **(CELL)**
9. **OCCUPATION:** _____ 10. **EMPLOYER'S NAME:** _____
11. **EMPLOYER'S ADDRESS:** _____
12. **NAME OF ACTUAL PLACE OF WORK:** _____
13. **ADDRESS OF ACTUAL PLACE OF WORK:** _____
14. **ARE YOU CURRENTLY EMPLOYED ELSEWHERE?** **YES** ◯ **NO** ◯
    (If "YES" state Name and Address of other employer.)
    NAME OF EMPLOYER: _____
    EMPLOYER'S ADDRESS: _____
15. **THE PERIOD FOR WHICH I CLAIM BENEFITS IS FROM:** _____ *dd/mm/yy* **TO:** _____ *dd/mm/yy*

SECTION "B" (OPTIONAL) – ASSIGNMENT TO EMPLOYER

ONLY COMPLETE IF YOU WILL BE PAID 100% OF YOUR EARNINGS BY YOUR EMPLOYER FOR THE PERIOD OF MATERNITY LEAVE WITH THE UNDERSTANDING THAT YOU WILL AUTHORIZE THE NIC TO REIMBURSE YOUR EMPLOYER FOR THE BENEFIT PAYMENT(S)

I _____ authorize the Director of the National Insurance Corporation to pay to my employer the benefit payment resulting from this claim.

SIGNATURE OR MARK OF CLAIMANT: _____ **DATE:** _____ *dd/mm/yy*

GOVERNMENT-ISSUED PHOTO IDENTIFICATION OF CLAIMANT TO BE SUBMITTED WITH CLAIM

SECTION "C" – YOUR FINANCIAL INFORMATION

ONLY COMPLETE IF YOUR BENEFIT PAYMENT IS NOT ASSIGNED TO YOUR EMPLOYER

FINANCIAL INFORMATION

By providing your account information for the purposes of payment of a benefit to you via direct deposit you agree that the National Insurance Corporation (the Corporation) will rely on the information which you provide for the processing of each payment of the benefit transmitted to you. You are responsible for providing the Corporation with accurate information including; the account number; the name of the Financial Institution; the Branch of the Financial Institution and any other information determined by the Financial Institution, since the payment to you will be processed based on said information.

NAME OF FINANCIAL INSTITUTION: _____ ADDRESS: _____

ACCOUNT NUMBER: _____ ROUTING NUMBER: _____

TYPE OF ACCOUNT: CHEQUING ◯ SAVINGS ◯ BRANCH: _____

SECTION "D" – MUST BE COMPLETED BY CLAIMANT

I understand that a false statement or misrepresentation makes me liable to a penalty under the National Insurance Corporation Act, Cap. 16. 01 of the Revised Laws of Saint Lucia. I hereby certify that the above-captioned statements are true to the best of my knowledge and belief, and I assume full responsibility as to their correctness. I declare that I am losing earnings and have not worked for the period claimed as a result of my maternity. I hereby give permission for NIC to update my contact information from this form. I hereby give consent for the Medical Certificate at Section "E" to be sent to the National Insurance Corporation.

I understand that I am solely responsible for any losses arising from the National Insurance Corporation's reliance on the information provided, including but not limited to losses associated with funds being incorrectly credited to the wrong beneficiary.

_____ _____

Date *dd/mm/yy* Signature or Mark of Claimant

PARTICULARS OF WITNESS (Lawyer, Notary Royal/Notary Public, Commissioner of Oaths) TO MARK OR SIGNATURE (Where Claimant Cannot Sign or Claimant is Overseas)

NAME: _____

ADDRESS: _____

EMAIL: _____

OCCUPATION: _____

STAMP OF WITNESS

SIGNATURE OF WITNESS: _____ DATE: _____ *dd/mm/yy*

SECTION "E" – TO BE COMPLETED BY MEDICAL PRACTITIONER OR MIDWIFE

To: _____
Name of Claimant

A. EXPECTED CONFINEMENT

I certify that I examined you on _____ and that in my opinion, you may expect to be confined on _____.
dd/mm/yy *dd/mm/yy*

Any other remarks by doctor or midwife _____

_____

B. ACTUAL CONFINEMENT

I certify that I attended to you during your confinement which took place at _____ on _____.
dd/mm/yy

Any other remarks by doctor or midwife _____

_____

And that you delivered Male/Female CHILD / CHILDREN _____ LIVING / DEAD _____

Please state number of children: _____ If dead, state the gestational age: _____

NAME OF MEDICAL PRACTITIONER/ MIDWIFE: _____

OFFICE ADDRESS: _____

MEDICAL PRACTITIONER/ MIDWIFE CERTIFICATE LICENSE NUMBER: _____

LICENSE EXPIRATION DATE: _____
dd/mm/yy

TELEPHONE NUMBER: _____

I hereby certify that the above-captioned statements are true to the best of my knowledge and belief and I assume full responsibility as to their correctness.

_____ _____
SIGNATURE OF MEDICAL PRACTITIONER/ MIDWIFE **DATE** *dd/mm/yy*

MEDICAL/DENTAL PRACTITIONER'S/ MIDWIFE STAMP

OTHER REMARKS BY DOCTOR/ MIDWIFE

_____

_____

_____

SECTION "F" – TO BE COMPLETED BY EMPLOYER

EMPLOYER'S NAME: _____ **REGISTRATION NUMBER:** _____

TELEPHONE NUMBER: _____ **EMAIL ADDRESS:** _____

1. The following information is with reference to Mr./Mrs./Ms.: _____

2. Employee's National Insurance Number: _____

3. The employee has been absent from work on account of maternity continuously from: _____ *dd/mm/yy*

4. The employee is expected to return to work on (*exact date*): _____ *dd/mm/yy*

5. The employee is scheduled for vacation leave during period of maternity leave. YES ◯ NO ◯

   If "YES" state exact period, from _____ *dd/mm/yy* to _____ *dd/mm/yy*

6. How much will employee be paid during the period of maternity leave? **(Select the appropriate response below)**

   (a) ◯ 100% of earnings with NO requirement for assignment of the NIC benefit to the employer

   State the exact period that the employee will be receiving full pay:

   From: _____ *dd/mm/yy* to _____ *dd/mm/yy*

   (b) ◯ 100% of earnings with the requirement that the NIC benefit payment is assigned to the Employer
   Note: if selected please provide your financial information via our website (stlucianic.org) to facilitate reimbursement.

   State the exact period that the employee will be receiving full pay:

   From: _____ *dd/mm/yy* to _____ *dd/mm/yy*

   (c) ◯ 35% of earnings (d) ◯ No Payment (e) ◯ Other: _____ *Please specify*

7. Is the claimant still employed? YES ◯ NO ◯

   If "NO" please state last date of employment: _____ *dd/mm/yy*

   NAME OF EMPLOYER'S REPRESENTATIVE: _____

   POSITION OF EMPLOYER'S REPRESENTATIVE: _____

I certify that the above statements are true to the best of my knowledge and belief and I assume full responsibility as to their correctness. I also undertake to notify the national insurance corporation as soon as possible of the return of the employee to my employ.

_____ SIGNATURE OF EMPLOYER'S REPRESENTATIVE

_____ DATE

EMPLOYER'S STAMP

SECTION "G" OPTIONAL – REASON(S) FOR LATE CLAIM
TO BE COMPLETED BY CLAIMANT OR EMPLOYER

NOTE: * To be completed and signed by the employee if the delay is as a result of the claimant's late submission to the employer.

OR

To be completed and signed by the employer if the delay is as a result of the employer's late submission to the NIC.

IMPORTANT: A Maternity Benefit Claim must be submitted to the National Insurance Corporation within 3 months after the date of confinement. Late claims may mean loss of the benefit. If this Maternity Benefit claim is late, please provide details of the reason(s) for lateness.

Please note that completion of this section does not guarantee payment of a claim which has been submitted late.

_____

_____

_____

_____

_____

_____
NAME OF EMPLOYER REPRESENTATIVE

_____
POSITION OF EMPLOYER REPRESENTATIVE

_____
SIGNATURE OF EMPLOYER REPRESENTATIVE

_____
NAME OF CLAIMANT

_____
SIGNATURE OR MARK OF CLAIMANT

Warning: Any person who knowingly makes a false statement or misrepresentation for the purpose of obtaining benefit for himself or herself or some other person commits a criminal offence punishable by a fine or imprisonment or both pursuant to the National Insurance Corporation Act Cap. 16.01 of the Revised Laws of Saint Lucia.

(iii) Form FB 1, Claim for Funeral Benefit, Reg. 61(3) with the following Form FB 1, Funeral Grant Claim Form, Reg. 61(3) —

Form FB1 (Reg. 61 (3))

NATIONAL INSURANCE CORPORATION
FUNERAL GRANT CLAIM FORM

SECTION "A" – TO BE COMPLETED BY CLAIMANT

PARTICULARS OF DECEASED PERSON

1. NAME: _____ 2. NATIONAL INSURANCE NUMBER: _____

3. DATE OF BIRTH: _____ *dd/mm/yy* 4. DATE OF DEATH: _____ *dd/mm/yy*

5. CAUSE OF DEATH: _____

PARTICULARS OF CLAIMANT

6. NAME: _____ 7. NATIONAL INSURANCE NUMBER: _____

8. DATE OF BIRTH: _____ *dd/mm/yy* 9. EMAIL ADDRESS: _____ 10. GENDER: MALE ◯ FEMALE ◯

11. HOME ADDRESS: _____ 12. POSTAL ADDRESS: _____ *(if different from home address)*

13. MARTIAL STATUS: MARRIED ◯ SINGLE ◯ WIDOWED ◯ DIVORCED ◯

14. TELEPHONE: _____ (HOME) _____ (WORK) _____ (CELL)

15. RELATION TO DECEASED: _____

16. TO THE BEST OF YOUR KNOWLEDGE AND BELIEF, ARE YOU THE ONLY PERSON WHO WILL BE ENTITLED TO MAKE THIS CLAIM?
YES ◯ NO ◯ IF 'NO', PLEASE ENSURE SECTION 'F' IS COMPLETED

SECTION "B" – YOUR FINANCIAL INFORMATION

ONLY COMPLETE IF YOUR FUNERAL BENEFIT PAYMENT IS NOT ASSIGNED TO A FUNERAL HOME

FINANCIAL INFORMATION

By providing your account information for the purposes of payment of a benefit to you via direct deposit you agree that the National Insurance Corporation (the Corporation) will rely on the information which you provide for the processing of each payment of the benefit transmitted to you. You are responsible for providing the Corporation with accurate information including; the account number; the name of the Financial Institution; the Branch of the Financial Institution and any other information determined by the Financial Institution, since the payment to you will be processed based on said information.

NAME OF FINANCIAL INSTITUTION: _____ ADDRESS: _____

ACCOUNT NUMBER: _____ ROUTING NUMBER: _____

TYPE OF ACCOUNT: CHEQUING ◯ SAVINGS ◯ BRANCH: _____

GOVERNMENT-ISSUED PHOTO IDENTIFICATION OF CLAIMANT TO BE SUBMITTED WITH CLAIM

SECTION "C" – ASSIGNMENT TO FUNERAL HOME (OPTIONAL)

NAME OF FUNERAL HOME: _____

I _____ **hereby authorize the Director of the National Insurance Corporation to pay the above-mentioned Funeral Home the full amount of any funeral benefit which is determined to be payable to me as a result of my claim for a funeral grant.**

DECLARATION

I understand that I am solely responsible for any losses arising from the National Insurance Corporation's reliance on the information provided, including but not limited to losses associated with the funds being incorrectly assigned to the Funeral Home.

SECTION "D" – MUST BE COMPLETED BY CLAIMANT

I understand that a false statement or misrepresentation makes me liable to a penalty under the National Insurance Corporation Act, Cap. 16. 01 of the Revised Laws of Saint Lucia. I hereby certify that the above-captioned statements are true to the best of my knowledge and belief, and I assume full responsibility as to their correctness. I hereby give permission for NIC to update my contact information from this form.

I understand that I am solely responsible for any losses arising from the National Insurance Corporation's reliance on the information provided, including but not limited to losses associated with funds being incorrectly credited to the wrong beneficiary.

_____ _____

Date **Signature or Mark of Claimant**

dd/mm/yy

PARTICULARS OF WITNESS (Lawyer, Notary Royal/Notary Public, Commissioner of Oaths) TO MARK OR SIGNATURE (Where Claimant Cannot Sign or Claimant is Overseas)

NAME: _____

ADDRESS: _____

EMAIL: _____

OCCUPATION: _____

STAMP OF WITNESS

SIGNATURE OF WITNESS: _____ **DATE:** _____

dd/mm/yy

SECTION "E" – TO BE COMPLETED BY THE FUNERAL HOME

NAME OF FUNERAL HOME: _____

BUSINESS ADDRESS: _____ **EMAIL ADDRESS:** _____

TELEPHONE: _____ _____
BUSINESS **MOBILE**

FINANCIAL ACCOUNT INFORMATION

By providing your account information for the purposes of payment of an assigned FUNERAL GRANT via direct deposit, you agree that the National Insurance Corporation (the Corporation) will rely on the information which you provide for the processing of the payment of the funeral grant. You are responsible for providing the Corporation with accurate information including the account number; the name of the Financial Institution; the Branch of the Financial Institution and any other information determined by the Financial Institution, since the payment will be processed based on the said information.

NAME OF FINANCIAL INSTITUTION: _____

ADDRESS: _____ **BRANCH:** _____

ACCOUNT NUMBER: _____ **ROUTING NUMBER:** _____
(If applicable)

TYPE OF ACCOUNT: **CHEQUING** ◯ **SAVINGS** ◯

DECLARATION

We understand that we are solely responsible for any losses arising from the National Insurance Corporation's reliance on the financial information provided, including but not limited to losses associated with the funds being incorrectly credited to the wrong beneficiary.

I understand that a false statement or misrepresentation makes me liable to a penalty under the National Insurance Corporation Act Cap.16.01 of the Revised Laws of Saint Lucia.

NAME OF FUNERAL HOME REPRESENTATIVE: _____ **POSITION:** _____

SIGNATURE: _____ **DATE:** _____
dd/mm/yy

SECTION "F" – TO BE COMPLETED BY PARTIES (OTHER THAN THE CLAIMANT) WHO ARE ELIGIBLE TO CLAIM FOR THE FUNERAL GRANT

BY COMPLETING THIS SECTION, I / WE HEREBY AGREE AND AUTHORISE THE DIRECTOR OF THE NATIONAL INSURANCE CORPORATION TO PAY THE FULL AMOUNT OF ANY FUNERAL BENEFIT TO THE CLAIMANT,

Ms./Mrs./Mr. _____
NAME OF CLAIMANT

I/we understand that having given this authorization I am / we are no longer entitled to make a claim for the funeral grant in the relation to the

deceased _____ NIC# _____
NAME OF DECEASED

PARTICULARS OF PERSON(S)

1. FULL NAME: _____ NIC#: _____ EMAIL: _____

TELEPHONE: _____ _____ _____
(HOME) (WORK) (CELL)

_____ _____
SIGNATURE DATE

2. FULL NAME: _____ NIC#: _____ EMAIL: _____

TELEPHONE: _____ _____ _____
(HOME) (WORK) (CELL)

_____ _____
SIGNATURE DATE

3. FULL NAME: _____ NIC#: _____ EMAIL: _____

TELEPHONE: _____ _____ _____
(HOME) (WORK) (CELL)

_____ _____
SIGNATURE DATE

GOVERNMENT-ISSUED PHOTO IDENTIFICATION OF ALL PARTIES MUST BE ATTACHED

SECTION "G" – REASON (S) FOR LATE CLAIM (OPTIONAL)

IMPORTANT: A Funeral Grant Claim must be submitted to the National Insurance Corporation within 6 months from the date of death of the deceased. Late claims may mean loss of the benefit. If this Funeral Grant claim is late, please provide details of the reason(s) for lateness.

Please note that completion of this section does not guarantee payment of a claim which has been submitted late.

_____

_____

_____

_____

_____

_____

SIGNATURE OF CLAIMANT

Warning: Any person who knowingly makes a false statement or misrepresentation for the purpose of obtaining benefit for himself or herself or some other person commits a criminal offence punishable by a fine or imprisonment or both pursuant to the National Insurance Corporation Act Cap. 16.01 of the Revised Laws of Saint Lucia.

FOR OFFICIAL USE ONLY

Invoice Received – ☐

Receipt Received – ☐

Death Certificate Received – ☐

Photo Identification of Deceased Received – ☐

Photo Identification of Claimant Received – ☐

(iv) Form EIB 2, Claim for Employment Injury Benefit, Reg. 66 with the following Form EIB 2, Employment Injury Benefit Claim Form, Reg. 66 —

NATIONAL INSURANCE CORPORATION
EMPLOYMENT INJURY BENEFIT CLAIM FORM

Form EIB 2 (Reg. 66)

SECTION "A" – TO BE COMPLETED BY CLAIMANT

1. **NAME:** _____ 2. **NATIONAL INSURANCE NUMBER:** _____

3. **DATE OF BIRTH:** _____ *dd/mm/yy* 4. **EMAIL ADDRESS:** _____ 5. **GENDER: MALE** ◯ **FEMALE** ◯

6. **HOME ADDRESS:** _____ 7. **POSTAL ADDRESS:** _____ *(if different from above)*

8. **MARTIAL STATUS: MARRIED** ◯ **SINGLE** ◯ **WIDOWED** ◯ **DIVORCED** ◯

9. **TELEPHONE:** _____ **(HOME)** _____ **(WORK)** _____ **(CELL)**

10. **OCCUPATION:** _____ 11. **EMPLOYER'S NAME:** _____

12. **EMPLOYER'S ADDRESS:** _____

13. **ADDRESS WHERE THE ACCIDENT OCCURRED:** _____

14. **WAS THE ACCIDENT REPORTED?** ◯ **YES** ◯ **NO**

15. **IF YES, TO WHOM:** _____

16. **ARE YOU CURRENTLY EMPLOYED ELSEWHERE?** **YES** ◯ **NO** ◯
(If "YES" state Name and Address of other employer.)

NAME OF EMPLOYER: _____

EMPLOYER'S ADDRESS: _____

17. **AS RESULT OF MY INJURY, I LAST WORKED ON:** _____ *dd/mm/yy*

18. **DATE OF ACCIDENT:** _____ *dd/mm/yy* **TIME OF ACCIDENT:** _____

19. **EXACT PLACE WHERE THE ACCIDENT HAPPENED:** _____

_____

20. **EXPLAIN HOW THE ACCIDENT HAPPENED:** _____

_____

_____

21. **DID ANYONE WITNESS THE ACCIDENT:** **YES** ◯ **NO** ◯

22. **IF YES, STATE THEIR NAME AND CONTACT NO.:** _____ **(NAME OF WITNESS)** _____ **(CONTACT NO.)**

GOVERNMENT-ISSUED PHOTO IDENTIFICATION OF CLAIMANT TO BE SUBMITTED WITH CLAIM

SECTION "B" (OPTIONAL) – ASSIGNMENT TO EMPLOYER

ONLY COMPLETE IF YOU WILL BE PAID 100% OF YOUR EARNINGS BY YOUR EMPLOYER FOR THE PERIOD OF ILLNESS WITH THE UNDERSTANDING THAT YOU WILL AUTHORIZE THE NIC TO REIMBURSE YOUR EMPLOYER FOR THIS BENEFIT PAYMENT(S)

I _____ authorize the Director of the National Insurance Corporation to pay to my employer the benefit payment resulting from this claim.

SIGNATURE OR MARK OF CLAIMANT: _____ **DATE:** _____
dd/mm/yy

SECTION "C" – YOUR FINANCIAL INFORMATION

ONLY COMPLETE IF YOUR BENEFIT PAYMENT IS NOT ASSIGNED TO YOUR EMPLOYER

FINANCIAL INFORMATION

By providing your account information for the purposes of payment of a benefit to you via direct deposit you agree that the National Insurance Corporation (the Corporation) will rely on the information which you provide for the processing of each payment of the benefit transmitted to you. You are responsible for providing the Corporation with accurate information including; the account number; the name of the Financial Institution; the Branch of the Financial Institution and any other information determined by the Financial Institution, since the payment to you will be processed based on said information.

NAME OF FINANCIAL INSTITUTION: _____ **ADDRESS:** _____

ACCOUNT NUMBER: _____ **ROUTING NUMBER:** _____

TYPE OF ACCOUNT: **CHEQUING** ◯ **SAVINGS** ◯ **BRANCH:** _____

SECTION "D" – MUST BE COMPLETED BY CLAIMANT

I understand that a false statement or misrepresentation makes me liable to a penalty under the National Insurance Corporation Act, Cap. 16. 01 of the Revised Laws of Saint Lucia. I hereby certify that the above-captioned statements are true to the best of my knowledge and belief, and I assume full responsibility as to their correctness. I declare that I am losing earnings and have not worked for the period claimed as a result of my illness. I hereby give permission for NIC to update my contact information from this form. I hereby give consent for the Medical Certificate at Section "E" to be sent to the National Insurance Corporation.

I understand that I am solely responsible for any losses arising from the National Insurance Corporation's reliance on the information provided, including but not limited to losses associated with funds being incorrectly credited to the wrong beneficiary.

_____ **Date**
dd/mm/yy

_____ **Signature or Mark of Claimant**

PARTICULARS OF WITNESS (Lawyer, Notary Royal/Notary Public, Commissioner of Oaths) TO MARK OR SIGNATURE
(Where Claimant Cannot Sign or Claimant is Overseas)

NAME: _____

ADDRESS: _____

EMAIL: _____

OCCUPATION: _____

STAMP OF WITNESS

SIGNATURE OF WITNESS: _____ **DATE:** _____
dd/mm/yy

SECTION "E" – TO BE COMPLETED BY MEDICAL PRACTITIONER

I hereby certify that Mr./Mrs./Ms._____

was examined by me on _____ and in my opinion was at the time suffering from _____ .

This patient will remain incapable of work for a period of _____days starting from _____ and will be fit to resume work
dd/mm/yy

on _____
dd/mm/yy

NAME OF MEDICAL PRACTITIONER: _____

OFFICE ADDRESS: _____

MEDICAL PRACTITIONER CERTIFICATE LICENSE NUMBER: _____

LICENSE EXPIRATION DATE: _____
dd/mm/yy

TELEPHONE NUMBER: _____

I hereby certify that the above-captioned statements are true to the best of my knowledge and belief and I assume full responsibility as to their correctness.

_____ **SIGNATURE OF MEDICAL PRACTITIONER**

_____ **DATE**
dd/mm/yy

MEDICAL/DENTAL PRACTITIONER'S STAMP

NOTE: In case of a FIRST CERTIFICATE, the period of certified incapacity must not exceed 7 DAYS (including Sundays and Public Holidays).

In case of a SECOND CERTIFICATE, the period of certified incapacity must not exceed 14 DAYS (including Sundays and Public Holidays and for a THIRD OR SUBSEQUENT CERTIFICATE the PERIOD indicated must not exceed 28 DAYS.

OTHER REMARKS BY DOCTOR

SECTION "F" – TO BE COMPLETED BY EMPLOYER

1. NAME OF EMPLOYEE: _____ 2. EMPLOYEE'S NIC NUMBER: _____

3. EMPLOYER'S NAME: _____ 4. REGISTRATION NUMBER: _____

5. TELEPHONE NUMBER: _____ 6. EMAIL ADDRESS: _____

7. ADDRESS OF WORKPLACE: _____

8. NATURE OF BUSINESS: _____ 9. ESTIMATED DURATION OF DISABILITY: _____
On basis of Medical Certificate

10. NORMAL RATE OF WAGES: _____

11. State wages paid for day of accident (if any): _____

12. The Employee has been absent from work on account of injury continuously from: _____
dd/mm/yy

13. The employee is expected to return to work on (*exact date*): _____
dd/mm/yy

14. The employee is scheduled for vacation leave during period of sick leave. ◯ YES ◯ NO

If "YES" state exact period, from _____ to _____
dd/mm/yy *dd/mm/yy*

15. How much will employee be paid during the period of illness? (Select the appropriate response below)

(a) ◯ 100% of earnings with NO requirement for assignment of the NIC benefit to the employer

State the exact period that the employee will be receiving full pay: From: _____ to _____
dd/mm/yy *dd/mm/yy*

(b) ◯ 100% of earnings with the expectation of assignment of NIC Benefit Payment to Employer

Note: if selected please provide your financial information via our website (stlucianic.org) to facilitate reimbursement.

State the exact period that the employee will be receiving full pay: From: _____ to _____
dd/mm/yy *dd/mm/yy*

(c) ◯ 35% of earnings (d) ◯ No Payment (e) ◯ Other: _____
Please specify

16. Is applicant still employed? YES ◯ NO ◯ Please state last date of employment: _____
dd/mm/yy

17. DATE AND TIME OF ACCIDENT: _____
DAY MONTH YEAR TIME

18. DATE AND TIME INJURED PERSON STOPPED WORKING: _____
DAY MONTH YEAR TIME

19. BETWEEN WHAT HOURS WAS INJURED PERSON NORMALLY EXPECTED TO WORK? From: _____ to: _____

20. EXACT PLACE OR LOCATION WHERE THE ACCIDENT OCCURRED? _____

_____

21. WAS THE INJURED PERSON AUTHORIZED TO BE IN THE PLACE AT THE TIME OF THE ACCIDENT? ◯ YES ◯ NO

22. EXACT TYPE OF WORK PERFORMED BY INJURED PERSON AT THE TIME OF ACCIDENT: _____

23. WAS THIS TYPE OF WORK AUTHORIZED OR PERMITTED? ◯ YES ◯ NO

24. WHAT WAS THE EXACT CAUSE OF THE ALLEGED ACCIDENT? HOW DID IT HAPPEN? _____

_____

25. IF CAUSED BY MACHINERY, GIVE NAME OF MACHINE AND PART CAUSING ACCIDENT: _____

26. STATE WHETHER MACHINE WAS MOVED BY MECHANICAL POWER AT TIME OF ACCIDENT: _____

27. WHAT WAS THE NATURE, LOCATION AND EXTENT OF THE INJURY OBSERVED AT THE TIME OF THE ACCIDENT? _____

_____

28. STATE WHETHER ACCIDENT WAS FATAL OR NOT: _____

29. STATE WHAT MEASURES WERE TAKEN TO PREVENT RECURRENCE OF SIMILAR ACCIDENT: _____

_____

30. WAS THE ACCIDENT REPORTED TO THE LABOUR DEPARTMENT? ◯ YES ◯ NO

31. COULD THE ACCIDENT HAVE BEEN PREVENTED? ◯ YES ◯ NO

I certify that the information given above is true and correct to the best of my knowledge and I understand that any false statement or misrepresentation renders me liable to a penalty under the National Insurance Corporation Act, Cap.16.01 of the Revised Laws of Saint Lucia

NAME OF EMPLOYER REPRESENTATIVE: _____

POSITION OF EMPLOYER REPRESENTATIVE: _____

EMPLOYER'S STAMP

_____ _____

SIGNATURE DATE

SECTION "G" OPTIONAL – REASON (S) FOR LATE CLAIM
TO BE COMPLETED BY CLAIMANT OR EMPLOYER

NOTE: * To be completed and signed by the Claimant if the delay is as a result of the Claimant's late submission to the employer.

OR

To be completed and signed by the employer if the delay is as a result of the employer's late submission to the NIC.

IMPORTANT: An Employment Injury Benefit Claim must be submitted to the National Insurance Corporation within 3 months from the date of expiration of sick leave. Late claims may mean loss of the benefit. If this Employment Injury Benefit claim is late, please provide details of the reason(s) for lateness.

Please note that completion of this section does not guarantee payment of a claim which has been submitted late.

_____

_____

_____

_____

_____

_____
NAME OF EMPLOYER REPRESENTATIVE

_____
POSITION OF EMPLOYER REPRESENTATIVE

_____
SIGNATURE OF EMPLOYER REPRESENTATIVE

_____
NAME OF CLAIMANT

_____
SIGNATURE OR MARK OF CLAIMANT

Warning: Any person who knowingly makes a false statement or misrepresentation for the purpose of obtaining benefit for himself or herself or some other person commits a criminal offence punishable by a fine or imprisonment or both pursuant to the National Insurance Corporation Act Cap. 16.01 of the Revised Laws of Saint Lucia.

Made this 14th day of November, 2024.

PHILIP J. PIERRE,
Minister responsible for the
National Insurance Corporation.

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