NATIONAL INSURANCE CORPORATION
COVID-19 SICKNESS BENEFIT FORM

THE FORM MUST BE SIGNED IN THE CASE OF AN INSURED PERSON EMPLOYED BY (1) THE CROWN OR STATUTORY BODY - BY ANY TWO SENIOR OFFICERS INCLUDING THE PERMANENT SECRETARY OR HEAD OF A DEPARTMENT, UNIT OR AGENCY (2) IF EMPLOYED BY AN INDIVIDUAL, PARTNERSHIP OR COMPANY - BY ANY TWO SENIOR EMPLOYEES INCLUDING THE CHIEF EXECUTIVE OFFICER, CHIEF FINANCIAL OFFICER OR HUMAN RESOURCE MANAGER.

INSTRUCTIONS FOR COMPLETION

This section must be completed by the Employer before the Application is submitted to the NIC.

Employer's Name: _____

Employer's Registration Number: _____ Telephone Number: _____

Email Address: _____

1. This is to certify that Mr/Mrs/Ms:

   _____ _____

   SURNAME FIRST NAME

2. Employee NIC Number: _____ Telephone Number: _____

   Address: _____

3. Employee has been absent from work from: _____

   mm/dd/yyyy

4. Please state exact date employee is expected to return to work: _____

   mm/dd/yyyy

5. The employee's absence is as a result of:

   i. ◯ **Quarantine** - He or she is required to abstain from work because he or she may have been exposed to COVID-19 through direct or indirect contact
   ii. ◯ **Isolation**- He or she is required to abstain from work due to the fact that he or she is manifesting signs and symptoms of COVID-19
   iii. ◯ **COVID-19** – He or she is required to abstain from work due to the fact that he or she has been diagnosed with COVID-19.
   iv. ◯ **NONE OF THE ABOVE**

If COVID-19 is selected please ensure the relevant medical certificate from a registered medical practitioner or a medical officer appointed by the Chief Medical Officer is attached to this form.

6. Will the employee be receiving his/her full pay for the entire period of absence?:

Yes ◯ No ◯

If "YES" state the exact period that the employee will be receiving full pay:

From _____ to _____

mm/dd/yyyy *mm/dd/yyyy*

7. Is Applicant still employed?: Yes ◯ No ◯
If "NO" please state reason(s):

DECLARATION

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 also undertake to notify the National Insurance Corporation as soon as possible of the return of the employee to my employ.

REPRESENTATIVE #1:

SURNAME	FIRST NAME

POSITION: **SIGNATURE:**

REPRESENTATIVE #2:

SURNAME	FIRST NAME

POSITION: **SIGNATURE:**

EMPLOYER'S STAMP: _____ **DATE:** _____

mm/dd/yyyy

THIS SECTION TO BE COMPLETED BY EMPLOYEE

Routing Number is necessary if your financial institution is either RBC or RBTT.

EMPLOYEE FINANCIAL INFORMATION

NAME OF FINANCIAL INSTITUTION:			
ADDRESS:			
ACCOUNT NO.:		CONFIRM ACCOUNT NO.:	
BRANCH:			
ROUTING NO.:			

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

DECLARATION

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.

EMPLOYEE SIGNATURE: _____ **DATE:** _____
mm/dd/yyyy

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.