

# NATIONAL INSURANCE CORPORATION

FORM MBI  
(Reg. 44(1))

## CLAIM FOR MATERNITY ALLOWANCE AND GRANT

(In accordance with the National Insurance Corporation Act, 2000).

I hereby apply for Maternity Benefit under the National Insurance Corporation Act, 2000, and furnish a Certificate of expected/Actual Confinement, together with the following particulars:

My full name is Jane Doe  
My Nat.Ins.No. is 123456 (Print Name)  
My address is Ti Rocher, Castries  
My Tel.No.is 450-0000  
My Date of Birth is 1st January 1901  
I am/was employed by ABC Studios  
I last worked there on 10th May 2021  
The period for which I claim benefits is from 11.05.2021 to 10.08.2021

I do not expect to receive any wages or salary from my employer during my absence from work. I will be given \_\_\_\_\_ weeks Maternity leave, from \_\_\_\_\_ to \_\_\_\_\_ during which period I will be paid \_\_\_\_\_ per week/month.

I understand that a False Statement or Misrepresentation makes me liable to a Penalty under the National Insurance Corporation Act, 2000.

19th May 2021 Date J.Doe Signature or Mark of Claimant

NOTE: Where the Claimant cannot sign, a responsible persons (Lawyer, J.P., Doctor, Senior Civil Servant on permanent establishment, etc.) should witness the mark by signing on the line below.

Witness to Mark \_\_\_\_\_  
Profession or Occupation \_\_\_\_\_  
Address \_\_\_\_\_  
Date \_\_\_\_\_

### TO BE COMPLETED BY EMPLOYER:

1. Name of Employer and Registration No. \_\_\_\_\_
2. Tel. No. \_\_\_\_\_
3. The above named employee has been absent from work continuously since \_\_\_\_\_ on account of \_\_\_\_\_
4. This Employee has been/will be paid wages/salary at the rate of \_\_\_\_\_ per week/month during the period of absence from work up to and including \_\_\_\_\_  
(insert last date from which wages/salary will be paid if absence continues)

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.

Date \_\_\_\_\_ Signature \_\_\_\_\_  
Employers Signature  
Print Name \_\_\_\_\_  
Position \_\_\_\_\_  
Stamp \_\_\_\_\_

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## MEDICAL CERTIFICATE OF EXPECTED/ACTUAL CONFINEMENT

(TO BE GIVEN BY A REGISTERED MEDICAL PRACTITIONER OR REGISTERED MIDWIFE)  
(A or B to be completed as appropriate)

To:

Mrs Jane Doe

(Print Name)

### A. EXPECTED CONFINEMENT

I certify that I examined you on \_\_\_\_\_  
and that in my opinion you may expect to be confined on the \_\_\_\_\_ day  
of \_\_\_\_\_ 20 \_\_\_\_\_

Any other Remarks by Doctor or Midwife \_\_\_\_\_

### B. ACTUAL CONFINEMENT

I certify that I attended to you during your confinement which took place at OKEU  
17th on the May day of 2021

CHILD

LIVING

And that you delivered Male Female

CHILDREN

DEAD

Name of Doctor or Midwife

Lauthrine Peggos

(Block Letters)

Signature and Stamp

L Peggos



DOCTOR CO.

Address

OKEU, Millenium Heights, Castries

Tel. No.

456-6777

Date

18th May 2021