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: John Doe
2. NATIONAL INSURANCE NUMBER: 000000
3. DATE OF BIRTH: 12/06/89 (dd/mm/yy)
4. EMAIL ADDRESS: jdoe@gmail.com
5. GENDER: MALE (X) FEMALE ( )
6. HOME ADDRESS: Belmar Lane, Morne Fortune
7. POSTAL ADDRESS: General Post Office (*if different from above*)
8. MARTIAL STATUS: MARRIED ( ) SINGLE (X) WIDOWED ( ) DIVORCED ( )
9. TELEPHONE: _____ (HOME) _____ (WORK) 123-4567 (CELL)
10. OCCUPATION: Receptionist
11. EMPLOYER'S NAME: BCD Inc
12. EMPLOYER'S ADDRESS: Corinth, Gros Islet
13. NAME OF ACTUAL PLACE OF WORK: BCD Inc
14. ADDRESS OF ACTUAL PLACE OF WORK: Corinth, Gros Islet
15. ARE YOU CURRENTLY EMPLOYED ELSEWHERE? YES ( ) NO (X)
    (*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 (X)
17. LAST DATE WORKED IMMEDIATELY BEFORE ILLNESS: 28/02/25 (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: Bank of Social Security

ADDRESS: Bridge Street, Castries

ACCOUNT NUMBER: 123456789

ROUTING NUMBER: 000000

TYPE OF ACCOUNT: CHEQUING ◯ SAVINGS (X)

BRANCH: Bridge Street

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.

01/03/25
Date
dd/mm/yy

John Doe
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. John Doe

was examined by me on 01/03/25 and in my opinion was at the time suffering from Jll .

This patient will remain incapable of work for a period of 7 days starting from 01/03/25 (dd/mm/yy) and will be fit to resume work on 08/03/25 (dd/mm/yy)

NAME OF MEDICAL PRACTITIONER: Dr. Primose Henry

OFFICE ADDRESS: Rodney Bay, Gros Islet

MEDICAL PRACTITIONER CERTIFICATE LICENSE NUMBER: 123895

LICENSE EXPIRATION DATE: 22/12/27 *dd/mm/yy*

TELEPHONE NUMBER: 450-0000

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.

P Henry

SIGNATURE OF MEDICAL PRACTITIONER

01/03/25

DATE *dd/mm/yy*

Dr. Henry M.D.

MEDICAL 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: BCD Inc **REGISTRATION NUMBER:** 657985

TELEPHONE NUMBER: 455-5255 **EMAIL ADDRESS:** sschol@bcdinc.com

1. The following information is with reference to (Mr.)/Mrs./Ms.: John Doe

2. Employee National Insurance Number: 000000

3. The Employee has been absent from work on account of sickness continuously from: 01/03/25 *dd/mm/yy*

4. The employee is expected to return to work on (*exact date*): 08/03/25 *dd/mm/yy*

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

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

   (c) (X) 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 (X)
   (If Yes Please Complete Form EIB(1) (Employment Injury Form))

8. Is applicant still employed? YES (X) NO ◯

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

   NAME OF EMPLOYER'S REPRESENTATIVE: Sepastien Schol

   POSITION OF EMPLOYER'S REPRESENTATIVE: Accountant

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

18/03/25
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: 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.

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_____
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.