(c)

Date of Medical attention or Hospitalization	COST OF MEDICAL CARE				
	Doc. Fees (Med. Exam)	Drugs & Dressing	X-ray	Other Treatment	Total Cost

Grand Total
$.....

(d) TYPE AND QUANTITY OF DRUGS USED

TYPE	QUANTITY	TYPE	QUANTITY

(Attach prescription when necessary)

3. I declare that the information given here is true and correct to the best of my knowledge and belief.

....
Date Signature or mark of Claimant

NOTE: Where the Insured Person cannot sign his/her name he/she should make his/her mark and have it witnessed by a responsible person (Doctor, Lawyer, Teacher, J.P. etc) who should sign on the dotted line below.

Witness to mark .....

Profession/Occupation.....

Address .....

.....

Date .....

FORM SB6A
(R&P Dept. Amended July 97)

NATIONAL INSURANCE AND SOCIAL SECURITY ACT, 1969

EMPLOYER'S STATEMENT IN SUPPORT OF SICKNESS BENEFIT/MEDICAL CARE

This Form is to be completed by the Employer and given to the Employee to take or send to the nearest National Insurance Office

WARNING: Any person who knowingly makes a false statement or false representation for the purpose of obtaining any payment for himself or some other person under the National Insurance and Social Security Act, 1969 or produces or furnishes any document or information which he knows to be false in a material particular, renders himself liable to prosecution.

1. PARTICULARS OF EMPLOYER

a) Name of Employer/Business: _____

b) Nature of Business: _____

c) Employer's Address: _____

d) Employer's Registration Number: | | | | | |

2. PARTICULARS OF EMPLOYEE

a) Name of Employee: _____

b) Address of Employee: _____

c) National Insurance Number: | | | | | | | | | | | |

d) National Registration Number: | | | | | | | | | | | |

e) Sex | | f) Date of Birth | | | |

3. PARTICULARS OF EMPLOYMENT

a) Date of commencement of Employment | | |

b) Last date Employee worked | | |

c) Date of commencement of absence from work | | |

d) Was work available on date of commencement of absence from work?

Yes	No

(e) Has employee been in your employment over the last 50 weeks? ……..

If no, state number of weeks ……

(f) How many contributions have you paid for employee during period referred to at e) above?

……

(g) Were contributions paid for employee for the last 13 weeks before commencement of illness? ……

If yes, state number of contributions ……

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4. STATEMENT OF EARNINGS: **(Complete this Section only if there is loss of earnings – disregard when claim is for Medical Expenses Only).**

a) Salary/Wage paid to Employee for the last 3 months/13 weeks worked.

MONTH SALARY	WEEK-ENDING WAGE	WEEK-ENDING WAGE
1.	1.	8.
2.	2.	9.
3.	3.	10.
	4.	11.
	5.	12.
	6.	13.
	7.	

b) Rate of Salary/Wage to be paid to Employee when absent from work:

…… per month/week from …….. to ……
(To be completed only when the Employee will be paid during the period of illness).

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.

Signature of Employer/Representative: ……

Date: ……

Employer's Stamp

Form SB1
(R&P Dept. Amended July 97)

NATIONAL INSURANCE AND SOCIAL SECURITY ACT, 1969
CLAIM FOR SICKNESS BENEFIT – MEDICAL CARE

WARNING: Any person who knowingly makes a false statement or false representation for the purpose of obtaining any payment for himself or some other person under the National Insurance and Social Security Act, 1969 or produces or furnishes any document or information which he knows to be false in a material particular, renders himself liable to prosecution.

I, the undersigned hereby apply for reimbursement of Medical Care Expenses under the National Insurance and Social Security Act, 1969 and furnish information with regard to such Medical Care charges and the following particulars:

1. PARTICULARS OF INSURED PERSON

a) Name in Full

b) Address

c) NIS No.

d) ID No. **e) Date of Birth**

f) Sex **g) Date of Commencement of illness**

h) Last Date Worked

2. PARTICULARS OF MEDICAL CARE

a) I was examined by ……
Name of Doctor (Hospital)

of ……
(Address)

b) My expense was $…… and I have attached receipt(s) to the value of $…….. which sum was paid by me for such medical care.

See breakdown overleaf at (c)