

NATIONAL INSURANCE AND SOCIAL SECURITY ACT, 1969

CERTIFICATE BY SELF-EMPLOYED PERSON IN SUPPORT OF MATERNITY BENEFIT CLAIM

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

PARTICULARS OF SELF-EMPLOYED PERSON

- 1. NAME:
- 2. ADDRESS OF BUSINESS:
- 3. HOME ADDRESS: (if different from 2)
- 4. NATIONAL INSURANCE NUMBER
- 5. NATIONAL REGISTRATION NUMBER
- 6. DATE OF BIRTH
- 7. Last date worked:
- 8. Date of confinement/expected confinement:
- 9. Declared income for previous year 19..... \$

10. Contributions paid to National Insurance for last 2 months/7 weeks worked:

Month	Contributions	Week Ending	Contributions	Week Ending	Contributions
1.		1.		5.	
2.		2.		6.	
		3.		7.	
		4.			

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:.....

(Self-employed person)

Date:.....

FOR OFFICIAL USE

The receipt (s), nos. _____ dated _____ for _____ as

paid National Insurance contributions were examined by me and I hereby also certify the correctness of the information stated at item 9 above.

Signature:.....
(N.I.Clerk)

Date:.....

FOR OFFICIAL USE

1. Document submitted with claims:

1. _____
2. _____
3. _____

Decision:

Allowed	<input type="checkbox"/>
Disallowed	<input type="checkbox"/>

(tick appropriate box)

3. IF ALLOWED

Calculation of rates:

MONTH RELEVANT SALARY

	Actual	Insurable
1.	_____	_____
2.	_____	_____
TOTAL	_____	_____
AVG. MONTHLY	_____	_____

WEEK ENDING RELEVANT WAGE

	Actual	Insurable
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
TOTAL	_____	_____
AVG. WEEKLY	_____	_____

RATE OF BENEFIT: \$ _____ PER MONTH/WEEK
 (70% avg. monthly/weekly insurable salary/wage)

4. PARTICULARS OF PAYMENT

Date of commencement Stop Date Review Date

Payments made:

From	To	Amt. Pd.	Prepared by	Date	Checked by	Date	B.P.V.No.	Date
1.								
2.								
3.								
4.								

IF DISALLOWED

5. Date Claim disallowed

6. Date claimant notified

7. Reason for disallowance

8. NOTIFICATION

Department/Section	Form No.	Date
1.		
2.		
3.		

Certified by:.....

Date:.....

