Striving for Social Justice

ST. CHRISTOPHER AND NEVIS SOCIAL SECURITY BOARD

CLAIM FOR MATERNITY BENEFIT

(ALLOWANCE AND GRANT)

To be completed by insured woman

Details of Insured Person:

1. Social Security No.

2. **FIRST NAME** **MIDDLE NAME(S)** **SURNAME**

3. Home Address

4. P.O. Box

5. E-mail Address

6. Tel./Cellular No.

7. Date of Birth *(dd/mm/yyyy)*

8. Occupation

Employer Details:

9. Name of present/last employer

10. Address

11. Employer's Social Security No.

12. My last day at work was *(dd/mm/yyyy)*

13. My other employers during the last thirty-nine (39) weeks have been:

14. Name of employer

15. Address

16. I hereby claim maternity benefit from the date of ______ to the date of *(dd/mm/yyyy)*

Please enter your bank details for payment of your benefit:

17. Name on Account ______ 18. Account No. ______

19. Name of Bank Institution

20. Are you the wife of an insured man? ☐ Yes ☐ No

21. If yes, state his name ______ & Social Security No.

I understand that it is an offence to receive benefit in respect of any period while I am at work and therefore give the undertaking that I will be away from work for the period for which benefit is hereby claimed.

Overleaf is a Medical Certificate of my expected confinement/Medical Certificate of my confinement, in support of my claim.

22. Claimant's signature ______ 23. Date *(dd/mm/yyyy)*

24. Signature of Witness ______

25. Name of Witness ______

(Affix right thumb print here if unable to write)

Notes:

TIME FOR CLAIMING: Your claim for Maternity Allowance MUST NOT be made before, and for any period earlier than six (6) weeks prior to the week in which your doctor expects delivery would occur. If your claim For Maternity Allowance was not made before confinement, it must be made within three (3) weeks beginning with the date of confinement. You may be disqualified from receiving Maternity Allowance or Maternity Grant if your claim is received later than the time stipulated by the Benefit Regulations outlined above.

Warning: Any person who knowingly makes any false representation for the purpose of obtaining benefit renders herself liable for prosecution.

Form M.B.1 (Revised 2013)

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*MEDICAL CERTIFICATE OF EXPECTED CONFINEMENT

To be completed by a Medical Practitioner in respect of the claim overleaf for Maternity Allowance BEFORE confinement. This certificate is not to be given for a period earlier than six (6) weeks before the week of expected confinement.

1. FIRST NAME MIDDLE NAME(S) SURNAME

2. I certify that on *(dd/mm/yyyy)* ____ I examined you and you are pregnant and it is expected that you will be confined on or about *(dd/mm/yyyy)* ____

3. Name of Medical Practitioner

4. Practitioner's Signature ____ 5. Certificate given on *(dd/mm/yyyy)* ____

Affix office stamp here

Form M.C.2 (revised 2010)

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*MEDICAL CERTIFICATE OF CONFINEMENT

To be completed by a Medical Practitioner or a registered Midwife if claim for Allowance and Grant is made AFTER confinement.

1. FIRST NAME MIDDLE NAME(S) SURNAME

2. I certify that I attended you at your confinement on *(dd/mm/yyyy)*

3. I certify that your confinement resulted in the birth of ____ *No. of (children delivered)*

4. The confinement took place at ____ 5. Gender of child/children ____

(Medical facility or place)

6. Name of Medical Practitioner/Midwife

7. Practitioner's/Midwife's Signature ____

8. Midwife's Registration No. 9. Certificate given on *(dd/mm/yyyy)* ____

***Form of Certificate and words not applicable should be deleted**

For Official Use

Date Received ____

Claim Number

Verification Document Received ____

Signature of Receiving Officer ____

Form M.C.3 (revised 2014)

*delete words not applicable