SOCIAL SECURITY BOARD

SOCIAL SECURITY CLAIM FOR DISABLEMENT BENEFIT (CHAPTER 44, LAWS OF BELIZE)

OFFICIAL USE ONLY	
Dis. Claim No.	
Or IB. Claim No.	

1. Full Name ..... (Block Capitals) Male ☐ Female ☐

2. Address .....

3. Date of Birth ☐☐/☐☐/☐☐☐☐ (Day Month Year) S.S.No. ☐☐☐☐☐☐☐

4. Date of accident in respect of which you are claiming disablement benefit. ☐☐/☐☐/☐☐☐☐ (Day Month Year)

5. State in what ways you are disabled as a result of the accident/disease

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6. Are you fit to travel if you are required to report for medical examination (Yes/No)

7. Have you received disablement benefit before? (Yes/No) .....

8. Is this your first injury at work? (Yes/No) .....

9. If no, state when first injured. Date: .....

10. Are you presently working? (Yes/No) ..... If no, are you capable for working? (Yes/No) .....

11. Give the following particulars about the treatment of your present injury.

Name of Hospital	State whether in-patient or out- patient	Period of Treatment		Were any X-Rays taken (yes/no)
		From	To	

Do you agree to your hospital records being obtained by the Manager of Social Security for the assistance of the Medical Board or Medical Referee in their consideration and assessment of you claim? (Yes/No) .....

DECLARATION

(WARNING: TO GIVE FALSE INFORMATION MAY RESULT IN PROSECUTION.)

I declare that to the best of my knowledge and belief, the information given above is true and complete. I claim disablement benefit accordingly.

Signature ..... Date: .....