SOCIAL SECURITY BOARD

CLAIM FOR MATERNITY BENEFIT
(Chapter 44 of the Laws of Belize)

IMPORTANT NOTICE

Claims for Maternity Benefit must be submitted within 8 weeks prior to the expected date of confinement. After the date of confinement , claim must be submitted within 3 weeks from the date of confinement . A late note stating reasons for lateness must be attached to late claims. Failure to submit claims on time may result in loss of benefit.

FOR OFFICIAL USE ONLY	
Date Claim Received:	______ / ______ / ______ (DAY / MONTH / YEAR)
Receiving Officer:	
Date Claim Returned:	______ / ______ / ______ (DAY / MONTH / YEAR)
Receiving Officer:	
Claim Number:	

WARNING: ANY PERSON WHO KNOWINGLY MAKES ANY FALSE REPRESENTATION FOR THE PURPOSE OF OBTAINING A BENEFIT COMMITS A CRIMINAL OFFENCE AND IS PUNISHABLE BY A FINE AND OR IMPRISONMENT.

PART I. PARTICULARS OF THE INSURED PERSON

To be filled out by the Insured Person

(a) Name of Insured Person: ________________________________
(Enter name as per SS Registration Card) FIRST MIDDLE SURNAME

(b) Social Security No: ☐☐☐☐☐☐☐☐☐ **(c)** Date of Birth: ______ / ______ / ______
DAY MONTH YEAR

(d) Address: ________________________________
HOUSE NO. STREET CITY/TOWN/VILLAGE DISTRICT

________________ E-MAIL ________________ PHONE NUMBER

(e) Occupation/Job Title: ________________ I hereby verify that I can be contacted at any of the above contact information provided ☐

PART II. EMPLOYMENT PARTICULARS

(f) I am employed by: ________________ EMPLOYER ________________ DATE OF EMPLOYMENT

(g) If employed by the Government of Belize (GOB), indicate Ministry/Dept.: ________________

(h) Business Address: ________________________________
NO. STREET CITY/TOWN/VIllAGE DISTRICT

________________ E-MAIL ________________ PHONE NUMBER

(i) Last **day** and **time** worked prior to your incapacity for work: ______ / ______ / ______ (DAY MONTH YEAR) Time: ________ A.M. ☐ P.M. ☐

(j) If you are working **less than one year** with your current employer, please provide below the information of previous employer(s):

EMPLOYER/BUSINESS NAME	BUSINESS ADDRESS	PERIOD OF EMPLOYMENT	
		FROM DD/MM/YY	TO DD/MM/YY

PART III. BENEFIT DEPOSIT AUTHORITY

(k) Deposit Benefit Payment to: ________________ NAME OF FINANCIAL INSTITUTION Location or Branch: ________

(l) Account Number: ________________ Name of Account Holder: ________________

I hereby verify Financial Institution and Account Number information provided ☐

PART IV. INSURED PERSON'S DECLARATION

(m) I hereby claim for Maternity Benefit from: DD ☐ MM ☐ YYYY ☐ to: DD ☐ MM ☐ YYYY ☐

(n) I attach (a) Medical Certificate of Confinement ☐ OR (b) Certificate showing Date of Delivery ☐

(o) signed by: ________________
Name of Medical Practitioner

(p) I will inform the Social Security Board if I will return to work prior the expiration of my Maternity Benefit Period.

(q) I declare that the information given above is true to the best of my knowledge.

________________ CLAIMANT'S FULL NAME (BLOCK LETTERS) ________________ SIGNATURE ______ / ______ / ______ DAY MONTH YEAR

NOTE: If you are unable to sign this claim, it may be signed on your behalf by someone who should state that he or she has done so.

PART V. MEDICAL CERTIFICATE OF EXPECTED DATE OF CONFINEMENT

To be completed by a Registered Medical Practitioner in Belize ***(Certificate must be filled in English and legible)***

Name of Insured Person ______________________________

Please Indicate Full Name as per SS Registration Card

I hereby certify that I have examined the above person and in my opinion she is pregnant and the expected date of confinement is

_____ / _____ / _____
DAY MONTH YEAR

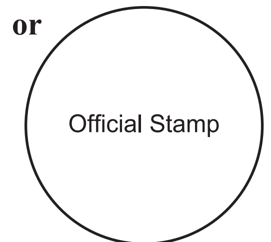
Medical Practitioner: ______________________________
(BLOCK LETTERS) FIRST MIDDLE SURNAME

Medical Council of Belize Registration No. ____________________ **or** GOB Approved Medical Officer ☐

Signature: ____________________ Date of Examination: _____ / _____ / _____
DAY MONTH YEAR

Institution: ____________________

or



Address: ____________________

Medical Comments: ____________________

PART VI. MEDICAL CERTIFICATE OF CONFINEMENT

To be completed by a Registered Medical Practitioner or Registered Midwife in Belize

Name of Insured Person ______________________________

Please Indicate Full Name as per SS Registration Card

I hereby certify that I attended the above person at her confinement date which took place on the _____ / _____ / _____
DAY MONTH YEAR

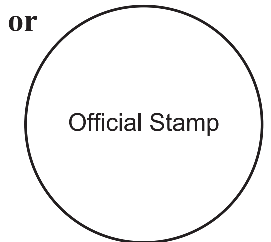
Medical Practitioner/Midwife: ______________________________
(BLOCK LETTERS) FIRST MIDDLE SURNAME

Medical Council of Belize Registration No. ____________________ **or** GOB Approved Medical Officer ☐

Signature: ____________________ Date: _____ / _____ / _____
DAY MONTH YEAR

Institution: ____________________

or



Address: ____________________

Medical Comments: ____________________

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Decision on Maternity Benefit Claim

(i) ☐ Allowed Period of Benefit **Allowed From:** _____ / _____ / _____ (DAY MONTH YEAR) **To:** _____ / _____ / _____ (DAY MONTH YEAR)

Weekly Benefit Rate: $ ____________ Amount Payable: $ ____________

(ii) ☐ Disallowed Period of Benefit **Disallowed From:** _____ / _____ / _____ (DAY MONTH YEAR) **To:** _____ / _____ / _____ (DAY MONTH YEAR)

ISCO Code ____________________

If disallowed, state the reasons for disallowance:

____

Amount of deductions: ____________________

Reason for deductions, if any: ____________________

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Claim Processing

	NAME IN PRINT	SIGNATURE	DAY / MONTH / YEAR
Customer Service Agent:			
Processing Clerk:			
Processing Agent:			
Team Leader or SDO:			

Relevant Notes: ______________________________

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