SOCIAL SECURITY BOARD

CLAIM FOR SURVIVORS' OR DEATH BENEFIT
(Chapter 44, Laws of Belize)

IMPORTANT NOTICE	FOR OFFICIAL USE ONLY	
Claims for Survivors' Benefit must be submitted to the Social Security Board within **thirteen weeks** from the date of death of the deceased person. Claims submitted **after** thirteen weeks must be accompanied by a note stating reason for lateness. Failure to submit a claim within **thirteen weeks** may result in loss of benefit.	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 1. Particulars of the Deceased Insured Person

(a) Name of Deceased Person: (Enter name as per Registration Card) ____ (SURNAME) ____ (FIRST) ____ (MIDDLE)

(b) Social Security No: ☐☐☐☐☐☐☐☐☐

(c) Date of Birth: ____ (DAY) ____ (MONTH) ____ (YEAR) **(d)** Date of Death: ____ (DAY) ____ (MONTH) ____ (YEAR)

(e) Last Address: ____ (HOUSE NO.) ____ (STREET) ____ (CITY/TOWN/VILLAGE) ____ (DISTRICT)

(f) Certified Cause of Death: **(i)** ____ **(ii)** ____

(g) Name of Last Employer: ____ (SURNAME) ____ (FIRST) ____ (MIDDLE)

(h) Business Name: ____

(i) Business Address: ____ (NO.) ____ (STREET) ____ (CITY/TOWN/VILLAGE) ____ (DISTRICT)

____ (EMAIL ADDRESS) ____ (PHONE NUMBER)

(j) What was the deceased last occupation? ____

(k) What type of activity was carried on at the work place (Type of Industry)? ____

(l) Was the deceased receiving a benefit? ☐ Yes ☐ No If Yes, please state Benefit Type: ____

(m) Was the death of the deceased caused by an accident at work? ☐ Yes ☐ No

Part 2. Particulars of the Claimant

(a) The claimant is a: ☐ Widow ☐ Widower ☐ Common-Law ☐ Parent ☐ Guardian

(b) Name: (Enter name as per Registration Card) ____ (SURNAME) ____ (FIRST) ____ (MIDDLE)

(c) Social Security No: ☐☐☐☐☐☐☐☐☐ **(d)** Date of Birth: ____ (DAY) ____ (MONTH) ____ (YEAR)

(e) Last Address: ____ (HOUSE NO.) ____ (STREET) ____ (CITY/TOWN/VILLAGE) ____ (DISTRICT)

____ (EMAIL ADDRESS) ____ (PHONE NUMBER)

(f) For Guardians, state relationship to child or children: ☐ Grandparent(s) ☐ Uncle ☐ Aunt ☐ Sister ☐ Brother ☐ Other (Specify:____)

[Proceed to Part 3 (ix) from a to d and also complete Part 4]

Part 3. Declaration of Widow/Widower/Common-Law

(i) Were you legally married to the deceased? ☐ Yes ☐ No If Yes, please indicate Date of Marriage: _____ _____ _____
DAY MONTH YEAR

If your answer is "Yes", then go to Part 3(iv). If "No", then proceed with the following questions:

(ii) Were you in a common-law union? ☐ Yes ☐ No If Yes, please indicate Commencement Date of Common-Law Union: _____
DAY MONTH YEAR

(a) Were you ever married? ☐ Yes ☐ No

(b) Was the deceased ever married? ☐ Yes ☐ No

If known, please state Name: _____
SURNAME FIRST MIDDLE

(iii) Were you and the deceased living together at the time of death? ☐ Yes ☐ No

(a) If the answer is "Yes", how long were you living together? | | |
YEARS MONTHS

(b) Indicate the address where you were residing?

_____
HOUSE NO. STREET CITY/TOWN/VILLAGE DISTRICT

(iv) Are you expecting a child of the deceased? ☐ Yes ☐ No
If so, please attach medical report certifying age/period of pregnancy.

(v) Do you have in your care a child/children of the deceased?
(a) under 16 years? ☐ Yes ☐ No
(b) under 21 years and receiving full-time education? ☐ Yes ☐ No

(vi) Do you know of any other children of the deceased? ☐ Yes ☐ No
If the answer is "Yes", please indicate the name(s) of child(ren) on **Part 4A**.

(vii) Do you have in your care a child of the deceased who is incapable of self-support due to a permanent disability/illness? ☐ Yes ☐ No

If the answer is "Yes", please attach medical report certifying the child's disability/illness.

(viii) Are you receiving a benefit? ☐ Yes ☐ No If Yes, please state Benefit Type:_____

(ix) I attach:
(a) Death Certificate of the Deceased Insured Person ☐
(b) Social Security Registration Card of the Deceased Person ☐
(c) Birth Certificate(s) of Dependent Child/Children/Parents ☐
(d) Medical Report of child who is incapable of self-support ☐
(e) Medical Report certifying pregnancy ☐
(f) Proof of Education for children over 16 years and are receiving full-time education ☐
(g) Marriage Certificate ☐
(h) Common-Law Declaration signed by a Justice of the Peace ☐

Part 4. Particulars of Dependent Children: Children under the age of 16 years or under 21 years and receiving full-time education.

FULL NAME			ADDRESS	DATE OF BIRTH DD/ MM / YR	CURRENT AGE	SOCIAL SECURITY NUMBER	INDICATE YOUR ANSWER IN THE RELEVANT SECTION THAT APPLIES TO YOUR CHILD		
SURNAME	FIRST	MIDDLE					If the child is currently in school, indicate name of educational institution	Place an ✘ if the child is not in school	Place a ✓ if the child has a permanent illness/ disability

(i) Do you know of any other children of the deceased under the age of 16 years or under 21 years and receiving full-time education, other than those mentioned above? ☐ Yes ☐ No

(ii) If the answer to the above question is Yes, please state the names and addresses of the children to the best of your knowledge in the below section of **Part 4A.**

Part 4A.									

Part 5. Signature of the Claimant

I declare that the information given is true to the best of my knowledge.

CLAIMANT'S FULL NAME IN PRINT _____ 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.

FOR OFFICIAL USE ONLY

Decision on Survivors' Benefit Claim

Four-digit Occupation Code: ☐☐☐☐ *[refer to Page 1 (j)]*

Four-digit Industry Code: ☐☐☐☐ *[refer to Page 1 (k)]*

Decision: ☐ Allowed ☐ Disallowed

Monthly Pension Rate: $_____ **OR** Amount of Grant: $_____

If disallowed, state the reasons for disallowance: _____

_____

_____

_____

Amount of Deductions: $_____

Please indicate reasons for deductions, if any: _____

_____

_____

_____

Claim Processing

Processing Clerk: _____ NAME IN PRINT _____ SIGNATURE _____/_____/_____ DAY MONTH YEAR

Verifier (FCC): _____ NAME IN PRINT _____ SIGNATURE _____/_____/_____ DAY MONTH YEAR

Authorizer (AA/ADMIN): _____ NAME IN PRINT _____ SIGNATURE _____/_____/_____ DAY MONTH YEAR

Relevant Notes: _____

_____

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