



SOCIAL SECURITY BOARD CLAIM FOR SICKNESS BENEFIT

(Chapter 44, Laws of Belize)

1 **WARNING:** Any person who knowingly makes a false statement or false representation for the purpose of obtaining benefits commits an offence punishable by fine or by imprisonment or both. The claimant is also liable to repay any sum received on a false basis.

Enter Name as per SS Registration Card

CLAIMANT'S PERSONAL INFORMATION

Name: _____

P.O. Box No: _____

House No. & Street _____

2 Address: _____

City/Town/Village: _____

District: _____

Tel/Fax: _____

Email address: _____

FOR OFFICIAL USE ONLY

Date Claim Recd: _____

Officer: _____

Claim No: _____

SOCIAL SECURITY NO.

MM DD YYYY

Date of Birth: _____

EMPLOYMENT PARTICULARS

Job Title: _____ Business No: _____

Current Employer/ Business Name: _____

Current Employer Business Address: _____

I worked there until _____ AM / PM on _____
(Time) *(Date)*

3 If you are working less than one year with your current employer please provide below the names, address and period worked with any previous employer(s).

Employer Name	Address	Period of Employment

METHOD OF BENEFIT PAYMENT

4 Deposit to a bank or credit union:

To be picked up:

Name of Bank: _____

Location of Branch: _____

Account Number: _____

Name of Account Holder: _____

INSURED PERSON DECLARATION

Overleaf is a medical certificate from: Dr. _____

on the basis of which I now claim Sickness Benefit for the period from:

MM DD YYYY

5 _____ to:

MM DD YYYY

I have read (been read) and understand the warning.

SIGNATURE OF CLAIMANT: _____

DATE: _____

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

IMPORTANT NOTICE

6 Claims for Sickness Benefit must be submitted to Social Security within four days from the first date of incapacity. When your claim is late please provide your reason(s) for the delay overleaf (Section 7: Other remarks).

AUTHORIZATION

I HEREBY AUTHORIZE THE DOCTOR TO DISCLOSE THE NATURE OF MY ILLNESS.

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First Name: _____ Last Name: _____

SIGNATURE OF CLAIMANT: _____ DATE: _____

MEDICAL CERTIFICATE

Mr. / Mrs. / Ms. _____
Enter Name as per SS Registration Card

I certify that I have examined you today and that in my opinion you are incapable of work by reason of:-

Diagnosis:

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In my opinion you will remain incapable of work from:

MM	DD	YYYY

to:

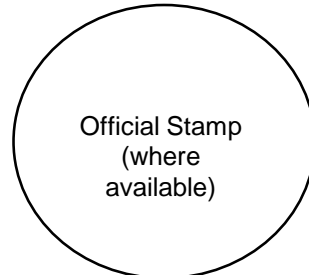
MM	DD	YYYY

OR, a total of _____ days (*in words*).

Name of Medical Practitioner
(In Block Letters)

Signature

Date of Examination



ANY OTHER REMARKS:

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