SOCIAL SECURITY ORDINANCE, 1979

CLAIM FOR INVALIDITY BENEFIT

TO BE COMPLETED BY INSURED PERSON

FOR OFFICIAL USE ONLY CLAIM NO.

SOCIAL SECURITY No.					

DATE OF BIRTH		

To: MANAGER, BELIZE SOCIAL SECURITY BOARD

I, ...

(full name in Block Capitals)

residing at . . . .

(Address)

hereby state that I have been incapable of work for thirteen (13) consecutive weeks as a result of a disablement which is likely to remain permanent and I claim Invalidity Benefit from . . . .

(Date)

Attached is a medical certificate of Permanent Incapacity for work from Dr. . . . .

(name)

PLEASE SUPPLY THE FOLLOWING INFORMATION :

Is your present incapacity caused by an accident at work? . . . .

(yes or no)

Name of last employer . . . .

Address of last employer . . . .

What was your usual occupation? . . . .

have you previously received INVALIDITY BENEFIT under the Social Security Scheme? . . . .

(yes or no)

Are you receiving any Social Security benefit? If so, please state

I declare that the foregoing statements given in this form are true to the best of my knowledge and belief.

. . . .

(Signature of Claimant) *(Date)*

If you are too ill ot sign this claim, it may be signed on your behalf by someone who should state that he or she has done so.

IMPORTANT WARNING -- *Any person who knowingly makes any false representation for the purpose of obtaining a benefit commits a criminal offence punishable by fine and or imprisonment.*

FORM INV. 1

MEDICAL CERTIFICATE OF PERMANENT INCAPACITY FOR WORK

To be completed by a Medical Board

Mr/Mrs/Miss . . . .

I hereby certify that I have examined the above named insured person and my report is are as follows:

1. Name and description of illness . . . .

   . . . .

2. Clinical Report . . . .

   . . . .

3. Laboratory and other tests . . . .

   . . . .

4. Diagnosis . . . .

   . . . .

5. Insured person is/is not an invalid . . . .

6. Conclusion and Diagnosis . . . .

   . . . .

   Recommendations . . . .

   . . . .

   . . . .

Signature . . . . *Date* . . . .

NOTE:

For the purpose of the Benefit Regulations the term INVALID means a person is incapable of work as a result of a specific disease or bodily or mental disablement which is likely to Remain PERMANENT.

MEDICAL CERTIFICATE OF PERMANENT INCAPACITY FOR WORK
To be completed by a Medical Board

Manager, Social Security Board:

We hereby certify that we have performed a thorough medical examination on Mr/Mrs/Miss . . . .
. . . . and our diagnosis is as follows:

1. Name and Description of illness: . . . .

   . . . .

2. Clinical Report: . . . .

   . . . .

3. Laboratoy and other tests: . . . .

   . . . .

4 Can the Insured Person return to his or her normal duties? If so, when?

   Yes . . . . No . . . . Date . . . .

5. Can the Insured Person perform any type of work? Yes . . . . No . . . .

6. Does the Insured Person needs to be reassured in the future? If so, when? Yes . . . .

   No . . . . Date . . . .

7. Final decision: . . . .

   . . . .

   . . . .

   NOTE: To be considered an INVALID the person has to be incapable of any type of work and likely to remain so permanently.

Signature of Medical Board:

1. . . . .

2. . . . .

3. . . . .

Date of Conclusion of Assessment: . . . .

FOR OFFICIAL USE ONLY

Decision on claim: . . . .

. . . .

. . . .

. . . .

. . . .

. . . .

Date . . . . *Signature* . . . .
(Benefits Section)