

**Section D: Claimant's Declaration** *(To be completed by the Claimant)*

**I declare that:**

38. My last day at work was \_\_\_\_\_.  
*dd/mm/yyyy*
39. I am incapable of work and have done no paid work since the date shown at question 38.
40. The information given by me on this form is true and correct to the best of my knowledge and belief.
41. I claim Benefit/Assistance under the National Insurance Act, 1972.
42. Claimant's Signature: \_\_\_\_\_
- OR**, if unable to sign,  
Agent/Representative's \_\_\_\_\_  
*Name (printed)*                      \_\_\_\_\_  
*Signature*
- Date: \_\_\_\_\_  
*dd/mm/yyyy*

**IMPORTANT NOTE:** Any person who for the purpose of obtaining benefit under The National Insurance Act, for himself or for some other person, knowingly makes any false statement or false representations or produces any document, etc. which he knows to be false, shall be liable to a fine not exceeding Two Thousand Five Hundred Dollars (\$2,500), or to imprisonment for a period not exceeding twelve (12) months or both.

For Official Use Only



**The National Insurance Act, 1972**  
Commonwealth of The Bahamas

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**MEDICAL CERTIFICATE OF INCAPACITY FOR WORK**

**Section A:**  
**To be completed by a Registered Medical Practitioner**

1. In Confidence to:  Mr. /  Mrs. /  Ms.

\_\_\_\_\_  
*Last Name*                      *First Name*                      *Middle Name(s)*

2. I certify that I examined you on \_\_\_\_\_ and that in my opinion, you were incapable of  
*dd/mm/yyyy*  
working at the time of the examination.

3. Diagnosis / Operation:

ICD-9 Code	Description of Diagnosis/Operation

4. You will remain incapable of work from \_\_\_\_\_ to \_\_\_\_\_  
*dd/mm/yyyy*                      *dd/mm/yyyy*

**(Note: The period entered must NOT exceed 13 weeks)**

5. Doctor: \_\_\_\_\_  
*Name (printed)*                      \_\_\_\_\_  
*Signature*

Date: \_\_\_\_\_  
*dd/mm/yyyy*

Affix Doctor's  
Stamp here

**Note:** Claims from Registered Medical Practitioners outside The Bahamas MUST be accompanied by a business card.

**Section B: Claimant Details** (To be completed by the Claimant)

**Note:** This claim form **MUST** be accompanied by a completed **Employer's Certificate** (Form Med.4), if you are currently employed. **This claim WILL NOT be processed until the Form Med.4 is received. (The Form Med.4 is not required for Self-Employed Persons.)**

6.  Mr./  Mrs./  Ms. \_\_\_\_\_  
Last Name First Name Middle Name(s)

7. N.I.# \_\_\_\_\_ 8. Date of Birth \_\_\_\_\_  
dd/mm/yyyy

9. House # & Street: \_\_\_\_\_

10. Telephone #1: \_\_\_\_\_ 11. Telephone #2: \_\_\_\_\_

12. P.O. Box: \_\_\_\_\_ 13. Email Address: \_\_\_\_\_

**Employment Details**

14. Occupation: \_\_\_\_\_

15. Are you Self-Employed?  Yes  No (If your response is 'Yes' then proceed to question 20)

16. Department: \_\_\_\_\_ 17. Supervisor: \_\_\_\_\_

18. Your Work Employee #: \_\_\_\_\_

19. Employer/Company: \_\_\_\_\_

20. Employer/Self-Employed N.I.#: \_\_\_\_\_

21. Employer/Company Address: \_\_\_\_\_

22. Telephone #1: \_\_\_\_\_ 23. Telephone #2: \_\_\_\_\_

24. P.O. Box: \_\_\_\_\_ 25. Email Address: \_\_\_\_\_

26. Employment History:

Previous Employer/Company Name	Start Date (dd/mm/yyyy)	End Date (dd/mm/yyyy)

27. If you were on vacation during the illness period, please state when: \_\_\_\_\_ to \_\_\_\_\_  
dd/mm/yyyy dd/mm/yyyy

28. If unemployed during the illness period, please state date employment ceased: \_\_\_\_\_  
dd/mm/yyyy

**Section C: Details of Industrial Disease or Accident** (To be completed by the Claimant)

**Note:** This section must be completed if you claim that your incapacity is due to an injury received or a disease contracted while working for an employer/company or due to the nature of your employment. This form **MUST** be accompanied by a completed **Employer's Report on Accident at Work** (Form B.44). **This claim for industrial benefit WILL NOT be processed until the Form B.44 is received.**

**Industrial Accident**

29. Where did the accident happen? \_\_\_\_\_

30. When did the accident happen? Date: \_\_\_\_\_ Time: \_\_\_\_\_  a.m.  p.m.  
dd/mm/yyyy

31. State briefly how the accident happened? \_\_\_\_\_

32. What injury did you sustain as a result of the accident? \_\_\_\_\_

**Employed Persons**

33. Did you report the accident to your employer?  Yes  No

34. If 'Yes', when? Date: \_\_\_\_\_ Time: \_\_\_\_\_  a.m.  p.m.  
dd/mm/yyyy

**Self-Employed Persons**

35. Did you report the accident to the National Insurance Board?  Yes  No

36. If 'Yes', when? Date: \_\_\_\_\_ Time: \_\_\_\_\_  a.m.  p.m.  
dd/mm/yyyy

**Industrial Disease**

37. What is the nature of your work which has caused the disease? \_\_\_\_\_