## 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*

<u>**Note**</u>: For further information about the Sickness or Industrial Benefit, please ask for the **Sickness Benefit / Invalidity Benefit** leaflet at your nearest Local Office or visit **www.nib-bahamas.com**.

<u>**IMPORTANT NOTE**</u>: 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

Form Med 1 (R 2009)

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

For Official Use Only

# 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 working at the time of the examination.
*dd/mm/yyyy*

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*

Affix Doctor's
Stamp here

Date: ______________________________
*dd/mm/yyyy*

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

Form Med 1 (R 2009)

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

<u>Note</u>: 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)*

<u>Note</u>: 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: ________ ☐ AM ☐ PM
    *dd/mm/yyyy*

31. State briefly how the accident happened? ________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

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

______________________________________________________________

______________________________________________________________

______________________________________________________________

<u>Employed Persons</u>

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

34. If 'Yes', when? Date: ________________ Time: ____________ ☐ AM ☐ PM
    *dd/mm/yyyy*

<u>Self-Employed Persons</u>

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

36. If 'Yes', when? Date: ________________ Time: ____________ ☐ AM ☐ PM
    *dd/mm/yyyy*

***Industrial Disease***

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

______________________________________________________________

______________________________________________________________