Section D: Payment details

Recipients of Short-Term Benefits (with the exception of persons who live on Bahamian islands where there are no banks) are required to have their benefit payments sent to the banks of their choice (in The Bahamas). Persons who live on islands where there are no banks, may continue to collect payments from their nearest NIB local office. ***Please provide information on where you want your payment(s) sent:***

38. ☐ **Bank** _____ **Branch:** _____

Account No: _____ **Account Type:** Joint ☐ Personal ☐

☐ **Cheque payment: Local Office** _____ **Island** _____

To confirm your bank account information, *submit a copy of your bank card or similar documentation. If account is jointly held, please have co-signatory complete declaration below:*

Co-Signer: _____ Tel: _____

Declaration: ***I*** *understand that entitlement to Sickness Benefit ceases upon the death of the above-named claimant. Further, I acknowledge that any funds deposited to our account for any period after his/her death remains the property of the National Insurance Board, and must be returned immediately.*

Signature: _____ Date: _____
Name (please print) *dd/mm/yyyy*

Section E: Claimant's Declaration *(to be completed by Claimant)*

I declare that:

39. I am incapable of work and have done no paid work since: _____
dd/mm/yyyy

40. The information given by me on this form is true and correct to the best of my knowledge and belief.

Claimant's Signature: _____

If unable to sign, Agent/Representative's Name: _____ Signature _____

Date: _____

IMPORTANT NOTE: Any person who for the purpose of obtaining benefit for himself or for some other person, knowingly makes any false statement or false representation 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.

Form Med 1 (Revised 2015)

The National Insurance Act, 1972
Commonwealth of The Bahamas

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 ☐ in person / ☐ remotely on _____ and that in my opinion
dd/mm/yyyy

☐ You were incapable of working at the time of the examination; or
☐ You are required to abstain from work because you are under observation by reason of being a carrier or having been in contact with a case of infectious disease.

3. **Diagnosis/Operation:**

ICD-9/10 code	Description of Diagnosis/Operation

4. You will remain incapable of work/under observation from _____ to _____
dd/mm/yyyy *dd/mm/yyyy*

(Note: The period of incapacity due to illness must NOT exceed 13 weeks)

5. Doctor: _____ Signature: _____
Name (please print)

Affix Doctor's Stamp here

Date: _____
dd/mm/yyyy

PLEASE NOTE:
A claim certified by a Registered Medical Practitioner practicing outside The Bahamas MUST be accompanied by a business card.

Form Med 1 (revised 2020)

Section B: Claimant Details *(to be completed by Claimant)*

Note: *If you are an employed person, this claim should be supported by a completed Employer's Certificate (Form Med.4); 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:

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 vacation started: ~~*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 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).

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? _____
    _____
    _____
    _____