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.

FOR OFFICIAL USE ONLY	
Date Claim Recd:	
Officer:	
Claim No:	

SOCIAL SECURITY NO.

2

Enter Name as per SS Registration Card

CLAIMANT'S PERSONAL INFORMATION

Name: __________

P.O. Box No: __________

Date of Birth:

MM	DD	YYYY

House No. & Street Address: __________

City/Town/Village: __________

District: __________

Tel/Fax: __________

Email address: __________

3

EMPLOYMENT PARTICULARS

Job Title: __________ Business No: __________

Current Employer/ Business Name: __________

Current Employer Business Address: __________

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

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

4

METHOD OF BENEFIT PAYMENT

Deposit to a bank or credit union: ☐ To be picked up: ☐

Name of Bank: __________ Location of Branch: __________

Account Number: __________ Name of Account Holder: __________

5

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

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.

6

IMPORTANT NOTICE

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).

7

AUTHORIZATION

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

First Name: ______________________ Last Name: ______________________

SIGNATURE OF CLAIMANT: ______________________ DATE: ______________

8

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:

In my opinion you will remain incapable of work from:

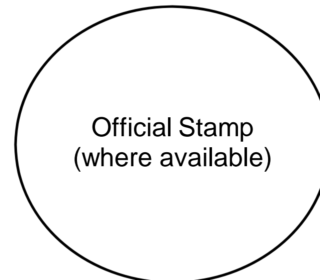
MM	DD	YYYY

to:

MM	DD	YYYY

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

Name of Medical Practitioner *(In Block Letters)* | Signature | Date of Examination



9

ANY OTHER REMARKS: