SOCIAL SECURITY BOARD
CLAIM FOR MATERNITY 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:	

Enter Name as per SS Registration Card

SOCIAL SECURITY NO.

CLAIMANT'S PERSONAL INFORMATION

Name: _____ MM DD YYYY

P.O. Box No: _____ Date of Birth: _____

2

House No. & Street Address: _____

City/Town/Village: _____

District: _____

Tel/Fax: _____

Email address: _____

EMPLOYMENT PARTICULARS

Current Job: _____

Current Employer Name: _____

Current Employer Business Address: _____

3

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).

Previous Employer Name	Address	Date Started	Date Ended

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

I hereby claim for Maternity Benefit from: MM DD YYYY

to: MM DD YYYY

I attach (a) Medical Certificate of Expected Date of Delivery ☐

OR (b) Certificate showing Date of Delivery ☐

signed by: _____
Name of Medical Practitioner

I hereby declare that I do not intend to work during the period for which I have claimed benefit.

I have read (been read) and understand the warning statement.

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.

MB - Maternity Benefit Claim Form

6

*MEDICAL CERTIFICATE OF
EXPECTED DATE OF CONFINEMENT

To be completed by a **REGISTERED MEDICAL PRACTITIONER ONLY**

I certify that I have examined Mrs. / Ms. _____ and that
Enter Name as per SS Registration Card

in my opinion she is pregnant and should be confined on _____
Date of Expected Confinement

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

Official Stamp (where available)

***MEDICAL CERTIFICATE OF CONFINEMENT**

7

To be completed by a **REGISTERED MEDICAL PRACTITIONER or REGISTERED MIDWIFE ONLY**

I certify that I attended Mrs. / Ms. _____
Enter Name as per SS Registration Card

at her confinement which took place on _____
Date of Confinement

Name of Medical Practitioner / Registered Midwife (In Block Letters) | Signature | Date of Signature

Official Stamp (where available)

8

INSTRUCTIONS

* Complete whichever section above is appropriate.

9

Decision: _____ Date: _____

Officer Authorizing: _____

Reason for Disallowance: _____