



SOCIAL SECURITY BOARD

APPLICATION FOR EMPLOYER REGISTRATION
SOCIAL SECURITY BOARD
CHAPTER 44 LAWS OF BELIZE

SECTION I	OFFICIAL USE ONLY
Employer (Parent / Corporate)	Employer Number:
Name: _____	Company Reg. Number: _____
Name of Partner (If any): _____	Sales Tax Number: _____
House Number.: _____ Street: _____	Business Tax Number: _____
City/Town: _____	Start Date: _____ / _____ / _____ <small>Day Month Year</small>
District: _____	Close Date: _____ / _____ / _____ <small>Day Month Year</small>
P.O. Box: _____	Ownership Type (Please indicate <input checked="" type="checkbox"/>) Government <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Quasi Government <input type="checkbox"/> Partnership <input type="checkbox"/> Foreign Owned <input type="checkbox"/> Limited Company <input type="checkbox"/> NGO/Church <input type="checkbox"/> Cooperative <input type="checkbox"/> Other (Specify) <input type="checkbox"/>
Phone Number: _____	
E-mail: _____	
Contact Person: _____	
Post/Job Title: _____	
Fax Number: _____	
<i>Proceed to complete Section II.</i>	

SECTION II	OFFICIAL USE ONLY
Business / Branches / Subsidiaries:	Business Number:
	Operating Zone:
Business Name: _____	Business Operation (Please indicate <input checked="" type="checkbox"/>) Casual <input type="checkbox"/> Contract <input type="checkbox"/> Full Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Registered Date: _____ / _____ / _____ <small>Day Month Year</small> Start Date: _____ / _____ / _____ <small>Day Month Year</small> Close Date: _____ / _____ / _____ <small>Day Month Year</small>
House Number.: _____ Street: _____	
City/Town: _____	
District: _____	
P.O. Box: _____	
Phone Number: _____	
E-mail: _____	
Contact Person: _____	
Post/Job Title: _____	
Industry (Business Activity Description): _____	



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SECTION III

ACCESS REQUEST: Online Contributions Portal

Ihereby request access to the Social Security Board's (SSB) Online Contributions Portal.

Name of Employer or authorized representative:
(PRINT IN CAPS)

Signature of Employer or authorized representative:

Date:/...../.....
Day Month Year

Social Security Board will confirm your registration to the Online Portal via e-mail.

SECTION IV

Employer Declaration

OFFICIAL USE ONLY

I certify the information I have given above is true and correct.

Name: _____
In Block Letters

Signature: _____
Employer or Authorized Representative

Date: _____/_____/_____
Day Month Year

Date Received: _____/_____/_____
Day Month Year

Received By: _____

Industry Code: _____

DE By: _____

Date: _____/_____/_____
Day Month Year

Received By: _____

Date: _____/_____/_____
Day Month Year