SOCIAL SECURITY BOARD

CLAIM FOR SICKNESS BENEFIT
(Chapter 44 of the Laws of Belize)

IMPORTANT NOTICE	FOR OFFICIAL USE ONLY	
Claims for Sickness Benefit must be submitted to the Social Security Board within **four days** immediately following the first day of certified incapacity for work. For claims submitted **after four days,** a late note should be attached to the claim stating reasons for lateness. Failure to submit a claim within four days may result in loss of benefit.	Date Claim Received:	____ / ____ / ____ (DAY / MONTH / YEAR)
	Receiving Officer:	
	Date Claim Returned:	____ / ____ / ____ (DAY / MONTH / YEAR)
	Receiving Officer:	
	Claim Number:	

WARNING: ANY PERSON WHO KNOWINGLY MAKES ANY FALSE REPRESENTATION FOR THE PURPOSE OF OBTAINING A BENEFIT COMMITS A CRIMINAL OFFENCE AND IS PUNISHABLE BY A FINE AND OR IMPRISONMENT.

PART I. PARTICULARS OF THE INSURED PERSON

To be filled out by the Insured Person

(a) Name of Insured Person: (Enter name as per Social Security Card) _____ (FIRST) _____ (MIDDLE) _____ (SURNAME)

(b) Social Security No: ☐☐☐☐☐☐☐☐☐ **(c)** Date of Birth: ____ / ____ / ____ (DAY / MONTH / YEAR)

(d) Address: _____ (HOUSE NO.) _____ (STREET) _____ (CITY/TOWN/VILLAGE) _____ (DISTRICT)

_____ (E-MAIL) _____ (PHONE NUMBER)

(e) Occupation/Job Title: _____ I hereby verify that I can be contacted at any of the above contact information provided ☐

PART II. EMPLOYMENT PARTICULARS

(f) I am employed by: _____

(g) If employed by the Government of Belize (GOB), indicate Ministry/Dept.: _____

(h) Business Address: _____ (NO.) _____ (STREET) _____ (CITY/TOWN/VILLAGE) _____ (DISTRICT)

(i) Last **day** and **time** worked prior to your incapacity for work: ____ / ____ / ____ (DAY / MONTH / YEAR) Time: _____ A.M. ☐ P.M. ☐

(j) Is your present incapacity caused by an accident at work? Yes ☐ No ☐

(k) If you are working **less than one year** with your current employer, please provide below the information of previous employer(s):

EMPLOYER/BUSINESS NAME	BUSINESS ADDRESS	PERIOD OF EMPLOYMENT	
		FROM DD/MM/YY	TO DD/MM/YY

PART III. METHOD OF COLLECTION OF BENEFIT DEPOSIT AUTHORITY

(l) Deposited Benefit Payment to: _____ (NAME OF FINANCIAL INSTITUTION) Location or Branch: _____

(m) Account Number: _____ Name of Account Holder: _____

(**n**) I hereby verify Financial Institution and account number information provided: ☐

PART IV. INSURED PERSON'S DECLARATION

(o) I am currently engaged in insurable employment: Yes ☐ No ☐ If **No**, please state last date of employment: ____ / ____ / ____ (DAY / MONTH / YEAR)

(p) I claim Sickness Benefit **From:** ____ / ____ / ____ (DAY / MONTH / YEAR) **To:** ____ / ____ / ____ (DAY / MONTH / YEAR)

(q) I will inform the Social Security Board if I return to work any day prior to the expiration of my Sickness Benefit period.

(r) I authorize my treating doctor to disclose the nature of my illness.

(s) I declare that the information given above is true to the best of my knowledge:

_____ (CLAIMANT'S FULL NAME (BLOCK LETTERS)) _____ (SIGNATURE) ____ / ____ / ____ (DAY / MONTH / YEAR)

NOTE: If you are unable to sign this claim, it may be signed on your behalf by someone who should state that he or she has done so.

PART V. MEDICAL CERTIFICATE OF INCAPACITY FOR WORK

To be completed by a Registered Medical Practitioner *(Certificate to be filled in English and must be legible)*

Name of Insured Person: _____
(PLEASE INDICATE FULL NAME AS PER SOCIAL SECURITY CARD)

I certify that the above person is incapable of work due to the medical condition for the period stated below:

a) Diagnosis:

i) Primary Diagnosis _____ ICD10 Code _____

ii) Secondary Diagnosis _____ ICD10 Code _____

b) Period of Incapacity From _____/_____/_____ To: _____/_____/_____
DAY MONTH YEAR DAY MONTH YEAR

☐ Five Days or Less
☐ Six days or more } (tick one)

c) Date of Examination _____/_____/_____
DAY MONTH YEAR

d))Patient is fit to return to work after above period of incapacity ☐ YES ☐ NO

Medical Practitioner: _____
(BLOCK LETTERS) FIRST MIDDLE SURNAME

Medical Council of Belize Registration No. _____ or GOB Approved Medical Officer ☐

Signature of Medical Practitioner: _____ Date: _____/_____/_____
DAY MONTH YEAR

Name of Institution: _____

or

Address: _____

Official Stamp

Physician Comments: _____

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Decision on Sickness Benefit Claim

(i) ☐ Allowed — Period of Benefit **Allowed From:** _____/_____/_____ **To:** _____/_____/_____
DAY MONTH YEAR DAY MONTH YEAR

Weekly Benefit Rate: $ _____ Amount Payable: $ _____

(ii) ☐ Disallowed — Period of Benefit **Disallowed From:** _____/_____/_____ **To:** _____/_____/_____
DAY MONTH YEAR DAY MONTH YEAR

ISCO Code _____

If disallowed, state the reasons for disallowance:

_____

Amount of deductions: _____

Reason for deductions, if any: _____

_____

Claim Processing

	NAME IN PRINT	SIGNATURE	DAY / MONTH / YEAR
Customer Service Agent:	_____	_____	_____/_____/_____
Processing Clerk:	_____	_____	_____/_____/_____
Processing Agent:	_____	_____	_____/_____/_____
Team Leader or SDO	_____	_____	_____/_____/_____

Relevant Notes:

_____

_____