



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: | ____/____/____ <small>DAY MONTH YEAR</small> |
| | Receiving Officer: | _____ |
| | Date Claim Returned: | ____/____/____ <small>DAY MONTH YEAR</small> |
| | 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: ____/____/____ Time: _____ A.M.
DAY MONTH YEAR 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 <small>DD/MM/YY</small> | TO <small>DD/MM/YY</small> |
| | | | |
| | | | |
| | | | |
| | | | |

PART III. METHOD OF COLLECTION OF BENEFIT DEPOSIT AUTHORITY

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

(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:** ____/____/____ **To:** ____/____/____
DAY MONTH YEAR 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 } (tick one)
 Six days or more }

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

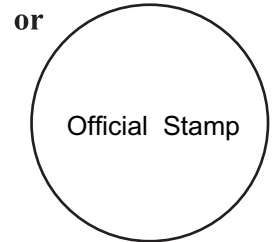
Medical Council of Belize Registration No. _____ or GOB Approved Medical Officer

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

Name of Institution: _____

Address: _____

Physician Comments: _____



FOR OFFICIAL USE ONLY

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

Customer Service Agent: _____
NAME IN PRINT SIGNATURE DAY MONTH YEAR

Processing Clerk: _____
NAME IN PRINT SIGNATURE DAY MONTH YEAR

Processing Agent: _____
NAME IN PRINT SIGNATURE DAY MONTH YEAR

Team Leader or SDO _____
NAME IN PRINT SIGNATURE DAY MONTH YEAR

Relevant Notes: _____
NAME IN PRINT SIGNATURE DAY MONTH YEAR
