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 Registration Card) SURNAME FIRST MIDDLE

(b) Social Security No: [ ][ ][ ][ ][ ][ ][ ][ ][ ] **(c)** Date of Birth: ______ / ______ / ______
DAY MONTH YEAR

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

______________________ ______________________
E-MAIL PHONE NUMBER

(e) Occupation/Job Title: ______________________________

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 **date** and **time** worked prior to your incapacity for work: ______ / ______ / ______ Time: ______________ A.M. ☐ P.M. ☐
DAY MONTH YEAR

(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

(l) To be collected at: ______________________________ ; **OR**
BRANCH OFFICE

(m) Deposited to a financial institute: ______________________________ Location or Branch: ______________
NAME OF FINANCIAL INSTITUTION

(n) Account Number: ______________________________ Name of Account Holder: ______________________________

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

Name of Insured Person: ______________________________

(PLEASE INDICATE FULL NAME AS PER REGISTRATION CARD)

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

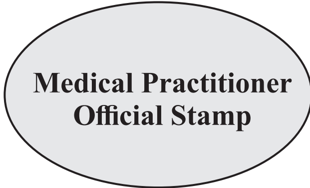
a) Diagnosis:

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

Name of Medical Practitioner: ______________________________
(BLOCK LETTERS) SURNAME FIRST MIDDLE

Address of Medical Practitioner: ______________________________
HOUSE NO. STREET CITY/VILLAGE DISTRICT

Signature of Medical Practitioner: ______________________________ ____ / ____ / ____
DAY MONTH YEAR

License Number of Medical Practitioner ☐☐☐☐☐☐☐

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 SDO	NAME IN PRINT	SIGNATURE	DAY / MONTH / YEAR

Relevant Notes: ______________________________

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