SOCIAL SECURITY BOARD
CLAIM FOR INVALIDITY BENEFIT
(Chapter 44, Laws of Belize)

IMPORTANT NOTICE	FOR OFFICIAL USE ONLY	
Claims for Invalidity Benefit must be submitted to the Social Security Board within **thirteen weeks** from the date in which apart from satisfying the condition, the claimant becomes entitled. Claims submitted **after** thirteen weeks must be accompanied by a note stating reason for lateness. Failure to submit a claim within **thirteen weeks** 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 1. 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/TOWN/VILLAGE / DISTRICT)

_____ (EMAIL ADDRESS) _____ (PHONE NUMBER)

(e) Name of Employer: _____ (SURNAME / FIRST / MIDDLE)

(f) Business Name: _____

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

_____ (EMAIL ADDRESS) _____ (PHONE NUMBER)

(h) What was your recent occupation? _____

(i) What type of activity is carried on at the work place (Type of Industry)? _____

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

(k) Are you currently receiving a benefit? ☐ Yes ☐ No If Yes, please state Benefit Type: _____

(l) I attach: ☐ Lab Test Results ☐ Diagnostic Imaging Tests

(m) I declare that the information given is true to the best of my knowledge.

_____ (CLAIMANT'S FULL NAME IN PRINT) _____ (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 2. MEDICAL CERTIFICATE OF PERMANENT INCAPACITY FOR WORK

To be completed by a Registered MEDICAL PRACTITIONER

IMPORTANT NOTICE: For the purpose of the Benefit Regulations, 17 (2) the term "**INVALID**" means a person who is incapable of work as a result of a specific disease or bodily or mental disablement which is likely to remain **PERMANENT**.

Name of Insured Person: _____
SURNAME FIRST MIDDLE

I hereby certify that I have examined the above named person and my findings are as follows:

1) Name and description of illness: _____

_____

2) Clinical Report: _____

_____

3) Laboratory and other tests reviewed: _____

_____

4) Diagnosis: _____

_____

5) Select the option that applies:

(i) Insured person is **not** an invalid ☐ **(ii)** Insured person is an invalid ☐

6) If the Insured Person is an Invalid:

(i) Please state reasons: _____ _____

-

_____

(ii) Please attach Medical History.

7) Conclusions and Diagnosis: _____

_____

_____

8) Recommendations: _____

_____

_____

_____ _____ _____/_____/_____
PRINTED NAME OF MEDICAL PRACTITIONER SIGNATURE DAY / MONTH / YEAR

Medical Providers Official Stamp

Part 3. MEDICAL CERTIFICATE OF PERMANENT INCAPACITY FOR WORK

To be completed by a MEDICAL BOARD

IMPORTANT NOTICE: For the purpose of the Benefit Regulations, 17 (2) the term "**INVALID**" means a person who is incapable of work as a result of a specific disease or bodily or mental disablement which is likely to remain **PERMANENT**.

Name of Insured Person: _____
SURNAME FIRST MIDDLE

I hereby certify that I have examined the above named person and my findings are as follows:

1) Name and description of illness: _____

_____

2) Clinical Report: _____

_____

3) Laboratory and other tests reviewed: _____

_____

4) Can the Insured Person return to his or her normal duties? ☐ Yes ☐ No

(i) If the Insured Person can return to work, please indicate the date: _____ /_____ / _____
DAY MONTH YEAR

5) Can the Insured Person perform any type of work? ☐ Yes ☐ No

6) Does the Insured Person needs to be reassessed in the future? ☐ Yes ☐ No

(i) If the Insured Person needs to be reassessed, please indicate the date: _____ /_____ / _____
DAY MONTH YEAR

7) Based on the definition of **Invalid** and the medical findings, the Insured Person is incapable of performing any type of work which is likely to remain PERMANENT, and is therefore considered an INVALID: ☐ Yes ☐ No

8) If the Insured Person is an Invalid, please state reasons for the decision: _____

_____

_____

_____

Printed Names of Doctors on the Medical Board:	**Signatures of Doctors:**
1) _____	_____
2) _____	_____
3) _____	_____

Date of Conclusion of Assessment: _____ /_____ /_____
DAY MONTH YEAR

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Decision on Invalidity Benefit Claim

Age of Insured Person: _____years *(confirm age using date of birth)*

Four-digit Occupation Code: ☐☐☐☐ *[refer to Page 1 (h)]*

Four-digit Industry Code: ☐☐☐☐ *[refer to Page 1 (i)]*

Invalidity Benefit Type: ☐ Invalidity Pension **OR** ☐ Invalidity Grant

Weekly Pension Rate: $_____ **OR** Amount of Grant: $_____

If disallowed, state the reasons for disallowance: _____

_____

_____

_____

Amount of Deductions: $_____

Please indicate reasons for deductions, if any: _____

_____

_____

_____

Claim Processing

Processing Clerk: _____ _____ _____/_____/_____
NAME IN PRINT SIGNATURE DAY MONTH YEAR

Verifier (FCC): _____ _____ _____/_____/_____
NAME IN PRINT SIGNATURE DAY MONTH YEAR

Authorizer (AA/ADMIN): _____ _____ _____/_____/_____
NAME IN PRINT SIGNATURE DAY MONTH YEAR

Relevant Notes: _____

_____

_____

_____