



SOCIAL SECURITY BOARD

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

IMPORTANT NOTICE

FOR OFFICIAL USE ONLY

Claims for Invalidation 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.

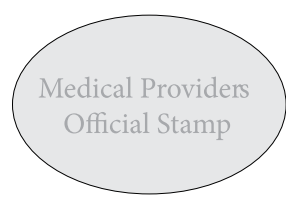
7) Conclusions and Diagnosis: _____

8) Recommendations: _____

PRINTED NAME OF MEDICAL PRACTITIONER

SIGNATURE

_____/_____/_____
DAY MONTH YEAR



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

