

I agree to my hospital records being obtained by the Medical Officer(s) designated by the Social Security Board
SECTION B – INFORMATION ON THE SPOUSE, AND CHILDREN WHO ARE UNDER AGE 16 AT THE DATE OF

15. Given Names: Mr., Mrs., Miss _____ Surname _____

16. Home address _____

	Given Names of Children	Surname	Date of Birth			Male	Female
			Day	Month	Year		
17A.						<input type="checkbox"/>	<input type="checkbox"/>
17B.						<input type="checkbox"/>	<input type="checkbox"/>
17C.						<input type="checkbox"/>	<input type="checkbox"/>
17D.						<input type="checkbox"/>	<input type="checkbox"/>
17E.						<input type="checkbox"/>	<input type="checkbox"/>
17F.						<input type="checkbox"/>	<input type="checkbox"/>

SECTION C – DECLARATION OF APPLICANT

18A. I hereby apply for a **disablement benefit**. Attached is a copy of my birth certificate and medical report.

I declare that to the best of my knowledge and belief, the information given on this application form is true and complete and I undertake to notify the Dominica Social Security of any changes in circumstances that may affect my eligibility for benefits.

Signature or Mark (X) of applicant: _____ Date _____

Tel.: # _____

NOTE: Signature or Mark (X) must be witnessed by a responsible person. The witness must complete the certificate declaration (18B) on the form.

18B. (WITNESS' CERTIFICATE, DECLARATION AND SIGNATURE)

I hereby certify that:

(a) the claimant signed the above declaration in my presence;

or

(b) the claimant made the necessary mark (X) to the above declaration in my presence; having expressed himself or herself as having fully understood the contents of this claim and declaration.

Name of Witness _____

Signature of Witness _____

Address of Witness _____

Qualification or occupation _____

Date

Day	Month	Year
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 Telephone Number _____

IMPORTANT: Please read before submitting claim.

If your claim is submitted more than 3 months from the date you became disabled, please attach a separate sheet explaining your reasons for lateness.