

I Claim Employment Injury Benefit for the period _____ to _____ as a result of an injury which arose out of my employment as stated briefly (if space is insufficient, continue on a separate sheet):

Name(s) of Person(s) who witnessed the accident or whom I mentioned it to:

**** EMPLOYEE'S AUTHORISATION TO REFUND EMPLOYER BENEFIT
ADVANCED DURING THE PERIOD OF INCAPACITY**

I hereby authorize DSS to refund _____
(Insert Employer's Name)

my employer, the amount due to me as Injury Benefit.

**I am aware that I am liable to serious penalties if I deliberately furnish false or incorrect information.

Name of Employee (BOLD PRINT)

Signature or Mark 'X'

Date _____

Signature of Witness to mark 'X' only

Date _____

TO BE COMPLETED BY PERSON WHO WITNESSED THE INJURY /ACCIDENT

Name of witness _____

Address _____

Did you actually see the accident happen? (Yes/No) _____

If not did the claimant mention it to you? (Yes/No) _____

If so, when? _____

Please state exactly what you saw or what knowledge you have of the accident (continue on another sheet if necessary)

**Applicable to both Sections

EMPLOYER'S REPORT OF INJURY

Details of Injury/Accident

Date _____ Time _____ am/pm Place _____

1. Description of Accident: _____

2. Nature of Injury: _____

3. Work performed at time of accident: _____

4. Machine (if any) being operated: _____

5. I.P.'s normal work: _____

6. Witness(es) interviewed: Yes No

7. Additional Comments: _____

I certify that the above arose _____/did not arise _____ out of and in the course of insurable employment (Tick as appropriate).

EMPLOYER'S CERTIFICATE

I certify that the Insured Person:

Surname _____

Name _____

S.S. No. _____

Occupation _____

Has been employed with the organization from _____ to _____. During the qualifying period (a)*) _____ to (b)* _____ the insured

Person was paid monthly/weekly wages as stated overleaf.

**See guideline for explanation.*

N.B. If employee has been employed for less than 2 weeks the basic earnings of a worker in a similar category may be used with an appropriate notation.

Week No.	Date	Amount \$	Week No.	Date	Amount \$
1.			8.		
2.			9.		
3.			10.		
4.			11.		
5.			12.		
6.			13.		
7.					

Last day claimant worked _____

DELETE AS APPROPRIATE

The insured person was absent/will be absent from work due to

Employment Injury for the period _____ to _____
 (Do not include days employee was at work). During the above period he/she was paid will be paid "Sick Pay" totaling \$_____. I have/have not advanced Social Security benefit payable during the period stated above and I wish/do not wish to apply for a refund under Employee Authorization duly completed and signed by Employee.

 I certify that the above statements are true to the best of my knowledge, and that the information corresponds with my employee's records.

Signature of Employer _____

Name and Address of Employer _____

Registration No. _____

Employer's Stamp _____

Date _____ Tel# _____

GUIDELINES FOR COMPLETING EMPLOYER'S CERTIFICATE

1. Qualifying Period

*(a) Period (a) refers to the date which is 13 weeks for weekly paid employees (or 3 months, if monthly paid) preceeding the date injury/accident occurred.

***(b) Period (b) is date of injury/accident.

2. In computing "Sick-Pay" do not include Sundays or days employee was at work for part of the day.

3. **Formula for Calculating Benefit**

For monthly paid employees: $(\text{Total of 3 mnths} \div 13 \times 60\% \div 6 \times \text{no. of days of incapacity (excluding Sundays)})$.

For weekly paid employees: $(\text{Total of 13 wks} \div 13 \times 60\% \div 6 \times \text{no. of days of incapacity (excluding Sundays)})$.

N.B. The rate of benefit remains the same during the entire Injury Benefit period which is 26 weeks commencing with the date of the injury/accident.

4. Fortnightly payments should be stated in weekly amounts.

5. Effective June 1, 1995 all Employment Injury claims in excess of three (3) days are paid from the first full day of incapacity.

6. Employers who have advanced their employees benefit may claim a refund with employee's consent (see Employee's Authorisation).

7. **IMPORTANT: read before submitting claim**

Claim for Injury Benefit must be submitted within four (4) days from the date of issue of medical certificate.

Failure to comply with the above could result in loss of benefit unless a reasonable excuse is presented.

DO NOT INCLUDE BENEFIT ADVANCED (60%)/SICK PAY (40%) IN WAGES DECLARED ON CONTRIBUTION FORM C8. NO SOCIAL SECURITY CONTRIBUTIONS ARE LIABLE FOR ANY FULL WEEK EMPLOYEE HAS RECEIVED EMPLOYMENT INJURY BENEFIT.



Place stamp
here for mailing
purposes

TO: The Director
Dominica Social Security
Cnr Hanover & Hillsborough Sts., Roseau
Commonwealth of Dominica

Claim for Employment Injury Benefit

FROM: Name _____
Address of _____
Employer _____

DOMINICA SOCIAL SECURITY
CLAIM FOR EMPLOYMENT INJURY BENEFIT ONLY



OFFICIAL USE
CLAIM NO.
DATE REC'D
INITIALS

MEDICAL CERTIFICATE

To: **Mr/Mrs/Miss** _____

I certify that I have examined you today and you are incapable of work because you are suffering from :

_____ CODE _____
(Nature of injury causing incapacity)

In my opinion you will be incapable of work during the period:

_____ to _____

Date of Examination _____

Medical Practitioner _____
(IN BOLD PRINT)

Signature of Medical Practitioner _____

Address _____

Telephone # _____

INJURY BENEFIT APPLICATION

To be completed by claimant before submitting to employer (s)

TO: Director – Dominica Social Security

Name in full _____

Home Address _____

Mailing Address _____

Date of Birth

D	M	Y
---	---	---

S.S. No. _____ Tel# _____

Continue Overleaf