



DOMINICA SOCIAL SECURITY

Warning:

It is an offence to make a false statement or representation or to produce or furnish any document or information known to be false for the purpose of obtaining any benefit under the Social Security Act, 1975.

Note: To claim invalidity one must be an invalid i.e. must be incapable of work as a result of a specific disease or bodily or mental disablement which is likely to remain permanent; or one who has exhausted his entitlement to sickness benefit.

APPLICATION INVALIDITY BENEFIT

Table with 1 column and 4 rows: FOR OFFICIAL USE, Claim No., Date Rec'd, Clerk's initials

SECTION A - INFORMATION ON THE INVALID CONTRIBUTOR

1A. Insured Person's Social Security No. OLD NEW

1B. Sex Male Female

1C. Date of Birth Day Month Year Age Established at Claim

2. Marital Status: Single, Widow(er), Married, Divorced, Separated, Common-Law

3. Given Names: Mr., Mrs., Miss Surname

4. Home Address Mailing Address

5. Name of last Employer

6. Address of last Employer

6B. Date last worked

Table with 4 columns: 7. Details of other employers for whom you worked. (If applicable), Name, Address, Period of Employment (From, To)

(P.S. If there were more employers please state the relevant particulars on an attached sheet)

8. Have you been a voluntary or self-employed contributor? Vol. S.E. NONE If 'Yes', state what year(s) Yes No

9. What is the nature of your illness or disease?

10. Did you receive sickness benefit for this spell of incapacity? Yes No

11. If yes, from what date to what date?

12. Provide medical certificate in support of your claim

13A. Have you ever received an invalidity grant? If 'Yes', what year? Yes No

13B. Are you presently receiving any Social Security benefit? If 'Yes' indicate benefit type Yes No

14. Have you ever participated in a social insurance plan of another country If 'Yes', indicate country and insurance number Yes No

**SECTION B – INFORMATION ON YOUR SPOUSE, AND CHILDREN WHO ARE UNDER AGE 16 AT THE DATE OF THE CLAIM.**

15. Particulars of Spouse

16. Given Names: Mr., Mrs., Miss \_\_\_\_\_ Surname \_\_\_\_\_

17. Home address \_\_\_\_\_

18. Name(s) of children under 16 years. \_\_\_\_\_ Address \_\_\_\_\_

18A. \_\_\_\_\_

18B. \_\_\_\_\_

18C. \_\_\_\_\_

18D. Name(s) of dependant Parent(s) or Grandparent(s) age 60 or over \_\_\_\_\_ Address \_\_\_\_\_

**SECTION C – DECLARATION OF APPLICANT**

19A. I hereby apply for an invalidity benefit. Attached is a copy of my birth certificate, medical certificate and Social Security card.

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: \_\_\_\_\_

Social Security No. of Applicant: \_\_\_\_\_

Telephone Number of Applicant \_\_\_\_\_

Date of Application

Day	Month	Year

**NOTE:** Signature or Mark (X) must be witnessed by a responsible person. The witness must complete the certificate declaration (19B) on the form.

**IMPORTANT: Please read this section before submitting claim. If your claim is submitted more than 3 months from the date you have been medically certified as being permanently incapable of work, please attach a separate sheet explaining your reasons for lateness.**

**19B. 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 \_\_\_\_\_

Tel. # \_\_\_\_\_

Date \_\_\_\_\_

\*Delete whichever does not apply.