

GUIDELINES FOR COMPLETING EMPLOYER'S CERTIFICATE

QUALIFYING PERIOD

* (a) *For employees claiming Sickness Benefit:*
Period (a) refers to the date which is 13 weeks (or 3 months, if monthly paid) preceding the date incapacity commenced.

For employees claiming Maternity Benefit:
Period (a) refers to the date which is 30 weeks (or 7 months, if monthly paid) preceding the commencement of maternity leave.

** (b) Period (b) is the start date of incapacity, or the commencement of maternity leave.

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

FORMULA FOR CALCULATING BENEFIT:

For monthly paid employees:

Total of 3 mths. ÷ 13 x 40% ÷ 6 x no. of days of incapacity (excluding Sundays).

For weekly paid employees:

Total of 13 wks. ÷ 13 x 40% ÷ 6 x no. of days of incapacity (excluding Sundays).

N.B: For Sickness Benefit, where period of incapacity is within 8 weeks of previous claim, benefit is at the previous rate.

Fortnightly Payments should be stated in weekly amounts.

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

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

IMPORTANT: (Read before submitting claim)

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

Claim for Maternity Benefit must be submitted no later than 3 weeks prior to expected date of confinement.

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

DO NOT INCLUDE BENEFIT ADVANCED (60%) OR SICK PAY (40%) IN THE WAGES DECLARED ON CONTRIBUTION FORM C8. THE EMPLOYER IS NOT LIABLE TO PAY SOCIAL SECURITY CONTRIBUTION FOR ANY FULL WEEK THAT THE EMPLOYEE HAS RECEIVED SICKNESS/MATERNITY BENEFIT.



TO:
The Director
Dominica Social Security Office
Cnr. Hanover & Hillsborough Streets
P.O. Box 772
ROSEAU
Commonwealth of Dominica

FROM:
Name: _____
Address: _____
Employer: _____
Employer's Address _____

CLAIM FOR SICKNESS/MATERNITY BENEFIT

Place Stamp
here for mailing
purpose

DOMINICA SOCIAL SECURITY CLAIM FOR SICKNESS/MATERNITY BENEFIT



OFFICIAL USE ONLY	
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:

1. SICKNESS suffering from _____	CODE: _____
<i>(Clearly State specific disease/bodily/mental disablement)</i>	
2. MATERNITY Pregnant and it is expected that you confinement will occur on the _____ day of _____, 20____.	
In my opinion, Ms _____ is able to perform her duties up to _____ weeks before her expected date of confinement	

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 #: _____

EMPLOYEE BENEFIT APPLICATION

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

TO: Director – Dominica Social Security

Name in Full: _____

BOLD PRINT

Home Address: _____

Mailing Address: _____

Date of Birth: Day: _____ Month: _____ Year: _____

SS Number: _____

Telephone #: _____

DELETE AS APPROPRIATE

I Claim Sickness/Maternity benefit for the period _____
to _____, 200____.

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

(Where Applicable)

I hereby authorise DSS to refund _____
(Insert Employer's Name)
my employer, the amount due to me as Sickness/Maternity 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 of Witness (*To Mark "X" only*)

(Applicable to both Sections)

Signature or Mark "X"

Date: _____

Date _____

EMPLOYER'S CERTIFICATE

I certify that the Insured Person:

SURNAME: _____

NAME: _____

S.S NO: _____

OCCUPATION: _____

has been employed with this organisation from _____ to
_____. During the qualifying period (a)*
_____ to (b)* _____ the
Insured Person was paid monthly/weekly wages as stated below. (*See
guidelines for explanation)

Week No.	Date	Amount (\$)	Week No.	Date	Amount (\$)
1.			16.		
2.			17.		
3.			18.		
4.			19.		
5.			20.		
6.			21.		
7.			22.		
8.			23.		
9.			24.		
10.			25.		
11.			26.		
12.			27.		
13.			28.		
14.			29.		
15.			30.		

Last day claimant worked: _____

DELETE AS APPROPRIATE

The Insured Person was absent/will be absent from work due to
Sickness/Maternity for the period _____ to
_____, 200____. (*Do not include
days employee was at work*).

During the above period He/She was paid/will be paid "Sick Pay"
totalling 40% \$_____. 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 Authorisation
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.No. _____