



**Certificate of Confinement**

I certify that on the \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_, I assisted at the confinement of Miss/Mrs. \_\_\_\_\_ Social Security Number \_\_\_\_\_. This confinement took place at the \_\_\_\_\_ \*on behalf of the services of this Government’s institution. Full name of Registered Medical practitioner/Midwife \_\_\_\_\_ Address \_\_\_\_\_ Signature \_\_\_\_\_ Telephone Number \_\_\_\_\_

\*(Delete this sentence if inapplicable)

**NOTE: Please read carefully before submitting to Social Security Office**

- 1. The insured person must have paid amounts due to the Government Institution to qualify for the full grant.
- \*2. Where the claim is made by a man on behalf of his spouse he is required to present:
  - (i) the birth certificate of the child
  - (ii) marriage certificate in support of marriage unions or
  - (iii) declaration made under oath before a Justice of Peace or Notary Public in support of common-law unions between the spouses of not less than three (3) years
  - (iv) any other supporting documents requested by the Director should it be deemed necessary.

**EMPLOYEE’S CLAIM FOR MATERNITY GRANT**

FOR OFFICIAL USE
Claim No.
Date Rec’d
Clerk’s initial

Insured woman already in receipt of weekly maternity Benefits need not send this form to her employer (s)

Claimant’s Full Name \_\_\_\_\_ S.S # \_\_\_\_\_  
Home Address \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Mailing Address \_\_\_\_\_ Tel. \_\_\_\_\_

I hereby claim maternity grant on behalf of myself/\*my spouse \*See 2 above  
(Delete as appropriate)

\_\_\_\_\_  
(insert spouse’s name) (SS# of spouse if applicable)  
Signature or Mark ‘X’ of Claimant \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Witness to Mark ‘X’ \_\_\_\_\_ Date \_\_\_\_\_

**Certification from Accounts Department, Princess Margaret Hospital or other relevant Government Institution**

- I certify that the above mentioned person has settled all amounts due in respect of the above confinement.
- I certify that the above mentioned person is indebted to this institution in the sum of \$ \_\_\_\_\_

\_\_\_\_\_  
**SIGNATURE FULL NAME DATE & STAMP**

**EMPLOYER'S CERTIFICATE**

**IMPORTANT: Only complete for an insured woman who is not in receipt of weekly maternity benefits, or for an insured man who is claiming on behalf of his spouse.**

I certify that the insured claimant referred to overleaf

Surname \_\_\_\_\_ SS# \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ has been employed with this organization as a/an \_\_\_\_\_  
 \_\_\_\_\_ from \_\_\_\_\_ 19\_\_\_\_\_, to \_\_\_\_\_ 20 \_\_\_\_.

*State occupation*

During the qualifying period \*(a) \_\_\_\_\_ to \*(b) \_\_\_\_\_ the insured person was paid monthly/weekly wages as stated below. (See \*(a) & \*(b) below for guidelines.)

Date	Wk	Amount	Date	Wk	Amount	Date	Wk	Amount	Date	Wk	Amount
	1			9			17			25	
	2			10			18			26	
	3			11			19			27	
	4			12			20			28	
	5			13			21			29	
	6			14			22			30	
	7			15			23			31	
	8			16			24			32	

Last Day insured person worked \_\_\_\_\_

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

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

Name of Employer \_\_\_\_\_ Employer's Stamp & Date \_\_\_\_\_

Address of Employer \_\_\_\_\_

\*(a) Refers to the date that is 26 weeks or 6 months in the last 52 weeks prior to the date of confinement

\*(b) Refers to the date of confinement.

**IMPORTANT: Read before submitting claim.**

**A claim after confinement must be submitted not later than 15 days after the date of confinement. Claims not submitted within the prescribed time must be accompanied by a written excuse explaining the reasons for lateness.**

**Failure to comply may result in loss of benefits.**