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: (Total of 3 mnths ÷ 13 x 60% ÷ 6 x no. of days of incapacity (excluding Sundays).

   For weekly paid employees: (Total of 13 wks ÷ 13 x 60% ÷ 6 x 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 <u>FULL</u> 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