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

Place Stamp here for mailing purpose

FROM:

Name: _____

Address: _____

Employer: _____

Employer's Address _____

CLAIM FOR SICKNESS/MATERNITY BENEFIT

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 **CODE:** _____
suffering from

_____

(Clearly State specific disease/bodily/mental disablement)

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 or Mark "X"

Date: _____

_____ Date _____

Signature of Witness ***(To Mark"X" only)***

(Applicable to both Sections)

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. _____