DOMINICA DSS SOCIAL SECURITY

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Warning:
Any person who knowingly makes any false statement or false representation for the purpose of obtaining Benefit commits a criminal offence punishable by fine or imprisonment or both.

FOR OFFICIAL USE			
Claim No.			
Date Rec'd	Day	Month	Year
Clerk's initials			

APPLICATION
DISABLEMENT BENEFIT

SECTION A – INFORMATION ON THE INSURED PERSON

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(s) Address Period of last employment

5A.

5B.

6. Have you been a voluntary or self-employed contributor? Vol. ☐ S.E. ☐ NONE ☐
(Tick as appropriate)
If 'Yes', state what year(s) ______________________________

7. Date of accident in respect of which you are claiming disablement benefit

8. State in what ways you are disabled as a result of the accident/disease.

9. Provide medical certificate in support of your claim

10. Are you fit to travel if you are required to report for medical examination? Yes ☐ No ☐

11A. Have you received disablement benefit before? Yes ☐ No ☐

11B. Are you presently receiving Social Security benefit? Yes ☐ No ☐
(Indicate benefit type)

12. Is this your first injury at work? Yes ☐ No ☐

13. If no, state when last injured. Date:

14. Give the following particulars about the treatment of your present injury:-

Name of Medical Institution	State whether in-patient or out-patient	Name of Ward if in-patient	Hospital reference or admission no.	Period of treatment		Were any X-rays and laboratory tests taken	
				From	To	(Yes)	(No)

I agree to my hospital records being obtained by the Medical Officer(s) designated by the Social Security Board
SECTION B – INFORMATION ON THE SPOUSE, AND CHILDREN WHO ARE UNDER AGE 16 AT THE DATE OF

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

16. Home address

	Given Names of Children	Surname	Date of Birth Day	Month	Year	Male	Female
17A.						☐	☐
17B.						☐	☐
17C.						☐	☐
17D.						☐	☐
17E.						☐	☐
17F.						☐	☐

SECTION C – DECLARATION OF APPLICANT

18A. I hereby apply for a **disablement benefit**. Attached is a copy of my birth certificate and medical report.

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: ______________________________ Date ______________________

Tel.: # ______________________

NOTE: Signature or Mark (X) must be witnessed by a responsible person. The witness must complete the certificate declaration (18B) on the form.

18B. (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 ______________________________

Date

Day	Month	Year

Telephone Number ______________________

IMPORTANT: Please read before submitting claim.
If your claim is submitted more than 3 months from the date you became disabled, please attach a separate sheet explaining your reasons for lateness.