



DOMINICA SOCIAL SECURITY ACT 1975
APPLICATION FOR REFUND OF CONTRIBUTIONS

Name of Employer: _____	Reg. Number: <table border="1" style="display: inline-table; width: 100px; height: 20px;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>																				
Address: _____ _____																					
Name of Employee: _____	S.S. No.: <table border="1" style="display: inline-table; width: 100px; height: 20px;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>																				
Address: _____	Date of Birth: <table border="1" style="display: inline-table; width: 60px; height: 20px;"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>																				

I hereby claim Refund of Contributions in respect of the following period:

Month	Income Received	Amount of Contributions paid (A)		Amount of contribution which should have been paid (B)		Refund amount claimed (Column A minus B)	
		Employee	Employer	Employee	Employer	Employee	Employer

Reasons for erroneous payment of contributions: _____

Application is hereby made for a refund of the contributions erroneously paid.

Signature of Employee: _____

Signature of Employer: _____

Date: _____

Date: _____