List below the employee's earnings for the previous month. If he/she is paid monthly, indicate the number of weeks worked using the Saturdays as your guideline.

| Weekly Paid | Monthly Paid |
|---|---|
| 1……20……..…$..... | |
| 2……20…….$..... | $..... |
| 3……20…… $..... | |
| 4……20…….$..... | For the month of ……20...….. |
| 5…….....20…….$..... | Number of weeks worked …….. |

For the month in which the employee became ill, state the number of weeks worked prior to the illness. Number of weeks ……

**I certify that the above information given by me is correct to the best of knowledge and belief. I understand that I can be prosecuted if I knowingly give incorrect information.**

Name of employer……...……..……

Registration Number of employer | | |

Name of person giving information…….…….…….

Signature……...Date……..…..……

**FOR OFFICAL USE ONLY**

26 Week? ☐ Yes ☐ No 8 in 13? ☐ Yes ☐ No

Insurable earnings for ……...20..….. $..... No. of Weeks…….

Insurable earnings for ……...20..….. $..... No. of Weeks…….

Insurable earnings for ……...20..….. $..... No. of Weeks…….

Total $.....

Prepared by…… Date……..

# ANTIGUA & BARBUDA SOCIAL SECURITY BOARD
# APPLICATION FOR SICKNESS BENEFIT

## TO PERSONS CLAIMING BENEFIT

You are required to take this form to your employer after a State Registered Medical Practitioner has filled out **sections A & B**, and you have filled out **Section C.** Your employer will then fill out section D. You must then bring or send it to the Social Security Office.

To avoid unnecessary delay in the payment of your benefit, please ensure that all aspects of **section C** are properly filled out and your signature is affixed.

**THIS FORM SHOULD REACH THE SOCIAL SECURITY OFFICE NOT LATER THAN 21 DAYS AFTER COMMENCEMENT OF THE ILLINESS.**

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## To Employer

You are kindly asked to fill out section D of this form and deliver it to the bearer. Section B is to be detached and retain by you for your records. If you receive the form after the employee has resumed work, kindly indicate when he/she resumed.

## Section A
## (To be completed by a State Registered Medical Practitioner)

To: Mr./Mrs./Miss…….

I hereby certify that on ……..……20……....., I examined you and found that you are suffering from…… In my opinion, you will be fit to resume work on ……..20……..

**Occupational Injury** ☐ ☐
**Yes** **No**

Name ……...…….
(Please Print)

Address……..……...

Official Stamp

Signature…….…... Date…….

## Section B
## (Medical Certificate for employer)

I hereby certify that on …….20…….. I examined ……..……and by reason of illness, he/she is incapacitated. In my opinion, he/she will be fit to resume work on…….. ……..20…….

Signature…….....……..…… Date……

## Section C
## (To be completed by Claimant)

Name……..Social Security No…….……

Telephone No.(H)…….(C)…….……(W)……...…...……

**PAYMENT OPTION (Please choose one)**

Mailing Address…….……

**Or**

Name …….……..……..……..……..A/C Type …….....A/C#.....

Bank……..……Address……..……..…….

.

Employer Name…….Address……...……

I claim Sickness Benefit from……20…… During the three months immediately before my illness, my other employer(s) was/were

| | Employer | Address |
|---|---|---|
| (a) | ……..…..…… | ……..……. |
| (b) | …… | ……. |
| (c) | …… | ……. |

Signature…….Date…….

## Section D
## (To be completed by employer)

This is to certify that……..…has been employed in this establishment from……..……..20……..…, his/her weekly/monthly rate being $..... He/She last worked on ……20…..…..

and has been absent from ……....20……. on account of incapacity which was/was not due to an injury sustained during the course of his/her employment here.

HE/SHE RETURNED TO WORK ON ……20…… ***(continued overleaf)***