FOR OFFICAL USE ONLY

Grant conditions satisfied ☐ Yes ☐ No 26wks in 52 prior to confinement

Maternity Allowance condition satisfied ☐ Yes ☐ No 26 wks in 52 imm. preceding 6wks before E.D.C.

Date of Monday 6 Wks prior to E.D.C. ☐☐☐ D M Y

PERIOD		NO. OF WEEKS	TOTAL EARNINGS		
FROM	TO				

A.I.W.E

REMARKS (IF ANY)_____

_____

_____

Signature……..……..…….. Date…….……

ANTIGUA & BARBUDA SOCIAL SECURITY BOARD
APPLICATION FOR MATERNITY BENEFIT

Section '**A'** of this form must be completed and signed by a **MEDICAL DOCTOR** or a **MIDWIFE** registered in **ANTIGUA-BARBUDA**.

Section '**B'** must be completed by the **CLAIMANT**.

Section '**C'** must be completed by the **EMPLOYER** on or after the last day of work preceding the maternity leave.

NOTE TO CLAIMANT

To avoid unnecessary delay in the processing of your benefit, please ensure that each section of this form is completed accurately as soon as possible after the commencement of your maternity leave. After your confinement (birth), obtain a Certificate of Confinement Form from the Social Security Office, have it completed by your doctor or midwife who assisted at your confinement and return to the Social Security Office.

SECTION A

TO BE COMPLETED BY A MEDICAL DOCTOR OR MIDWIFE REGISTERED IN ANTIGUA-BARBUDA

To: Miss/Mrs.……I certify that I have examined you today and in my opinion you are pregnant. It is expected that your Confinement will occur on……,,……. 20…….

OR

To: Miss/Mrs ……..I certify that I attended to you at your Confinement which took place on ……. ……20……

NAME OF DOCTOR/MIDWIFE……..

SIGNATURE…….. DATE…….

SECTION B

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 Maternity Benefit from……20…… to ……20…….
having last worked on……..……..20…….
During the past 14 months I was employed by:-

	Employer	Address
a)	……	….……
b)	……	…….
c)	……	…….

Signature……..…… Date……

SECTION C

TO BE COMPLETED BY EMPLOYER

This is to certify that Miss/Mrs ……..…….

has been employed in this establishment from ……20..……, her

present weekly/monthly earnings being $..... She last worked on…….

20…… and should resume work on ……...……20……

PREVIOUS MONTH

Weekly paid employee			Monthly paid employee
W/E			
1……20…..	$.....		$..... for
2……20…..	$.....		the month of
3……20…..	$.....		…….20……
4……20….	$.....		
5..……. 20….	$.....		Number of weeks worked…….

MONTH IN WHICH LEAVE STARTED

Weekly paid employee			Monthly paid employee
W/E			
1……20…..	$.....		$..... for
2……20…..	$.....		the month of
3……20…..	$.....		…….20……
4……20….	$.....		
5……20….	$.....		Number of weeks worked….

I certify that the above information given by me is correct to the best of my 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…….