ANTIGUA & BARBUDA SOCIAL SECURITY BOARD
CERTIFICATE OF CONFINEMENT

(To be completed by a Medical Doctor of midwife registered in Antigua & Barbuda)

Miss/Mrs……..……...…..……

I certify that I attended to you at your confinement which took place on……..……20…….

after……..weeks of pregnancy.

Multiple births: Yes ☐ No ☐

If "Yes" provide details……

Official Stamp

……..… ……..……..…… …….
Name of Doctor/Midwife ***Signature*** ***Date***

Claim for Maternity Grant

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……..……..…….

Signature……..……. Date……..…….

To be completed by the husband applying on behalf of his wife

Name ……..…….. Social Security No……..……..……..……

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

Name of Wife……..…… Social Security……..…….

Current Employer(s): 1.. …… 2..... ……

PAYMENT OPTION (Please choose one)

Mailing Address……..…….

Or

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

Bank……..……....…… Address……..……..…….

Signature……. Date……..…..……