Social Security Board
P.O. Box 698
Road Town, Tortola
Virgin Islands
Tel:1-284-852-7800/Fax: 1-284-494-6022
Email: info@bvissb.vg/Website:www.bvissb.vg

BENEFIT CLAIM FOR:

- ☐ **SICKNESS**
- ☐ **EMPLOYMENT INJURY**
- ☐ **INVALIDITY**
- ☐ **EMPLOYMENT INJURY DISABLEMENT**

To avoid delay in processing your claim, complete all sections of this form in Capital Letters.

Name……………………………………………………………………………………... Social Security #

Mailing Address………………………………………………………………………………………………

Occupation………………………………………………………… Date of Birth: ……. /........ /…..
day month year

Contact Numbers:
Home………………… Cell………………… Work……………… Date of Marriage……/………/…….
day month year

E-mail……………………………………………………………………………

EMPLOYMENT DATA

Current Employer…………………………………………………………………………………………………

Last date worked before illness ……. /…..… /……. day month year

Date intend to resume work ……./ ……. /…….. day month year

If regular days off are other than Saturday and Sunday, please state your normal days off

………

If you had more than one employer in the (13) weeks before your incapacity began, please state employer(s)………………………………………………………………………………………

Was incapacity due to the nature of employment? ☐ Yes ☐ No

The information given above is true and correct to the best of my knowledge and belief. I claim benefit accordingly.

……………………………………………………… (Signature)

……………………………………………………… (Date)

If unable to write, mark X, and have it witnessed. ………………………………………………

Name ……………………………………………… Witness to mark

Signature…………………… Witness to mark

…………………… Date

☐ **Deposit / Bank Name and Account Number**____________________________________

☐ **Pick up cheque / By whom**______________________________

☐ **Please Mail**

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Medical Certificate

I certify that I examined ………………………………………………residing at…………………………….
Name of Patient

on ………../………../……….. and in my opinion, he/she is suffering from ……..…..……..…………….
day month year

……………………………………….………………………………………..……….… and is

deemed incapable of work.

* **Circle whichever is applicable:**

***A. In my opinion, he/she will remain incapable of work for a period of ………………………..…. days.**

***B. In my opinion he/she will be fit to resume work on ……………………………………..…… (Date).**

***C. In my opinion, he/she is permanently disabled. (Doctor must give detailed remarks when patient is permanently unable to work.)**

Remarks by Doctor…………………………………………………………………………………...……

………

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………

Doctor's Name: ……………….……………….… ….………………………. ……………………
(Please Print) Doctor's Signature Date

Doctor's Registration No…………….………..…… Telephone No……………………………………..…

Address………………………………………………………………………………………………….

Stamp (if applicable)