MB 1

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

CLAIM FOR MATERNITY BENEFIT (Expected Confinement)

Please use Capitals Letters

Name……………………………………………………………. Social Security Number [ ]

Mailing Address…………………………………………………….… Date of Birth ……/………/...….. (day month year)

………………………………………….Email……………………..…………..……………

Contact Number(s) Home ………………..… Cell …………..…….….…... Work………………….……….

EMPLOYMENT DATA

Current Employer…………………………………………………………………………………...

Occupation……………………………………………………………………………………….…

Last Date Worked ……./ …… / …… (day month year)

Date of Maintenity Leave: From …………./……...…/……..…… to …..……….…/…..…………/……....…. (day month year day month year)

If you had more than one employer in the thirty-nine (39) weeks before your confinement began, please give details of previous employer(s)……………………………………………………………..…………………………

………………………………………………….………. (Signature) ………………………………………… (Date)

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

Name………………………………………………. **Signature………………………………………**

Occupation…………………………………….. **Date……………………………………………….**

Note: 1. Maternity Benefit cannot be paid for any period earlier than six weeks before expected confinement as certified by a Medical Doctor.

2. Maternity Benefit will not be paid for any period during which you are engaged in gainful employment.

Please tick the appropriate box:

☐ Deposit / Bank Name and Account No. ____________________________________

☐ Pick up cheque / By Whom: ______________________ ☐ Mail

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Medical Certificate of Expected Confinement

To be given by a Medical Practitioner, not earlier than six weeks before the date of expected confinement.

I certify that I examined ……………………………………..…………………residing at……………………
(Name)
…………………………… . On the under mentioned date, and in my opinion, she is expected to be confined in the week which include the …...day of ………………....20…….

Any other remarks by Medical Practitioner.

………
………
………
………
…………………………………………………………………………………………..………..……..……
………
………
…….…

Doctor's Name: ……..……………………………………… Doctor's Registration Number……..…………..…
(Please Print)

Doctor's Signature:………………………….…………………… Contact Number………...................................

Address: …………………………………………………………..……………………….………………….……

Date of Examination………………………………….. Date of Signing:………………...…………….………

Stamp (if applicable)