PRINT

APPLICATION FOR RETIREMENT (OLD AGE) AND INVALIDITY BENEFITS

UNDER THE NATIONAL INSURANCE ACT OF 1965 JAMAICA

INSTRUCTIONS:

I. **This form is to be completed in BLOCK CAPITALS using black or blue ink pen;**
II. **Tick (✓) boxes where applicable;**
III. **Submit documentary proof of age (Birth Certificate or Passport), Bank Account Number and Tax Registration Number (TRN);**
IV. **Submit Marriage Certificate and/or Deed Poll if applicable;**
V. **Submit valid Picture Identification of the Applicant;**
VI. **Benefits payable to overseas applicants who are not holders of a Jamaican commercial bank account will be mailed to the applicant;**
VII. **Applicant is required to sign the bottom of each page and the Declaration at Part 5 on Page 4.**

PART 1 – PARTICULARS OF APPLICANT
This section is to be completed by all Applicants

1. Indicate the type of benefit being applied for:

☐ Retirement (Old Age) ☐ Invalidity

2. National Insurance Number(s) ……..…… **3.** TRN……..……..

4. Name ☐ Mr. ☐ Miss ☐ Mrs.

……..……..……
(Last Name) *(First Name)* *(Middle Name(s))*

5. State all other names (including maiden name) that you have been known by.

……

6. Sex

☐ Male ☐ Female

7. Date of Birth

……
Year -Month- Day

8. Parish/Province/State and Country of Birth

……/……..……
Parish/Province/State *Country*

9. Marital Status

☐ Single ☐ Common-Law ☐ Married ☐ Separated ☐ Widowed ☐ Divorced

10. Home Address

……..……

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……/……..……..
Parish/Province/State *Country*

11. Mailing Address *(if different from home address)*

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……..……/……
Parish/Province/State *Country*

12. E-mail Address: ……

13. Contact Number(s): …… …… ……..……..
(Home) *(Work)* *(Mobile)*

14. State your **mother's** name. ☐ Miss ☐ Mrs.

……..……..……
(Last Name) *(First Name)* *(Middle Name(s))*

Mother's Maiden name: .....

15. State your **father's** name.

……..……..……
(Last Name) *(First Name)* *(Middle Name(s))*

Signature of Applicant.....

16. (a) Have you ever applied for a benefit under the National Insurance Scheme? Yes ☐ No ☐

(b) If "Yes", state (i) benefit type(s) ……..……

(ii) claim/pension number(s) ……..……

PART 2 - PARTICULARS OF EMPLOYMENT
This section is to be completed by all Applicants

17. List all particulars of employment in Jamaica since 1966.

Name and Address of Employer(s)	Employer's Reference No.	Employee's Number	Occupation	Periods of Employment	
				From	To

Use additional sheet(s) of paper if necessary.

18. (a) Have you ever been employed outside of Jamaica? ☐ Yes ☐ No

(b) If "Yes", indicate in the boxes below and supply the information requested in the table at 18(c).

☐ Canada ☐ Quebec ☐ United Kingdom

☐ CARICOM/Caribbean Countries, please state ……..……..…..

☐ USA Farm Work Programme J # ……..……

☐ Canada Farm Work Programme JC# ……..……

☐ Other.....……..…..……..……

(c) List all particulars of employment outside of Jamaica.

Name and Address of Employer(s)	Social Security/ Social Insurance Number	Occupation	Periods of Employment	
			From	To

Use additional sheet(s) of paper if necessary.

PART 3 - PARTICULARS OF RETIREMENT
This section is to be completed by Applicants for Retirement (Old Age) Benefit

SECTION A. COMPLETE THIS SECTION IF YOU HAVE RETIRED.

19. State the date you last worked. ……/……/…….
Year Month Day

20. (a) Have you had any gainful employment since retirement? ☐ Yes ☐ No

(b) If "Yes", state-

(i) Classification of Employment: ☐ Self - Employed ☐ Employed ☐ Domestic

(ii) The number of hours worked weekly ……..

Signature of Applicant.....

SECTION B. COMPLETE THIS SECTION IF YOU HAVE NOT YET RETIRED BUT INTEND TO DO SO WITHIN THE NEXT FOUR MONTHS.

21. When do you intend to give up ***regular*** employment? ……/…..……/……..…
Year Month Day

22. (a) Do you intend to be gainfully employed after the date given at question 21? ☐ Yes ☐ No

(b) If "Yes", indicate below-

(i) Classification of Employment: ☐ Self - Employed ☐ Employed ☐ Domestic

(ii) The number of hours per week you expect to work ……..

PART 4 - PARTICULARS OF INCAPACITY

This section is to be completed by Applicants for **Invalidity Benefit**

23. State the nature of your illness or disease .....

24. State the date of incapacity as a result of your illness or disease ……..…/……/……
Year Month Day

25. AUTHORITY BY APPLICANT TO MEDICAL PRACTITIONER TO REVEAL THE NATURE OF HIS/HER ILLNESS OR DISEASE.

I ……..……hereby authorize the medical practitioner completing
(Name)
the Medical Report to disclose the nature of my illness or disease for the purpose of this application.

Signature or Mark of Applicant…… ***Name of Witness* ……..……

Signature of Witness……..…..……

** Necessary only if Applicant is unable to read and/or write. *Date* ……/……/…..…...
Year Month Day

26. MEDICAL REPORT

Note to Doctor

Among the conditions for Invalidity Benefit are that the individual must be incapable of work by reason of a specific disease, bodily or mental disablement which is likely to be permanent. Applicant for Invalidity Benefit must have been so incapable for a continuous period of **not less** than 26 weeks.

I certify that ..……..……

A. (1) is incapable of work by reason of *(indicate medical condition diagnosed)*

……..……..……..…

……; and

(2) to my knowledge or in my judgement he/she has been so incapable, and

(3) in my opinion his/her incapacity is likely to be permanent, and

(4) to the best of my knowledge or belief, the incapacity began on or about ……/…..…../…….
Year Month Day

NOTE: It is important that the date recorded above be stated as precise as possible.

B. Is medical condition likely to change and therefore will require a review? ☐ Yes ☐ No

If "yes", state period of review requested .....

General Remark(s) ***(include the level of incapacity diagnosed)***

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Name and Address of Medical Centre ……..……..…….....……..…….....

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Name of Doctor…….....

Signature ……....….....…….……..……

MCJ Registration No.……..……..

Date ……/….....…./……
Year *Month* *Day*

Stamp Here

PART 5 - DECLARATION AND CERTIFICATE
This section is to be completed by all Applicants

SECTION A. APPLICANT'S DECLARATION AND SIGNATURE

I hereby certify that the information provided by me is true to the best of my knowledge and belief.

Signature or Mark of Applicant ….....……..……..……

Date ……/……/……....
Year *Month* *Day*

SECTION B. WITNESS' CERTIFICATE AND SIGNATURE

INSTRUCTIONS:

(1) To be completed for applicant who is unable to read and write due to illness or illiteracy.

(2) This certificate is to be completed by a Justice-of-the Peace or Notary Public. If certified by a Notary Public outside of Jamaica, the relevant certificate of commission is to be obtained from the County Clerk's Office and attached.

I hereby certify that the applicant made the necessary mark to the Declaration in my presence after same was first explained to him/her and he/she indicated that he/she fully understood.

Name of Witness…… Occupation or……..……...……..……..….
Qualification

Address …….....

Signature of Witness..……..…… Contact Number ……

Date …..……/……/…….
Year *Month* *Day*

WARNING

ANY PERSON WHO KNOWINGLY MAKES A FALSE STATEMENT ON THIS FORM IS LIABLE TO CRIMINAL PROSECUTION PURSUANT TO SECTION (44)(2)(e) OF THE NATIONAL INSURANCE ACT

OFFICIAL USE ONLY

NIS No(s). _____/_____

Parish Claim No. _____

Pension No(s). _____/_____

Previous Claim No(s). _____/_____

DATE RECEIVED

Checked by: Name_____

Signature_____

Date: _____

Application Verified by:

(Indicate the country of issue for the respective documents)

- ☐ Passport No. _____
- ☐ Driver's Licence No. _____
- ☐ Electoral ID No. _____
- ☐ Birth Certificate No. _____
- ☐ Deed Poll No. _____
- ☐ Marriage Certificate No. _____
- ☐ Decree Absolute _____
- ☐ Medical Certificate _____

Verified By: Name_____

Signature_____

Date: _____

FOR OFFICIAL USE ONLY
MINISTRY'S MEDICAL ADVISOR'S REVIEW

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Signature ……..…… Date …..……/……/…….
Year Month Day

NATIONAL INSURANCE SCHEME
DIRECT DEPOSIT INFORMATION FORM

INSTRUCTIONS:

I. This form is to be completed in BLOCK CAPITALS using black or blue ink pen;
II. This form is to be completed by all Applicants residing in Jamaica;
III. This form is to be completed by Applicants who do not reside in Jamaica but elect to receive payments in Jamaica;
IV. Direct Deposit Payments are only made to Jamaican Commercial Bank Accounts;
V. Applicant must be the primary holder of the bank account provided;
VI. All fields marked with an asterisk (*) are Mandatory.

PART 1 – PARTICULARS OF APPLICANT

1. Name* ☐ Mr. ☐ Miss ☐ Mrs.

……..……
(Last Name) *(First Name)* *(Middle Name(s))*

2. National Insurance No. ……. **3.** TRN ……..……..

4. Home Address

……..……

……..……

……..……
Parish/Province/State *Country*

5. Mailing Address *(if different from home address)*

……..……

……..……

……..……
Parish/Province/State *Country*

6. E-mail Address: ……..……..……..

7. Contact Number(s): …… ……. ……..……..
(Home) *(Work)* *(Mobile)*

PART 2 – APPLICANT'S BANKING INFORMATION

8. Name of Commercial Bank*.....

9. Branch where Account was opened*.....

10. Bank Account Number*.....

11. Type of Account (Savings or Chequing)*.....

DISCLAIMER

The Applicant agrees and warrants that the account provided is a legitimate account to which a NIS benefit can be paid and therefore indemnifies the Ministry against any loss or damage suffered as a result of any error in the account information provided herein. The Applicant shall at all times, indemnify and save harmless the Ministry (including its officers, agents and employees), of and from all loss and damage and all actions, claims, costs, demands, expenses, fines, liabilities and suits of any nature whatsoever for which the Ministry shall or may become liable, incur or suffer by reason of making payments through the transfer of funds to the account specified by the Applicant. The Applicant's obligations under this authorisation shall survive the termination of the arrangement between the Ministry and the Client, whether by expiration of time or otherwise.

PART 3 - APPLICANT'S SIGNATURE

SECTION A. APPLICANT'S DECLARATION AND SIGNATURE

I hereby certify that the information provided by me is true to the best of my knowledge and belief.

Signature or Mark of Applicant ……..…… *Date* ……/……/……..
Year *Month* *Day*

PART 4 - WITNESS' CERTIFICATE AND SIGNATURE

I HEREBY CERTIFY THAT (indicate appropriate response below):

☐ The Applicant signed the above declaration in my presence.

☐ The Applicant made the necessary mark to the above declaration in my presence. The contents of the foregoing claim/declaration were first carefully read over and explained to the Applicant, who, being unable to read or write, in order to express full understanding of their meaning to vouch thereto, affixed the necessary mark as aforesaid.

I ALSO CERTIFY THAT the Applicant is known to me and that the particulars given above are correct to the best of my knowledge and belief.

TO BE WITNESSED BY A JUSTICE OF THE PEACE, ATTORNEY, MEDICAL PRACTITIONER , MINISTRY OF LABOUR AND SOCIAL SECURITY PARISH MANAGER, OR NATIONAL INSURANCE ADMINISTRATOR

NAME ……...Occupation/Qualification ……..……..

ADDRESS ……..……...……..

Telephone No: ……...……Seal/Stamp ……...…….……..

Signature of Witness..……..……..…….. Date …..……/……/……
Year Month Day

FOR OFFICIAL USE ONLY

DATE RECEIVED

Claim Number ……

Pension Number ……

Name of Receiving Officer: ……

Signature Receiving Officer: ……

Date: ……/……/……
Year Month Day

Name of Certifying Officer: ……

Signature Certifying Officer: ……

Date of Certification: ……/……/……
Year Month Day