NI 8

THE NATIONAL INSURANCE BOARD
FUNERAL GRANT APPLICATION

(PLEASE USE CAPITALS LETTERS)

NOTE: This claim must be submitted within 3 months of the Date of Death of the Insured Person.

(FOR OFFICIAL USE)
CLAIM NO:
SERVICE CENTRE CODE:
ACCIDENT NO:

SECTION "A" - TO BE COMPLETED BY APPLICANT

PARTICULARS OF APPLICANT (Questions1 to 8 and 20)

1. NAME: SURNAME OTHER NAME(S)

2. *HOME ADDRESS: (STREET)
(CITY/DISTRICT/COUNTY)

3. *POSTAL ADDRESS (if different from above): (STREET)
(CITY/DISTRICT/COUNTY)

4. DATE OF BIRTH: YYYY MM DD

5. VALID IDENTIFICATION: (Tick one box)
☐ PASSPORT ☐ DRIVER'S PERMIT ☐ ELECTORAL I.D. NUMBER:

6. TELEPHONE NUMBERS: -- (HOME) -- (OFFICE/WORK) -- (CELLULAR)

7. RELATIONSHIP TO DECEASED INSURED PERSON:

8. DOCUMENTS TO ATTACH IN RESPECT OF DECEASED INSURED PERSON:
☐ a) DEATH CERTIFICATE ☐ b) BIRTH CERTIFICATE AND SUPPORTING AFFIDAVIT(S)
☐ c) BILLS AND RECEIPTS OF FUNERAL EXPENSES ☐ d) NATIONAL INSURANCE REGISTRATION CARD

PARTICULARS OF DECEASED INSURED PERSON (Questions 9 to19)

9. NAME OF DECEASED: SURNAME OTHER NAME(S)

10. LAST ADDRESS: (STREET)
(CITY/DISTRICT/COUNTY)

11. NATIONAL INSURANCE NO:

12 . GENDER: ☐ Male ☐ Female

13. DATE OF BIRTH: YYYY MM DD

14. BIRTH CERTIFICATE PIN NO: (IF KNOWN)

15. DATE OF DEATH: YYYY MM DD

16. DID DEATH OCCUR AS A RESULT OF ACCIDENT/INDUSTRIAL DISEASE ARISING FROM EMPLOYMENT? ☐ YES ☐ NO

If "Yes", please state date of accident/development of disease YYYY MM DD (See Section 'B')

17. NAME OF LAST EMPLOYER:

18. ADDRESS OF LAST EMPLOYER: (STREET)
(CITY/DISTRICT/COUNTY)

SECTION "A" - TO BE COMPLETED BY APPLICANT CONT'D

19. DID THE DECEASED WORK OR LIVE IN CANADA OR WORKED IN ANY OF THE CARICOM COUNTRIES? ☐ YES ☐ NO

If "Yes", please provide:

(i) SOCIAL SECURITY NO.

(ii) COUNTRY

20. PLEASE INDICATE THE METHOD OF PAYMENT OF BENEFIT

☐ COLLECT AT SERVICE CENTRE ☐ MAIL TO POSTAL ADDRESS

PLEASE ENQUIRE FROM YOUR SERVICE CENTRE ABOUT THE SURVIVOR/DEATH BENEFIT WHERE APPLICABLE.

APPLICANT'S DECLARATION

I declare that to the best of my knowledge and belief the information given by me is true and correct and I am aware that if there is any statement in this declaration which is false in fact or which I know or believe to be false or do not believe to be true, I am liable on summary conviction to a fine of three thousand dollars ($3,000.00) and to imprisonment for two years in accordance with Sect 33, NI Act Chap 32:01.

SIGNATURE OR MARK

DATE: YYYY MM DD

PARTICULARS OF WITNESS TO MARK (Where applicant cannot sign)

NAME: SURNAME OTHER NAME(S)

ADDRESS: (STREET)

(CITY/DISTRICT/COUNTRY)

VALID IDENTIFICATION: (Tick Appropriate Box) ☐ PASSPORT ☐ DRIVER'S PERMIT ☐ ELECTORAL I.D.

OCCUPATION:

NUMBER:

SIGNATURE OF WITNESS TO MARK

DATE: YYYY MM DD

SECTION "B"- TO BE COMPLETED BY EMPLOYER

To be completed by the employer when the worker died as a result of an accident/disease which arose out of and in the course of employment

1. Date of accident/development of disease (YYYY MM DD) Time of accident _____ am/pm

2. Exact place of accident _____

3. Did accident occur while travelling in employer's transport? ☐ YES ☐ NO
(If "yes", give details)

i. Place of embarkation _____

ii. Destination _____

iii. Purpose of presence on transport:

iv. Was transport owned/rented by employer? ☐ YES ☐ NO
If "no", was transport used through arrangement with employer? (describe)

4. State clear details of the cause of the accident _____

5. State clear details of injury sustained _____

6. Was accident reported to you? ☐ YES ☐ NO If "yes" state date of report (YYYY MM DD)

7. Was employee engaged in his/her duties at the time of accident? ☐ YES ☐ NO

If "No" to (3) or (7) give details:

8. Did employee die at time of accident? ☐ YES ☐ NO

If "No", please state date of death. (YYYY MM DD)

EMPLOYER'S DECLARATION

I declare that to the best of my knowledge and belief the information given by me is true and correct and I am aware that if there is any statement in this declaration which is false in fact or which I know or believe to be false or do not believe to be true, I am liable on summary conviction to a fine of three thousand dollars ($3,000.00) and to imprisonment for two years in accordance with Sect 33, NI Act Chap 32:01.

NAME:

SURNAME

OTHER NAME(S)

POSITION:

SIGNATURE OF EMPLOYER

COMPANY STAMP (If any)

DATE: (YYYY MM DD)

SECTION "C" - FOR OFFICIAL USE

APPLICATION RECEIVED BY:

PART "I" - CUSTOMER SERVICE REPRESENTATIVE

NAME: SURNAME | OTHER NAME(S)

1. NAME, N.I. NO. AND DATE OF BIRTH CONFIRMED ON I.A. SYSTEM?	☐ YES	☐ NO
2. IS THE CLAIMANT LINKED TO EMPLOYER?	☐ YES	☐ NO
3. IS THE REGISTRATION RECORD COMPLETE? (If "NO" complete forms NI 4/NI 165/NI 182 as applicable).	☐ YES	☐ NO
4. CHECK FOR DUPLICATE REGISTRATION. (SIRF file included)	☐ YES	☐ NO
5. IS REGISTRATION RECORD UPDATED? (If "NO", state reason)	☐ YES	☐ NO
6. CLAIM HISTORY GENERATED.	☐ YES	☐ NO
7. HAS THIS INSURED PERSON APPLIED FOR A BENEFIT PREVIOUSLY?	☐ YES	☐ NO
8. (a) CONTRIBUTION RECORD GENERATED?	☐ YES	☐ NO
(b) OUTSTANDING CONTRIBUTION RECORDS CAPTURED?	☐ YES	☐ NO
9. APPLICATION COMPLETE AND ACCEPTABLE FOR PROCESSING?	☐ YES	☐ NO

SERVICE CENTRE RECEIVED STAMP

SIGNATURE OF CUSTOMER SERVICE REPRESENTATIVE

DATE: YYYY MM DD

PART "II" - SUPERVISOR/CLERICAL OFFICER II

1. DETAILS OF CLAIM PROFILE VERIFIED?	☐ YES	☐ NO
2. CLAIM AUTHORISED?	☐ YES	☐ NO
3. VOUCHER GENERATED AND AUTHORISED?	☐ YES	☐ NO

SIGNATURE OF SUPERVISOR/CLERICAL OFFICER II

DATE: YYYY MM DD

PART "III" - MANAGER/ SUPERVISOR SERVICE CENTRE

1. CHEQUE ISSUED	☐ YES	☐ NO
2. CHEQUE NUMBER		
3. DATE CHEQUE ISSUED	DATE: YYYY MM DD	

SIGNATURE OF MANAGER/SUPERVISOR SERVICE CENTRE

DATE: YYYY MM DD