

INTERNATIONAL LABOUR OFFICE

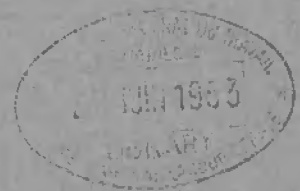
HAND BOOK
OF
SOCIAL INSURANCE
ADMINISTRATION

Volume II

DRAFT POSTERS, LEAFLETS AND FORMS



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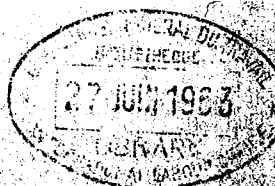
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VOLUME II

DRAFT POSTERS LEAFLETS AND FORMS

(Part VI of the Handbook)

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Part VI

Draft Posters, Leaflets and Forms

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PART VI

Draft Posters, Leaflets and Forms

Introduction

I. Posters and Leaflets

1401. In connection with the administration of any social security scheme, and particularly of a compulsory social insurance scheme, which must affect the interests and, to some extent, the lives of large numbers of persons, it will be necessary to arrange for a considerable amount of publicity to be given to the provisions of the scheme. This subject is dealt with in some detail in Section 3 of Part II of the Plan, in which reference is made to the use of posters and leaflets for publicity purposes.

1402. In Section A of this part of the plan there are three drafts of posters designed for this purpose, while Section B contains drafts of nine leaflets, each dealing with a particular aspect of the scheme. These drafts are intended only to give a certain amount of guidance in regard to the sort of thing which may be dealt with in this way, and it is not, of course, considered that these exhaust the needs of the scheme or that their wording or layout is ideal for the purpose. It will be entirely for the persons in authority who are responsible for the introduction of any particular scheme to consider what are the best ways in which to bring its provisions to the attention of the persons who will be paying contributions or receiving benefits in the country to which it applies.

1403. So far as posters of the type of Draft Poster 1 are concerned, very much depends on the general reaction of those persons to publicity of this sort - it may be that small editions of the posters, in the form of hand bills for general distribution, may be considered to be more effective for the purpose. Posters of the type of Draft Posters 2 and 3 are, of course, only for use in connection with more specialised aspects of the administration.

II. Forms

1404. The question of the need for and use of forms is discussed in Note 10 of Part V of the Plan, which should be read carefully by all persons who are to be concerned with the drafting and control of forms in connection with the administration of the scheme.

1405. The drafts contained in Section C are intended to serve solely as a guide to those persons and, as in the case of the use of posters and leaflets, careful consideration should be given by those persons to the layout and wording of the forms. This is particularly necessary in the case of those forms which may be regarded as the basic forms of the scheme, such as the registration forms (R.1 and R.4), the identity card (R.6), the medical certificates (M.C.12, 12A, 12B and M.1 and 2) and benefit claim forms (S.1 and 1A, M.1, E.5 and 10 and F.2), the contribution card (C.1) and the various record sheets (R.3 and 9. M.C.6 and S.8 and 8A).

1406. It is also, of course, desirable to consider critically the phraseology of forms which are to be sent to the employers and insured persons, to ensure that their meaning is clear and not likely to give rise to any misunderstanding, on the part of those persons, as to what they are being required to do or what information they are being asked to give.

1407. In some instances, e.g. in the case of the Appeal Forms, a complete series of draft forms have been prepared to illustrate all stages in the procedure, and to serve as a model for adaptation in connection with other procedures which have not been so fully developed in the plan.

1408. Many of the forms, such as Form R.5, are designed to contain a number of entries, but where it is not possible to provide room on a single sheet for all entries which may have to be made, the use of continuation sheets is suggested. This method will not, however, be practicable always; thus in the case of Form R.9, the record of contributions and benefits on the original form would have to cover as long a period as possible, and thereafter a new form, containing full details of the insured person, would have to be prepared for the record during the ensuing period; in the case of Form R.6, on the other hand, the difficulty might be overcome by including, as part of the identity card, extra pages for the purpose of recording information as to additional periods of employment, after the space provided on the card itself has been completely filled up.

1409. The draft forms have been reproduced for the purposes of the plan on paper of the size (about 30 x 20 cms) normally available for copying work, and it is suggested that in actual practice the forms should similarly be printed on paper of whatever sizes are generally used in the country concerned. Obviously the same size of paper should not be used for all forms, smaller sizes being used where practicable, e.g. for index slips, for the sake of economy both of the paper itself and of storage space.

Where it is thought that smaller paper might usefully be used for any particular form, the approximate dimensions have been noted on the draft form itself the length being given first. Where there is no such note, it can be assumed that paper of approximately the full size should be used.

1410. In a few instances a note has been added on the draft form where it is thought that a material other than ordinary paper should be used.

1411. In general it has been assumed that identification will be by means of finger prints, but clearly the same print must be used throughout. For the purpose of the draft forms the right thumb print has been indicated, but it would, of course, be in order to adopt the impression of some other finger if preferred.

Where photographs are to be used for identification purposes the necessary adjustments should be made to the forms.

PART VI

Section A. Draft Posters

- | | |
|------------------------|--|
| <u>Draft Poster 1.</u> | General Poster dealing with registration of employers and employees. |
| <u>Draft Poster 2.</u> | Poster explaining functions of Medical Tribunal. |
| <u>Draft Poster 3.</u> | Poster explaining function of Local Tribunal. |

DRAFT POSTER 1 (See Part II. Paragraph 147(ii))

SOCIAL INSURANCE ACT,

REGISTRATION OF EMPLOYERS AND EMPLOYEES

THE SOCIAL INSURANCE ACT HAS NOW BEEN PASSED INTO LAW
AND WILL COME INTO OPERATION ON

BENEFITS

SICKNESS, MATERNITY, AND EMPLOYMENT INJURY BENEFITS AND
FUNERAL GRANT ARE TO BE PROVIDED FOR WORKERS ENGAGED IN
EMPLOYMENT WITH INDUSTRIAL FIRMS EMPLOYING 20 OR MORE
WORKERS.

CONTRIBUTIONS

TO PAY FOR THESE BENEFITS THE EMPLOYERS AND THEIR EMPLOYEES
WILL BECOME LIABLE FROM TO PAY CONTRIBUTIONS AS
FOLLOWS:

EMPLOYER	<u>Insert particulars of</u> contributions payable
EMPLOYEE	
TOTAL	

WHAT YOU HAVE TO DO

EMPLOYERS (AN EMPLOYER WHO EMPLOYS 20 OR MORE WORKERS MUST
(AT ONCE OBTAIN A REGISTRATION FORM (FORM R.1) FROM
(THE SOCIAL INSURANCE OFFICE AT AND RETURN
(IT TO THAT OFFICE AS SOON AS IT HAS BEEN COMPLETED.

WORKERS (EMPLOYERS WHO HAVE BEEN REGISTERED WILL BE SUPPLIED
(WITH REGISTRATION FORMS TO BE COMPLETED BY THEIR
(EMPLOYEES. WHEN YOU RECEIVE A REGISTRATION FORM
(FROM YOUR EMPLOYER, YOU SHOULD ANSWER ALL THE
(QUESTIONS CAREFULLY AND FULLY AND HAND IT BACK TO
(HIM. ANY INQUIRIES WITH REGARD TO THESE REGISTRA-
(TIONS SHOULD BE MADE AT THE
(OFFICE AT

SPECIAL NOTE: WILL THOSE WORKERS WHO CAN READ, PLEASE TELL ANY
FELLOW WORKERS WHO ARE UNABLE TO READ WHAT THE
SOCIAL INSURANCE ACT PROVIDES AND WHAT THEY HAVE
TO DO.

DRAFT POSTER 2 (See Part IV, Section 2, Chapter 2, paragraph 765)

SOCIAL INSURANCE ACT

MEDICAL TRIBUNAL

The Medical Tribunal has been set up to assist the Social Insurance Board to determine the title of insured persons to receive DISABILITY PENSIONS in respect of their loss of earning capacity as a result of injury at work, and to determine, in connection with applications for SURVIVORS' PENSIONS, the question whether death resulted from an employment injury.

The Tribunal, which is independent of the Social Insurance Board, consists of a legal chairman and two doctors, who must not be medical officers employed by the Board.

In accordance with the Regulations made under the Social Insurance Act, when a case is submitted to a Tribunal by the Board for decision:-

1. The Tribunal must hold a hearing of which reasonable notice is given to the applicant for pension; if reasonable notice is not given, the hearing must not proceed without the applicant's consent.
2. No person may be present at the hearing except the applicant himself and, with his consent, any other person who the Tribunal considers may be likely to help them in giving their decision.
3. The applicant must be given written notice of the Tribunal's decision as soon as may be practicable after the hearing.
4. The decision of the Tribunal is final.

The Medical Tribunal also advises the Social Insurance Board when an insured person complains about the medical treatment which he has received under the Social Insurance Act.

DRAFT POSTER 3 (See Part IV, Section 2, Chapter 2, paragraph 765)

SOCIAL INSURANCE ACT

LOCAL TRIBUNAL

The Local Tribunal has been set up to consider appeals by insured persons against decisions of the Social Insurance Board with regard to their title to benefit under the Social Insurance Act.

The Tribunal, which is independent of the Social Insurance Board, consists of a legal chairman, a representative of employers and a representative of insured persons.

In accordance with the Regulations made under the Social Insurance Act, when an appeal is made against a decision of the Board:-

1. The Tribunal must hold a hearing of which reasonable notice is given to the insured person; if reasonable notice is not given, the hearing must not proceed without the insured person's consent.
 2. The insured person is entitled to be present at the hearing, and to be represented by any other person, who is not a lawyer. The Board also may send a representative, who is not a lawyer. Any other person, who appears to the Tribunal to be interested in the case, may be present but may not give evidence.
 3. The Tribunal with the insured person's consent, may proceed with the hearing if only the chairman and one other member are present; the Tribunal may also proceed with the hearing of a case if the insured person is absent without giving a reasonable explanation for his absence.
 4. When the Tribunal are considering their decision on the appeal, no other person may be present except the Clerk to the Tribunal.
 5. The insured person must be given written notice of the Tribunal's decision on his appeal as soon as may be practicable after the hearing.
 6. The decision of the Tribunal is final.
-

Section B Leaflets

Leaflet No.

- | | |
|---|-----------------------------------|
| 1 | General Guide to Social Insurance |
| 2 | Guide to Insured Persons |
| 3 | Guide to Employers |
| 4 | Medical Care |
| 5 | Sickness Benefit |
| 6 | Maternity Benefit |
| 7 | Employment Injury Benefits |
| 8 | Funeral Grant |
| 9 | Right of Appeal |
-

Section B

Leaflets

Introductory Notes

1412. In order that a proper degree of publicity may be given to the objects and operation of the social insurance scheme it will be necessary (as indicated in Section 3 of Part II) to prepare and circulate a series of leaflets dealing with general aspects of the scheme.

1413. It is suggested that the particular leaflets which will be needed, some before the scheme is introduced and the rest soon after its introduction, are as follows:

- | | |
|-----------------------|---|
| Leaflet No. 1 | A general leaflet describing the objects and scope of the scheme for the information of the general public. |
| Leaflet No. 2 | A leaflet giving more particular guidance to insured persons. |
| Leaflet No. 3 | A similar leaflet for employers. |
| Leaflets Nos. 4 to 8. | Leaflets dealing with individual benefits i.e. No. 4, Medical Care; No. 5, Sickness Benefit; No. 6, Maternity Benefit; No. 7, Employment Injury Benefits; No. 8, Funeral Grant; and describing in detail the conditions governing title to the benefit, how the benefit should be claimed, and how it will be provided. |
| Leaflet No. 9 | A leaflet dealing with the right of appeal and how it may be exercised. |

1414. In view of the wide variety of provisions which may be contained in the various social insurance schemes it would obviously be impossible to do more in the Plan than to indicate the general framework of these leaflets, leaving the details of the individual scheme to be filled in when they have been determined.

1415. The attached drafts of Leaflets No. 1 to 9 have been prepared accordingly on this basis.

As will be seen Leaflet No. 1 is not intended to be anything more than a general handout in order to give the public a broad outline of the scheme. More detailed explanations of the various provisions of the scheme should be given in the other leaflets, the degree of detail being developed as the field to be covered is narrowed.

Thus, paragraphs 5 and 6 of Leaflet No. 1 should give just the bare information as to the contribution rates and method of payment, but these particulars should be developed in paragraphs 4 and 5 of Leaflet No. 2. In Leaflet No. 3 the employer's responsibilities in regard to registration of his business and his employees, the procedure for purchasing stamps to affix to contribution cards and exchanging the cards for new ones at the end of the period of currency, or alternatively for making cash payments in respect of contributions at regular intervals, should be set out in detail, together with particulars of the position and powers of inspectors appointed under the Act, and of other matters of concern to employers.

1416. Similarly, only a bare description of each benefit is given in Leaflet No. 1, but more detail is given in Leaflet No. 2, while full details with regard to each benefit would be given in the leaflet appropriate to that benefit.

1417. At a later stage, as the scheme develops the need for other leaflets to deal with more specialised matters may arise, such as a need to give an authoritative explanation of the interpretation to be placed on "contract of service or apprenticeship", particularly in relation to certain groups of employment which are near the borderline, the exact method for calculating or averaging the wages, for the purpose of determining the rates of contributions payable or of benefit due, or the circumstances in which a particular disease is to be regarded as "an occupational disease", but it is not possible to anticipate such needs with any certainty.

Leaflet No. 1

General Guide to Social Insurance

Part I: Benefits

1. What is Social Insurance?

The scheme set up under the Social Insurance Act provides certain benefits for insured persons during periods of special need such as medical treatment during illness and cash payments during suspension of wages for periods of involuntary absence from work due to illness or accident at work, or expected child-birth. These benefits are described in paragraph 3 below.

The money to pay for these benefits comes from contributions paid by insured persons and their employers, and the State also contributes towards the cost (see Part II).

2. Who is insured?

The scheme applies within certain areas to all persons working in any industrial establishment, factory or other place of business at which at least persons are employed. At present the areas within which the scheme operates are

3. What benefits are provided?

The benefits provided under the scheme are as follows:-

- (a) Medical Care: that is to say, medical practitioner or hospital treatment during the illness, pregnancy, etc. of the insured person and the provision of essential medicines and dressings.
- (b) Sickness Benefit: cash payments during suspension of wages when the insured person is unable to work for an employer owing to illness or disablement.
- (c) Maternity Benefit: cash payments during suspension of wages when the insured woman is absent from work for certain periods before and after her confinement.

(d) Employment Injury Benefits:

- (i) cash payments during suspension of wages for a certain period when the insured person is unable to work as a result of an accident arising out of and in the course of his employment;
- (ii) cash payments continuing to be paid thereafter so long as the insured person suffers loss of earning capacity as a result of such an accident;
- (iii) cash payments to the survivors of an insured person who dies as the result of such an accident.

(e) Funeral Grant: cash payments towards the cost of the funeral of an insured person.

The conditions governing the title to these benefits, and the method in which claims are to be made and, in the case of cash benefits, are to be paid, are described in separate leaflets which may be obtained from the Social Insurance Local Office.

4. What must the worker do?

- (a) In the first place the worker must be registered as an insured person. For this purpose he must give to his employer certain information as to his date of birth, address etc., in order that a form of application for registration may be completed for him.
- (b) When the form has been completed and the worker has signed or impressed his thumb mark on it, the employer will send it to the Social Insurance Institution in order that an identity card may be prepared for the worker.
- (c) The identity card, which will be sent to the employer to give to the worker, must be kept carefully by the worker, as it is evidence that he has been registered as an insured person and must be produced whenever he wishes to claim benefit.

Part II: Contributions

5. What contributions are to be paid?

The contributions payable under the Social Insurance Act are as follows:-

6. How are they to be paid?

The contributions are to be paid by the employer as follows:-

7. What must the employer do?

An employer who is liable to pay contributions for his workers (see paragraph 2 above) is first required to apply to be registered by completing an application for registration and sending it to the Social Insurance Institution. Thereafter he will be supplied with forms of application for the registration of his workers, and after these have been completed and returned to the Institution he will be supplied by the Institution with the necessary instructions as to the payment of the contributions due for his employees.

[Note. Insert here either the addresses of the Social Insurance Local Offices or particulars of the places at which those addresses may be found.]

Leaflet No. 2

Social Insurance

Guide to Insured Persons

1. All persons working in any industrial establishment, factory or other place of business at which at least persons are employed and which is situated within the area(s) of are required to be insured under the Social Insurance Act.

2. Any question as to whether the Act applies to a particular place of business, or whether an individual person employed there is insurable is for decision by the Social Insurance Board - see Leaflet No. 9.

3. When a person becomes employed in an establishment described in paragraph 1, he should give his identity card to his employer. If he has not received an identity card at that time, because he was not previously engaged in insurable employment, he should inform his employer, who will then complete an application for him to be registered as an insured person. When he has been registered as an insured person he will be supplied with an identity card which he will need to produce when he claims benefit.

If, however, he has previously been insured, but has lost his identity card, he must go to the Social Insurance Local Office and complete a form of application for a new card.

4. Subject to certain conditions insured persons are entitled to receive the following social insurance benefits.

A. Medical Care, which consists of treatment by a medical practitioner at a Social Insurance Dispensary, or where necessary, at a hospital as an out-patient or in-patient, and of essential medicines and dressings. The period for which this benefit is provided and the conditions which have to be satisfied are explained in Leaflet 4.

B. Sickness Benefit, which consists of cash payments made, normally as from the fourth day of incapacity for work as a result of illness or disablement, in respect of a period for which no wages are paid. The period for which this benefit is provided, the conditions which have to be satisfied and the method of claiming, are explained in Leaflet 5.

- C. Maternity Benefit, which consists of cash payments made normally for a period of six weeks before and six weeks after the confinement of an insured woman, during which she is away from work and not in receipt of wages from her employer. The conditions of entitlement and method of claiming this benefit are explained in Leaflet 6.
- D. Employment Injury Benefits, which consist of cash payments made, normally as from the fourth day, in respect of a period of incapacity for work resulting from an accident which arose out of and in the course of the insured person's employment; and in respect of further periods when the person was suffering from loss of earning capacity by reason of such an accident; and, also, in the case of the death of the insured person by reason of such an accident, to his survivors. The conditions governing the title to these benefits, the procedure for claiming them and the method of payment are explained in Leaflet 7.
- E. Funeral Grant, which consists of a payment towards the cost of the funeral of an insured person. Further information with regard to this benefit is given in Leaflet 8.

Whenever application is made for any one of these benefits the insured person's identity card must be produced to the Dispensary or the Social Insurance Local Office at which benefit is claimed.

5. Contributions are payable under the Social Insurance Act as follows:-

Employer's contribution

Worker's contribution

In addition the State makes a supplementary payment of

6. The employer's and worker's contributions, are both payable in the first instance by the employer in the following manner:

The Act authorises the employer to deduct the worker's contribution from his wages before they are paid to him.

Note. An addition should be made here giving either the addresses of the Social Insurance Dispensaries and Local Offices or particulars of the places where those addresses may be found.

Leaflet No. 3

Social Insurance

Guide to Employers

1. All persons employed under a contract of service or apprenticeship in any industrial establishment, factory or other place of business at which at least persons are so employed and which is situated within the area(s) of are required to be insured under the Social Insurance Act.....

2. Contributions under the Act are payable in respect of each insured person as follows:-

Employer's contribution

Employee's contribution

in the following manner
.....

3. Any question as to whether the Act applies to a particular place of business, or as to the employer's liability to pay contributions, and at what rate, for an individual employee, is for decision by the Social Insurance Board - see Leaflet No. 9 which may be obtained from the Social Insurance Local Office.

4. In accordance with the Act the employer is entitled to recover the employee's contribution by deduction from his wages for the period covered by the contribution, but is not entitled to recover it in any other way.

5. If an employer has a business which comes within the limits defined in paragraph 1 which has not already been registered, he must register the business with the Social Insurance Institution. In order to do this he must obtain a form of application for registration (Form R1) from that Institution and, after completing it, send it to the Institution for consideration.

6. After the business has been registered the Institution will notify the employer of his registered number, and will furnish him with the appropriate number of forms (Form R4) together with instructions for the completion and return of one in respect of each of his employees.

7. When the completed forms are received by the Institution the employees will be registered as insured persons and an identity card will be prepared for each of them and sent to the employer to hand to the employee.

8. When a person becomes employed in a business which has already been registered, the employer should obtain from him his identity card and note the Social Insurance number of the employee in his records, thereafter returning the identity card to the employee.

9. If the employee cannot produce his identity card, Form R4 should be completed in respect of him and sent to the Social Insurance Institution (as in paragraph 6 above).

[Paragraphs 5 to 9 set out the basic principles of the registration procedure, and will, of course, have to be amplified to cover all necessary details of the actual procedure.

Further paragraphs will also have to be added explaining precisely the employer's duties as set out in the Contribution Regulations in connection with the actual method and time of payment of contributions for his employees and the furnishing of any necessary notifications and returns to the Institution, e.g. in connection with claims by employees for benefit and particularly in regard to accidents at work.

Finally paragraphs should be added explaining that the Social Insurance Board has appointed Inspectors with powers to enter employers' premises to inspect wage records, accounts, books, etc., and setting out the penalties which may be imposed for failure to comply with the requirements of the regulations or for making wilful mis-statements in connection with the operation of the scheme.]

[Note. Insert here either the addresses of the Social Insurance Local Offices or particulars of the places where those addresses may be found.]

Leaflet No. 4

Social Insurance

Important Keep this
leaflet for future
reference

Medical Care

What is Medical Care?

1.A. Under the Social Insurance Act an insured person who is ill is entitled to receive, free of charge -

- (a) medical treatment from a general medical practitioner at a Social Insurance dispensary, or, where necessary, at his home;
- (b) specialist treatment at a hospital either as an out-patient or in-patient, as may be necessary; and, in the case of in-patient treatment, free board, lodging and nursing;
- (c) essential medicines and dressings as may be prescribed by the doctor;
- (d) when suffering from an employment injury (that is to say an injury received in the course of and as the result of employment) any appliances needed for his treatment and rehabilitation.

B. In addition, an insured woman is entitled to receive free of charge medical care before and after confinement from a doctor or midwife, or hospital treatment when necessary.

Who is Insured?

2. All persons working in any industrial establishment, factory or other place of business at which at least persons are employed and which is situated within the area(s) of are required to be insured under the Social Insurance Act.

What are the Qualifying Conditions?

3. No qualifying conditions have to be satisfied by persons who need medical care on account of pregnancy or confinement, or treatment on account of an employment injury (see paragraph 1.A(d) above). In other cases the insured person must have been employed

in insurable employment during at least 13 weeks in the 26 weeks immediately before the date on which he first attended for treatment/.

The appropriate details of the actual scheme will have to be inserted here, including an explanation of the effect of any "linking up" of illnesses provisions./

How Long Does Title to Receive Treatment Continue?

4. Title to receive treatment continues

- (a) so long as a person suffering from an employment injury (see paragraph 1.4(d) above) needs treatment for the injury;
- (b) whenever necessary during pregnancy and the first six weeks following confinement in the case of an insured woman; and
- (c) in other cases whenever necessary during insurable employment and during a period of thirteen weeks after the employment ends/.

The appropriate details of the actual scheme will have to be inserted here including an explanation of the effect of any "linking up" of illnesses provisions./

How is Medical Care Obtained?

5. The insured person will be supplied soon after his entry into insurance with an Identity Card (Form R.6) which he must produce whenever he wants to claim Social Insurance benefit.

This card will show to which Social Insurance Dispensary the person has been allotted for treatment.

6. When the person needs medical treatment he should obtain from his employer a certificate of employment (Form M.C.3) and take it with his identity card to the Dispensary and give them to the reception clerk who, after making any necessary enquiries to confirm entitlement to medical care, will arrange for the person to be examined by a doctor. If he has not been able to obtain Form M.C.3 from his employer he should explain the position to the reception clerk.

7. After examining the person the doctor will give directions as to the treatment and medicine which are necessary, and in appropriate cases will issue a certificate of incapacity for work. He will also issue instructions as to when the person should next attend the dispensary for treatment.

8. Where necessary the doctor will make arrangements for a special laboratory examination of the insured person, X-ray, etc., or for him to receive treatment at a hospital.

9. If the insured person is unable by reason of illness or infirmity to go to the dispensary, he should give his identity card to a relative or other representative to take to the dispensary and explain the position. The doctor at the dispensary will then consider whether it is necessary that the insured person should be examined in his home or taken to a hospital for examination.

10. It is a condition of the continued receipt of medical care that the insured person must -

- (a) attend for treatment so long as it is considered necessary for his recovery;
- (b) comply with the doctor's instructions;
- (c) not do anything which may prevent or prejudice his recovery; and
- (d) submit when required to be medically examined.

Pregnancy Cases

11. In accordance with the Benefit Regulations an insured woman is required to give notice of pregnancy to the Dispensary within three months of its commencement. The doctor will then examine her and determine the date on which her confinement may be expected to occur, and will inform her when she should next attend the Dispensary for a further medical examination.

By Whom is Title to Medical Care Decided?

12. Decisions with regard to title to medical care are given under the authority of the Social Insurance Board by officers of the Board. Any complaint against medical treatment given under the Social Insurance Act as part of medical care is dealt with by an independent Medical Tribunal.

✓Note. Insert here either the addresses of the Social Insurance Dispensaries and Local Offices or particulars of the places where those addresses may be found.✓

Leaflet No. 5

Social Insurance

Important. Keep this leaflet for future reference.

Sickness Benefit

What is Sickness Benefit?

1. Sickness benefit is a cash payment in lieu of wages which is paid to an insured person who is rendered incapable of performing his work as the result of illness or disablement.

Who is Insured?

2. All persons working in any industrial establishment, factory or other place of business at which at least persons are employed and which is situated within the area(s) of are required to be insured under the Social Insurance Act.

What are the Qualifying Conditions?

3. The insured person must have been employed in insurable employment [during at least 13 weeks in the 26 weeks immediately before the week in which he became incapable of work]. [The appropriate details of the actual scheme will have to be inserted here and in other parts of the leaflet which are enclosed in square brackets.]

What is the Rate of Sickness Benefit?

4. [The rate of benefit or the method of its calculation as laid down in the Social Insurance Act or Benefit Regulations must be shown here in detail, and in addition it should be pointed out, if necessary, that benefit is not payable for any period for which wages are paid and is liable to be reduced when the person is an in-patient of a hospital.]

How Long Does Title to Benefit Continue?

5. Sickness Benefit commences to be payable as from the fourth day of incapacity for work, and continues so long as the insured person remains incapable of work, up to a maximum period of [thirteen weeks]. No benefit is, however, payable for any period before benefit is claimed, unless good cause is shown for the claim not having been made earlier.

6. If, after the insured person has ceased to be incapable of work, and to receive benefit, he again falls ill and becomes incapable of work within [six] weeks after his earlier recovery, benefit becomes payable from the first day of the new period of incapacity and the contribution condition referred to in paragraph 3 is not required to be satisfied in respect of the new illness. The former period for which benefit has been paid is, however, added to the new period in calculating the period of [thirteen weeks] for which benefit is payable.

7. If more than [six] weeks has elapsed between two periods of incapacity, the later period is treated as an entirely separate period; the contribution conditions of paragraph 3 are applied anew and benefit, if due, becomes payable only from the fourth day of the new period of incapacity, and continues up to a maximum of [thirteen weeks].

How is Sickness Benefit Obtained?

8. When the insured person who is attending for treatment at the Social Insurance Dispensary first receives a certificate of incapacity from the Dispensary doctor, he should give it to the reception clerk who will tell him how to fill in his claim for sickness benefit. The reception clerk will retain the certificate and the claim for consideration of title to benefit.

9. Benefit will not normally become payable until after insured person has been medically examined on his next visit to the Dispensary and received a further certificate of incapacity from the doctor. This certificate will also be retained by the reception clerk who will tell the insured person on what date to call at the Social Insurance Local Office to receive payment of benefit.

10. The insured person should call at the Local Office on that date, taking with him his identity card, and payment of benefit, if due, will be made to him. Benefit will be paid by the cashier at the Local Office in cash.

11. The same procedure, as in paragraphs 9 and 10, should be followed on each occasion on which a medical certificate of incapacity is received from the Dispensary doctor, until either the doctor certifies that the insured person is no longer incapable of work, or the period of which benefit is payable ends (see paragraphs 5 to 7).

12. If the insured person has received a medical certificate of incapacity from a private doctor from whom he has been receiving treatment, he should take it with his identity card to the Social Insurance Local Office where he will be instructed as to the procedure to be followed.

13. If the insured person is given a certificate of incapacity by the hospital at which he has received treatment, he should take or send it with his identity card to the Local Office, who will instruct him as to the further action to be taken.

14. If at any time the insured person is incapable of going to the Local Office to receive payment, he should nominate a relative or other representative to receive the payment on his behalf. The representative should produce the nomination and the insured person's identity card when he or she calls at the Local Office to draw the money.

Other Provisions

15. Sickness benefit and injury benefit are not both payable for the same period of incapacity; but if, when title to sickness benefit is due to come to an end, it seems possible that the incapacity for work may have been caused by an injury at work, possible title as to injury benefit will be considered. Sickness benefit and maternity benefit are not both payable for the same period; but, if the insured woman is incapable of work when her title to maternity benefit comes to an end, her possible title to sickness benefit will then be considered.

16. The right to receive payment of sickness benefit in respect of any particular period of a week or less will be lost if payment is not claimed within eight weeks after the end of the period.

17. An insured person may be suspended from receiving sickness benefit for a period of up to six weeks if -

- (a) he does any remunerative work during a period for which the benefit has been claimed; or
- (b) his incapacity for work was caused by his wilful misconduct, or by a criminal offence committed by him; or
- (c) he fails to comply with the doctor's orders; or
- (d) he does anything which may prevent or prejudice his recovery; or
- (e) he refuses to submit, when required, to be medically examined; or
- (f) he neglects unreasonably to make use of the medical or rehabilitation services placed at his disposal.

18. A person who wilfully makes a false statement or representation with a view to obtaining benefit for himself or someone else is liable on conviction to serious penalties by way of a fine or imprisonment, or both.

By Whom is Title to Sickness Benefit Decided?

19. Decisions with regard to title to sickness benefit are given under the authority of the Social Insurance Board by officers of the Board. Any person, who is not satisfied with a decision of the Board, may appeal against it to a local tribunal, whose decision on the matter is final. (See Leaflet No. 9)

[Note. Insert here either the addresses of the Social Insurance Dispensaries and Local Offices or particulars of the places where those addresses may be found.]

Leaflet No. 6

Important Keep
this leaflet for
future reference

Social Insurance

Maternity Benefit

What is Maternity Benefit?

1. Maternity Benefit is a cash payment in lieu of wages to an insured woman during a certain period before and after her confinement.

Who is Insured?

2. All persons working in any industrial establishment, factory, or other place of business at which at least persons are employed and which is situated within the area(s) of are required to be insured under the Social Insurance Act.

What are the Qualifying Conditions?

3. The insured woman must have been employed in insurable employment [during at least 26 weeks in the period of 52 weeks immediately before the date on which payment of benefit would be due to commence - see paragraph 5].

[The appropriate details of the actual scheme will have to be inserted here.]

What is the Rate of Maternity Benefit?

[The rate of benefit or the method of its calculation as laid down in the Social Insurance Act or Benefit Regulations must be shown here in detail and in addition it should be pointed out, if necessary, that benefit is not payable for any period for which wages are paid and is liable to be reduced when the person is an in-patient of a hospital.]

How Long Does Title to Benefit Continue?

5. Maternity benefit commences to be payable from a date six weeks before the confinement is expected to occur, or, if on that date, the insured woman is still employed or is in receipt of wages, as from the day following the cessation of wages. Benefit continues to be payable until six weeks after the day on

which the confinement takes place. No benefit, is, however, payable for any period before benefit is claimed, unless good cause is shown for the claim not having been made earlier.

How is Maternity Benefit Obtained?

6. About seven weeks before her confinement is due, or as soon afterwards as she leaves employment, the insured woman should ask the doctor at the Social Insurance Dispensary for a certificate showing the date on which her confinement is expected to take place, and should give this certificate to the reception clerk, who will tell her how to fill in a claim for maternity benefit. The reception clerk will retain the certificate and the claim for consideration of title to benefit and will tell the insured woman on what date to call at the Social Insurance Office to receive the first payment of benefit.

7. The insured woman should call at the Local Office on that date, taking her identity card with her, and payment of benefit, if due, will be made to her. Benefit will be paid by the cashier at the Local Office in cash, and further payments will be made week by week thereafter, so long as title continues.

8. As soon as the confinement has occurred a certificate of confinement should be obtained from the dispensary doctor. and given to the reception clerk.

9. If at any time the insured woman is incapable of going to the Local Office to receive payment she should nominate a relation or other representative to receive the payment on her behalf. The representative should produce the nomination and the insured woman's identity card when he or she calls at the Local Office to draw the money.

Other Provisions

10. Sickness benefit and maternity benefit are not both payable for the same period of incapacity, but if an insured woman continues to be incapable of work after the end of the period for which maternity benefit is payable to her, she may then become entitled to receive sickness benefit subject to the conditions explained in Leaflet No. 5. Injury benefit and maternity benefit are also not both payable for the same period of incapacity.

11. The right to receive payment of maternity benefit in respect of any particular period of a week or less, will be lost if payment is not claimed within eight weeks after the end of that period.

12. An insured woman may be suspended from receiving maternity benefit for a period of up to six weeks if

- (a) she does any remunerative work during a period for which the benefit has been claimed; or
- (b) during the period for which maternity benefit is payable she fails without good cause to take due care of her health.

13. A person who wilfully makes a false statement or representation with a view to obtaining benefit for herself or someone else is liable on conviction to serious penalties by way of a fine or imprisonment or both.

By Whom is Title to Maternity Benefit Decided?

14. Decisions with regard to title to maternity benefit are given under the authority of the Social Insurance Board by officers of the Board. Any person who is not satisfied with a decision of the Board may appeal against it to a local tribunal, whose decision on the matter is final. (See Leaflet No. 9.)

✓Note. Insert here either the addresses of the Social Insurance Dispensaries and Local Offices or particulars of the places where those addresses may be found.✓

Leaflet No. 7

Important Keep
this leaflet for
future reference

Social Insurance

Employment Injury Benefits

What are Employment Injury Benefits?

1. When an insured person suffers an employment injury, that is to say, an injury which occurs in the course of and arising out of his insurable employment, then:-

- (a) he is entitled to a cash payment in lieu of wages for a certain period if he is rendered incapable of performing his work as a result of the injury; this benefit is called injury benefit;
- (b) thereafter he becomes entitled to further cash payments as long as he suffers loss of earning capacity, which is likely to be permanent, as a result of the injury; this benefit is called disability pension; where the degree of loss of earning capacity is assessed at less than 20 per cent. a lump sum payment is made instead of a disability pension;
- (c) if he should die as a result of the injury, his widow and children become entitled to cash payments; this benefit is called survivors' pension.

Who is Insured?

2. All persons working in any industrial establishment, factory or other place of business at which at least persons are employed and which is situated in the area(s) of are required to be insured under the Social Insurance Act.

What are the Qualifying Conditions?

3. No qualifying conditions have to be satisfied to give title to employment injury benefits.

What are the Rates of Employment Injury Benefits?

4. The rates of the various benefits or the method of their calculation as laid down in the Social Insurance Act or Benefit Regulations must be shown here in detail and in addition it should be pointed out, if necessary, that injury benefit is not payable for any period for which wages are paid and is liable to be reduced when the person is an in-patient of a hospital.

How Long Does Title to Benefit Continue?

5. (a) Injury benefit commences to be payable as from the fourth day of the incapacity for work resulting from the injury and continues so long as the insured person remains incapable of work, but not beyond the date which is 52 weeks after the date of the injury.

(b) Disability pension commences to be payable as from the date following that up to which injury benefit has been paid, or from any later date as at which the loss of earning capacity is assessed at 20 per cent. or more. The pension remains payable so long as the loss of earning capacity continues to be assessed at 20 per cent. or more.

(c) A survivors' pension commences to be payable as from the date following that up to which disability pension was paid to the insured person, or from the date of the person's death, if no such pension was paid to him.

(d) No employment injury benefit is, however, payable for any period before the benefit is claimed unless good cause is shown for the claim not having been made earlier.

How is Injury Benefit Obtained?

6. When the insured person attends at the Social Insurance Dispensary for treatment in respect of an employment injury and is given a certificate of incapacity by the dispensary doctor, he should give it to the reception clerk who will tell him how to fill in his claim for benefit. The reception clerk will retain the certificate and the claim for consideration of title to benefit.

7. Injury benefit will not become payable until after the insured person has been medically examined on his next visit to the Dispensary and received a further certificate of incapacity from the doctor. This certificate will also be retained by the reception clerk who will tell the insured person on what date to call at the Social Insurance Local Office to receive payment of benefit.

8. The insured person should call at the Local Office on that date, taking with him his identity card, and payment of benefit, if due, will be made to him. Benefit will be paid by the cashier at the Local Office, in cash.

9. The same procedure as in paragraphs 7 and 8 should be followed on each occasion on which a medical certificate of incapacity is received from the dispensary doctor, until either the doctor certifies that the insured person is no longer incapable of work as a result of the employment injury or the period for which benefit is payable ends (see paragraph 5(a)).

10. If the insured person is given a certificate of incapacity by a private doctor from whom he receives treatment or by the hospital at which he is being treated, he should take or send the certificate with his identity card to the Local Office, who will instruct him as to the procedure to be followed.

11. If at any time the insured person is incapable of going to the Local Office to receive payment, he should nominate a relative or other representative to receive the payment on his behalf. The representative should produce the nomination and the insured person's identity card when he or she calls at the Local Office to draw the money.

How is Disability Pension Obtained?

12. Shortly before payment of injury benefit is due to come to an end (see paragraph 5(a)), or when the doctor certifies that the insured person is no longer rendered incapable of work as a result of the employment injury, the Local Office will refer the insured person for examination by an independent medical tribunal who will decide whether he has suffered a permanent loss of earning capacity as a result of the employment injury, and, if so, at what degree the loss is to be assessed.

13. The Social Insurance Board will send the insured person a copy of the medical tribunal's decision as to his title to disability pension and, if his claim is allowed, tell him when to call at the Local Office to receive payment of his pension, or of the lump sum payment if the degree of loss of earning capacity is assessed at less than 20 per cent.

14. The insured person should call at the Local Office on the date indicated, taking with him his identity card, when payment will be made to him in cash by the cashier. Payment of disability pension will be made monthly in advance, and when he receives each payment the insured person will be told when to call to receive the next payment.

15. If the decision of the medical tribunal only covers a certain period, arrangements will be made for the insured person to be re-examined towards the end of that period (as in paragraph 12) and for a fresh decision to be given on his case.

16. If at any time the insured person is incapable of going to the Local Office to receive payment of his pension, he should nominate a relation or other representative to receive the payment on his behalf. The representative should produce the nomination and the insured person's identity card when he or she calls at the Local Office to draw the money.

How is a Survivors' Pension Claimed?

17. When an insured person dies as a result of an employment injury, his widow, or the person having charge of the children should at once notify the death to the Local Office, where she will be given assistance in completing an application for survivors' pension, and told what documents, such as certificates of the death of the insured person, of his marriage and of the births of his children, and his identity card, to produce in support of the application.

18. When the application has been considered, the applicant will be notified of the decision, and, if the claim is allowed, will be told when she should go to the Local Office to receive payment of the pension.

19. The pensioner should call at the Local Office on the date indicated, taking the notice of award with her, when payment will be made in cash to her by the cashier. Payment of survivors' pension will be made monthly in advance, and when she receives each payment, the pensioner will be told when to call to receive the next payment.

20. If at any time the pensioner is incapable of going to the Local Office to receive payment of the pension, she should nominate a relation or other representative to receive payment on her behalf. The representative should produce the nomination when she calls at the Local Office to draw the money.

Other Provisions

21. Injury benefit and sickness benefit are not both payable in respect of the same period of incapacity; but if, when title to sickness benefit is due to come to an end, it seems possible that the incapacity for work may have been caused by an injury at work, possible title to injury benefit will be considered.

22. The right to receive payment of injury benefit in respect of any particular period of a week or less, will be lost if payment is not claimed within eight weeks after the end of that period.

23. The right to receive payment of disability pension or survivors' pension in respect of any particular period of a month or less, will be lost if payment is not claimed within six months after the end of that period.

24. All title to a disability pension or to a survivors' pension will be lost if the pension is not claimed within 52 weeks after the date from which the pension would have been paid if it had been claimed at the proper time.

25. An insured person may be suspended from receiving injury benefit for a period of up to six weeks if

- (a) he does any remunerative work during a period for which injury benefit has been claimed; or
- (b) he fails to comply with the doctor's orders; or
- (c) he does anything which may prevent or prejudice his recovery; or
- (d) he refuses to submit, when required, to be medically examined; or
- (e) he neglects unreasonably to make use of the medical or rehabilitation services placed at his disposal.

26. A person who wilfully makes a false statement or representation with a view to obtaining benefit or pension for himself or someone else is liable on conviction to serious penalties by way of a fine or imprisonment or both.

By Whom is Title to Employment Injury Benefit Decided?

27. Any decision with regard to whether an insured person has suffered a loss of earning capacity as a result of an employment injury, and, if so, whether that loss is likely to be permanent and at what degree the loss is to be assessed, is to be given by the medical tribunal, as stated in paragraph 12, and that tribunal is also responsible for deciding whether or not an insured person's death resulted from an industrial injury. The decision of the medical tribunal on any of these matters is final.

28. Any other decisions with regard to title to employment injury benefits are given under the authority of the Social Insurance Board by officers of the Board. Any person who is not satisfied with a decision of the Board may appeal against it to a local tribunal, whose decision on the matter is final. (See Leaflet No. 9.)

Note. Insert here either the addresses of the Social Insurance Dispensaries and Local Offices or particulars of the places where those addresses may be found.

Leaflet No. 8

Social Insurance

Important Keep this leaflet for future reference
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Funeral Grant

What is a Funeral Grant?

1. A Funeral Grant is a cash payment towards the cost of the funeral of an insured person.

Who is Insured?

2. All persons working in any industrial establishment, factory or other place of business at which at least persons are employed and which is situated within the area(s) of are required to be insured under the Social Insurance Act.

What are the Qualifying Conditions?

3. The insured person must have been employed in insurable employment /during at least 13 weeks in the 26 weeks immediately before he died, or, if he was receiving medical care prior to the date of his death, immediately before the date on which he became entitled to that benefit/.

/The appropriate details of the actual scheme will have to be inserted here./

What is the Amount of the Funeral Grant?

4. /The amount of the Grant or the method of its calculation as shown in the Social Insurance Act or Benefit Regulations must be shown in detail here./

How is Funeral Grant Obtained?

5. When an insured person dies, his death should at once be notified to the Dispensary at which he was receiving medical treatment or the Local Office by the person who is responsible for seeing to the funeral. The Dispensary or the Local Office will give the person assistance in completing an application for funeral grant and will tell him what documents, such as a certificate of the death and evidence of the insurance of the deceased person, to produce in support of the application.

6. When the application has been considered the applicant will be notified of the decision, and, if the claim is allowed, will be told when to go to the Local Office to receive payment of the grant.

7. The applicant should call at the Local Office on the date indicated, taking the notice of award, when payment of the grant will be made in cash by the cashier.

Other Provisions

8. All title to a funeral grant will be lost if it is not claimed within 52 weeks after the date of the death of the insured person.

9. A person who wilfully makes a false statement or representation with a view to obtaining a funeral grant for himself or someone else is liable on conviction to serious penalties by way of a fine or imprisonment or both.

By Whom is Title to Funeral Grant Decided?

10. Decisions with regard to title to Funeral Grant are given under the authority of the Social Insurance Board by officers of the Board. Any person who is not satisfied with a decision of the Board may appeal against it to a local tribunal, whose decision on the matter is final. (See Leaflet No. 9.)

[Note. Insert here either the addresses of the Social Insurance Dispensaries and Local Offices or particulars of the places where those addresses may be found.]

Leaflet No. 9

Important Keep
this leaflet for
future reference

Social Insurance

Right of Appeal

How Decisions under the Social Insurance Act are Given

1. Under the Social Insurance Act, decisions on most questions of insurability and title to benefit, etc. are given under the authority of the Social Insurance Board by officers of the Board.

2. Any question, however, as to whether an insured person has suffered a loss of earning capacity as a result of an employment injury (see Leaflet No. 7) and, if so, whether that loss is likely to be permanent and at what degree the loss is to be assessed, or whether an insured person's death resulted from an employment injury, is to be decided by an independent medical tribunal constituted as explained in paragraph 6 below. The decision of the tribunal on such a question is final.

Right of Appeal

3. Except in regard to the questions referred to in paragraph 2, any person who is not satisfied with the decision of the Board has, in general, a right of appeal against the decision, but this right of appeal may be dealt with in special ways.

4. Questions which relate to whether the Social Insurance Act applies to a particular place of business, whether a certain employee is liable to be insured, what contributions are due to be paid and by whom, and whether the contribution conditions for any benefit are satisfied, are for decision by the Social Insurance Board in the first place. But, if any question of law, as distinct from one of fact, arises in connection with such a question, the Board may refer the question to the Court for decision, or, if the Board has decided the question and someone is not satisfied with their decision, that person may appeal to the Court against the decision. The court decision on such a question is final. There is no right of appeal against a decision of the Board on any question which is based solely on fact.

5. In any other case where a person is not satisfied with a decision of the Social Insurance Board, for example in connection with a claim for benefit, he may appeal against the decision to a local tribunal constituted as explained in paragraph 7. The decision of the local tribunal is final.

Constitution of Tribunals

6. A medical tribunal consists of a chairman, who is a lawyer of considerable standing, and two medical practitioners, who must not be medical officers in the employment of the Social Insurance Board.

7. A local tribunal consists of a chairman, who is a lawyer of considerable standing, one member representative of insured persons and one member representative of employers.

Procedure in connection with Appeals

8. Any question as to the correctness of advice given by the Social Insurance Board as to insurability or the payment of contributions (see paragraph 4) may be raised by completing an application for a formal decision on a form which will be supplied on request by the Board. After the Board has considered the evidence submitted, the applicant will be notified of the Board's decision and informed of his right of appeal to the Court if he is not satisfied with the decision so far as it applies to a question of law. The Board will, on request, advise the applicant how he should proceed in order to bring such an appeal before the Court, where it will be dealt with in accordance with the Rules of Court.

9. When a person is not satisfied with the Board's decision on a claim for benefit he may give notice in writing of his desire to appeal against the decision. This notice which must be given within 21 days after the date of the decision, must include a statement of the reasons why the claimant considers that the decision was wrong.

10. The claimant will be informed by the clerk of the local tribunal of the time and place which has been fixed for the hearing of his appeal, and the claimant should attend at that time and place accordingly. If it is not possible for him to do so, he must notify the clerk of the local tribunal of the reasons as early as possible, in order that other arrangements may be made for his appeal to be heard. If he fails to attend without giving a reasonable explanation, the tribunal may proceed to consider the appeal in his absence. The claimant may be represented at the hearing by any other person, who is not a lawyer.

11. The claimant will be notified in writing of the tribunal's decision either before he leaves the tribunal office, or by post as soon as possible afterwards. If the appeal is allowed the claimant will also be told by the Social Insurance Board as to how effect will be given to the decision.

Review of Decisions

12. A decision of the Social Insurance Board or of a tribunal may be reviewed if fresh evidence affecting the decision is received. If a person whose application or appeal has been disallowed obtains fresh evidence which he thinks may affect the decision, he should send the evidence to the Board with an application in writing for the decision to be reviewed, stating his reasons for the application. He will be informed of the result of the review, and of the effect of the review, if the original decision is altered.

Section C - Forms
(See also Part V, Note 10)

- | | |
|-----------------------------|--------|
| 1. Registration Forms, etc. | - R. |
| 2. Benefit Forms | |
| Medical Care | - M.C. |
| Sickness Benefit | - S. |
| Maternity Benefit | - M. |
| Employment Injury | - E. |
| Funeral Grant | - F. |
| 3. Contribution Forms | - C. |
| 4. Appeal Forms | - A. |

[Note. As regards the wording, layout, sizes and materials of the forms when prepared for actual use, see paragraphs 1405 to 1410.]

Part VI

Section C.1

Registration and Record Forms

- R.1 Employer's application for registration.
- R.1A Request to employer for further details.
- R.1B Returning duplicate Form R.1 completed by employer.
- R.2 Notification to employer of registration number.
- R.3 Employer's contribution register sheet.
- R.3A Jacket for employer's contribution record.
- R.4 Insured person's registration form.
- R.4A Family registration form.
- R.5 Employer's list of employees.
- R.5A Notification to employer of insurance number of new employee.
- R.5B Letter to employer in regard to duplicate registration of an employee.
- R.5C Notification to dispensary of the cancellation of a duplicate insurance number.
- R.6 Identity card of insured person.
- R.6A Family identity card.
- R.6B Covering letter to insured person enclosing Form R.6A.
- R.6C Application for replacement of Identity Card.
- R.7 Covering letter to employer accompanying identity cards for his employees.
- R.7A Notification to employer of insurance number of new entrant into insurance.
- R.8 Insured person's index slip.
- R.8A Action sheet in connection with duplicate registrations.
- R.8B Reference to Inspector in a duplicate registration case.
- R.9 Insured person's Contribution and Benefit Record Sheet.

Registration

Social Insurance Act..... No. Allotted

Employer's Registration Form

BLOCK CAPITALS
PLEASE

Name of Firm
in full

Employer's Name
(if different)

Address of Princi-
pal Place of
Business

Telephone No.

Nature of
Business

Number of Employees liable to be insured.....

Certified that the information given above is correct.

Signature of employer
or stamp of firm

Form R.1.

Date

[Suggested size of form 15 x 20.]

For Official Use Only

	Action Taken	
	Initials	Date
Registration form checked		
Industry Code Number entered in space overleaf		
Serial number allotted and entered in space overleaf		
Forms R.2. and R.3. prepared		
Forms R.2. and R.3. checked		
Forms R.2., R.4. and R.5. issued		

Social Insurance Act ...

To

Name of Firm

..... Address

.....

Your reference

From the Social Insurance Board

.....

.....

Date

Form R.1 is returned herewith
in order that:

x

(a) it may be completed
where marked X

x

(b) it may be confirmed that
the information given as
to
.....
is accurate. On the
basis of this information
it would appear that
your employees are not
liable to be insured.
(See marked portion of
leaflet 3 enclosed.)

If the information is
inaccurate will you please
correct the form accordingly
and return it to this
Office.

.....

x (a) or (b) should be
deleted as necessary

Form R.1A.

REPLY

(a) Form R.1 returned herewith
completed.

(b) ∅ (i) The information given
is accurate.

(ii) The information given
was not accurate and
Form R.1 returned
herewith has been
corrected accordingly.

.....

Date

∅ (i) or (ii) should be deleted
as appropriate.

[Suggested size of form 25 x 15 cms.]

Social Insurance Act

To From the Social Insurance Board
..... (Address)
.....
Your reference Date

The enclosed Form R.1 is returned because, according to the records of this office, you have already been registered under number, and contributions for the period as from are now due to be paid by you under that number. Perhaps you will let me know if there is any further difficulty in this matter.

(signed)
for Social Insurance Board

Form R.1B

[Suggested size of form 15 x 20 cms.]

From the Social
Insurance Board

• • • • •

• • • • •

Date

See Over

[Suggested size of form 15 x 20 cms.]

Together with this Form I enclose a number of Forms R.4 for the registration of your employees, and two Forms R.5 with continuation sheets on which to furnish in duplicate a list of the employees.

It would be of great assistance to the Board if you would fill in a Form R.4 for each employee giving the information asked for and arrange for him to sign it, if he can write, and make an impression of his right thumb in the space provided on the form.

When the forms have all been completed will you please send them to me in one packet with the two copies of Form R.5 and the continuation sheets giving the names of all your employees.

In due course Identity Cards (Forms R.6) will be sent to you for distribution to your employees, together with one copy of Form R.5 and one set of the continuation sheets showing the Insurance Numbers allotted to them.

Signed

Form R.2

Social Insurance Board.

.....(Name of Firm)

.....(Address)

Registration

Number.....

.....(Telephone Number)

Nature of Business.....

Month Ending	Number of Employees	Contributions Received		Month Ending	Number of Employees	Contributions Received	
		Amount	Date			Amount	Date
<p>[Note. The headings of the columns will have to be adapted to the particular method of collection of contributions which is to be used, and, where stamped cards are involved, a column may be included to record the surrender on exchange of the expired cards]</p>							

(Front of Jacket for Employer's Contribution Record)

Social Insurance Act

Employer's Registration Number

Name of Firm

Nature of Business Local Office

[illegible]

Social Insurance Act

Insured Person's Registration Form

Insurance
Number
Allotted

--	--	--	--	--	--	--	--	--	--

In Block Capitals ONLY

Particulars of Insured Person:

SURNAME IN FULL

OTHER NAMES IN FULL

MOTHER'S SURNAME

FULL ADDRESS

.....

Date of Birth

Day	Month	Year

Place of Birth

Sex

Man	
-----	--

Woman

--	--

Marital
Status

Single

--	--

Married

--	--

Mark with X

Widow

--	--

Widower

--	--

Mark with X as appropriate

[Civil Registration Number]

If married give full name

of husband/wife

Occupation

Signature of Insured Person

Date

Signature of Employer
or stamp of firm

Name of Firm

Address

Telephone number

Impression of
Insured person's
right thumb

See Note 1 over-
leaf

Registration
Number of
Firm

For official use only

Insurability confirmed Initls. Date.

Insurance number allotted Assigned to Dis ensary.
and entered at head of Form M.C. 1 prepared.
form and on Form R.5 Initls. Date.

Checked Initls. Date.

- ✓Notes. 1. Where photographs are to be used for identification purposes it will be necessary to amend the heading here and to ask for two copies of the person's photograph, one to be affixed in this space and the other to be affixed to the person's identity card.
2. For the purpose of registrations after the scheme has been introduced it may be found desirable to include extra questions as to possible earlier insurable employment as a safeguard against duplicate registration.✓

Form R.4

Social Insurance Act ...

Family Registration Form

NOTE

This form must be completed by the Insured Person and taken by him to the local Social Insurance Office with his marriage certificate and certificates of the births of his children, if available /and also a photograph of himself/ (this addition to be made only if photographs are to be used for identification purposes.)

IN BLOCK CAPITALS
ONLY

Particulars of Insured Person

Surname in Full

Insurance Number

--	--	--	--	--	--	--	--	--	--

Other Names in Full

Address

Date of Birth

Day	Month	Year

Place of Birth Sex

NAME OF WIFE Date of Wife's Birth
in Full

Day	Month	Year

WIFE'S MAIDEN NAME Place of Wife's Birth

Date of Marriage Place of Marriage

Particulars of Dependent Children Marriage Certificate Herewith Yes/No^x

^xIf certificate is attached enter "Yes" here

Full Name of Child	Date of Birth			Place of Birth	Birth Certificate attached ^x
	Day	Month	Year		
1.					
2.					
3.					
4.					
5.					
6.					

IN BLOCK CAPITALS
ONLY

I hereby declare that the information given above relates to my wife and children who live with me and are dependent on me for their support. This information is true to the best of my knowledge and belief. I attach my marriage certificate and ... certificates of the births of my children.^x

Signature of Insured Person

Date

Impression of Insured Person's Right Thumb

^x Delete as necessary if the marriage certificate or birth certificates are not attached.

⁶ Enter number of birth certificates enclosed.

For Official Use Only

Particulars checked against Form R.4.

Form R.6A prepared

..... Initials Date

Form M.C.2 prepared

Assigned to Dispensary.

Checked Initials Date

Form R.6A despatched with certificate Initials Date

Form R.4A.

Social Insurance Act

List of Employees for Registration
(to be completed in duplicate)

..... (Name of Firm)
..... (Address)
..... (Telephone number) Registration
Number

Nature of Business Reference

The following is a full list of the persons employed by this firm.
A Form R.4 completed by each of them is enclosed.

Signature of the Employer
or stamp of Firm

Date

Name of Employee in full	Insurance Number Allotted by Social Insurance Board	Name of Employee in full	Insurance Number Allotted by Social Insurance Board
<p><u>Note:</u> Where contribution rates are to be related to the rates of wages, whether actual or notional, columns will have to be added in order that the necessary information may be furnished - See para. 376 and 392 (Contribution Regulations).]</p>			
Form R.5			

Continuation Sheet No.
to Form R.5

Registration
Number of Firm

Social Insurance Act ...

List of Employees for Registration
(to be completed in duplicate)

Name of Employee in Full	Insurance Number Allotted by Social Insurance Board	Name of Employee in Full	Insurance Number Allotted by Social Insurance Board
Form R.5 (continuation sheet)			

Social Insurance Act

Insurance Number

--

To
Name of Firm

.....

.....

Your Reference

From the Social Insurance Board

.....

.....

Date

The attached Form R.4. is returned herewith as the employee named thereon has already been registered as an insured person under the insurance number shown above.

Will you please note this number in your records and also be so good as to inform the employee of his insurance number and tell him that if he has lost his identity card, he should get a new one from this Office.

Any enquiry on this matter should be addressed to this Office quoting the above-mentioned insurance number.

Form R.5A

[Suggested size 15 x 20 cms.]

Social Insurance Act

To
Name of Firm

From the Social Insurance Board

..... (Address)

..... Registration No.

Date

re

Insurance Numbers

--	--	--	--	--	--	--	--

and

--	--	--	--	--	--	--	--

Two Forms R.4. have been received from you for the above-named man and two insurance numbers have been allocated to him as shown.

/A. Stamped Card System

Will you please state below what insurance number appears on the contribution card you are stamping for him, and return the contribution card and identity card (Form R.6) bearing the other number.

Signed
for Social Insurance Board

To the Social Insurance Board

I am stamping contribution card bearing Insurance Number
I return herewith the contribution card and identity card bearing
Insurance Number

Signed employer
or stamp of firm

Date/

/B. Cash Payment System

Will you please note that Insurance Number should be
cancelled and return the identity card bearing that number.

Signed
for Social Insurance Board

To the Social Insurance Board

I have noted the position as stated above and I return herewith the
identity card bearing Insurance Number

Signed employer
or stamp of firm

Date/

Social Insurance Act

Duplicate Registration

To Dispensary

Will you please note that Form M.C.1 in respect of
..... bearing Insurance Number should be
cancelled.

Signed
Records Section

Date

Form M.C.1 cancelled accordingly.

Signed
Dispensary

Form R.5C.

Date

[Suggested size 15 x 20 cms.]

Important Advice

Keep this card carefully. You may lose benefit if the card is lost. A charge may be made if a fresh card has to be issued.

Hand this card to your employer when you leave his employment so that he may enter the period of your employment on page 3.

When you obtain further employment hand this card to your new employer so that he may enter the particulars on page 3.

Always take this card with you whenever you go to the local office to claim cash benefits or to make enquiries, or when you go to the dispensary to receive medical treatment (see page 2).

Always quote your Insurance Number if you write to the local office.

On the death of the insured person this card should be taken to the Social Insurance dispensary at which he was receiving medical care, or to the local Social Insurance Office.

Social Insurance Act

Insured Person's

Identity Card

[Suggested size when folded 20 x 15 cms. Material
to be very stout paper or cardboard.]

To be folded along this line.

Social Insurance Act . . .

Insured Person's Identity Card

(Name) Sex Insurance
BLOCK CAPITALS Number

--	--	--	--	--	--	--	--

(Address).....

.....

This is to certify that you have been registered as an insured person under the Social Insurance Act and allotted the Insurance Number shown above. You must sign the card and make an impression of your right thumb in the spaces provided below. In the space provided above your photograph.^x

You must also read the advice given on page 4.

For completion by Insured
Person

Prepared by

Stamp of Social Insurance Board

Signature

x Photograph
or Impres-
sion of
Right Thumb

Dispensary

Local Office

^x Note. Omit whichever is inappropriate to the requirements of the scheme.

To be folded along this line.

Record of Employment

[illegible]

Social Insurance Act

Family Identity Card

Name of Insured Person Sex

Address
.....

Insurance
Number

--	--	--	--	--	--	--	--	--	--

For completion by
Insured Person only

Signature

Impression of
Right Thumb

--

[or Photograph]

Dispensary

Local Office

Prepared by

--

 Stamp of Social Insurance Board

Form R.6A.

See advice overleaf

[Suggested size 15 x 20 cms.]

Important Advice

This card is for use when any member of your family needs medical treatment, as provided under the Social Insurance Act

In order to receive treatment the person must take this card to the dispensary named overleaf.

Keep this card carefully. Your family may lose benefit if the card is lost. A charge may be made if a fresh card has to be issued.

Form R.6A.

Social Insurance Act

Family Registration

Insurance
Number

--	--	--	--	--	--	--	--	--	--

To

From Social Insurance Board

.....

.....

.....

.....

Date

The enclosed identity card, Form R.6A is for use when any member of your family needs medical treatment, as provided under the Social Insurance Act You should sign the card, if you can write, and make an impression of your right thumb in the space provided. ^x in the space provided above your photograph. ^x Instructions as to how they may receive treatment are given on the back of the card.

Form R.6B

^x Omit whichever is inappropriate to the requirements of the scheme.

Suggested size 15 x 20 cms. ⁷

Social Insurance Act

Application for Replacement of Identity Card

Insurance Number
(if known)

--	--	--	--	--	--	--	--

I hereby give notice that I have lost my Social Insurance Identity Card in the following circumstances

.....
.....
.....

and I accordingly apply for the issue to me of a new one.

☒ I attach a photograph to be affixed to the new identity card.⁷^x

Signed

Address

Date

Witness

Impression of Right Thumb

^x

Form R.6C

☒ Note x : Omit whichever is inappropriate to the requirements of the scheme.

Suggested size of form 20 x 20 cms.⁷

Social Insurance Act

To:	Name of Firm	From the Social Insurance Board
.....	Address
.....	
Your reference:		Date

I enclose herewith Form R.5 and continuation sheets on which have been entered the insurance numbers which have been allotted to your employees. Will you please note these numbers in your records.

I also enclose Identity Cards, Forms R.6, for all your employees and request you to be so good as to give each one his card after he has signed it, if he can write, ^x/ and make an impression of his right thumb in the space provided on the card⁷. If a person who enters your employment in future has no identity card, will you please complete a Form R.4 for him and send it to the Board for action.

Will you please be so good as to acknowledge the receipt of these forms on the slip below which should be detached and returned to this office.

(Signed)

Social Insurance Board

Form R.7

FORM R.7 (Attachment)

Social Insurance Act

Registration
Number of Firm

I acknowledge the receipt of Forms R.5, R.6 and R.7. The Identity Cards, Forms R.6, have been given to the employees as requested.

(Signed)

Stamp of firm

[/]Notes. The necessary additions should be made when contribution cards also have to be issued with this form.

^x To be omitted where a photograph is to be used for identification purposes.⁷

Social Insurance Act

Registration
Number of Firm

To: Name of Firm From: Social Insurance Board

..... Address

.....

Your reference: Date

With reference to Form R.4. recently sent in by you for
....., Insurance Number,
which has now been allotted to him, should be noted in your records.

Will you please be so good as to give him the enclosed
Identity Card, Form R.6., after he has signed it, if he can write,
^x/and made an impression of his right thumb in the space provided
on the card⁷.

(Signed)
Social Insurance Board

Form R.7A

^x/ To be omitted where a photograph is to be used for identifica-
tion purposes.

Suggested size of form 20 x 20 cms.⁷

Social Insurance Act

Insured Person's Index Slip

Insurance
Number

--	--	--	--	--	--	--	--

Surname in full

Other names in full

Sex

M/F

Mother's surname

If married woman, maiden
name

Married

Single

Widow

Widower

Address

.....

Date of birth

--	--	--

 Place of birth

Occupation

Employed by

Registration number of Firm

--	--

Assigned to
Dispensary

Name of husband/wife

Form R.8

[Suggested size 10 x 15 cms.]

Social Insurance Act

Duplicate Registration

Name of Insured Person

Insurance)

--	--	--	--	--	--	--	--	--	--

Numbers)

--	--	--	--	--	--	--	--	--	--

A. Records Section

The two index slips (Forms R.8) attached, and bearing the two insurance numbers shown above, appear to refer to the same insured person. Will you please confirm the identity by reference to the relative Forms R.4 and advise further action.

Signed

Index Section

Date

Delete B or C and D as appropriate

B. Index Section

Inspection of the two Forms R.4 shows that they refer to two different persons and Forms R.8 suitably noted are returned herewith.

Signed

Records Section

Date

C. Contribution Section

It has been confirmed that the two insurance numbers quoted above refer to the same person and Insurance Number has been cancelled. The relative Forms R.4, R.8 and R.9 have been noted and Form R.5C has been sent to the dispensary. Will you please delete the entry on Form R.5 relative to this number.

Signed

Records Section

Date

D. Index Section

Form R.5 noted as to cancellation of Insurance Number
Will you please file the index slip bearing the other number.

Signed

Contributions Section

Date

Action completed accordingly.

Signed

Index Section

Date

Social Insurance Act

Duplicate Registration

re (Name of Insured Person)

Insurance)

--	--	--	--	--	--	--	--

Numbers)

--	--	--	--	--	--	--	--

To the Inspector

The two Forms R.4 attached relate to the same insured person and it will be necessary to cancel one of the insurance numbers and arrange that the other will always be used in respect of him in future.

The particulars of employment which we have recorded are:

A. for Insurance Number

.....

.....

B. for Insurance Number

.....

.....

Will you please make local enquiries with a view to obtaining answers to the following questions:-

1. By whom is he employed at present?
2. Which insurance number is now being used?
3. Is the record of insurable employment as shown at A. and B. complete?
4. If not, what further employment has he had?

Will you also please arrange that the number ascertained as at 2 above is clearly recorded by that employer for use in future, and, if possible, recover the identity card bearing the other number.

Your replies to these questions should be given overleaf together with any other details relevant to the matter as ascertained by you.

Signed
Records Section

Date

Records Section

The replies to the four questions overleaf are:

1.
2.
3.
4.

Additional Remarks (if any)
.....

Signed
Inspector

Date

Social Insurance Act

Insured Person's Contribution and Benefit Record Sheet

A. Initial Particulars

Insurance
Number

--	--	--	--	--	--	--	--	--	--

Insured person's

Surname

Other names

Date of Birth

Sex M/F

Date of coming
into insurance

Insert X
as appropriate

Single	Married	Widow	Widower

Occupation

Registration No.
of employer

B. Contribution or Employment Record

Contribution Cards			Changes of Employment				Special remarks
Period	Number of contribu- tions	Rate of contri- butions	Registra- tion number of employer	Date of com- mencement of employment	Date of leaving employ- ment	Wage rate of group	

C. Benefit Record

Sickness Benefit Paid		Injury Benefit Paid		Other Benefits Paid	Special Remarks
From	To	From	To		

Form R.9

Notes. Suggested size 20 x 20 cms.

Material to be used - fairly stout paper or thin cardboard.7

PART VI

Section C.2

Medical Care Forms

- M.C.1. Insured Person's Index Slip.
- ✓M.C.2. Dependants' Index Slip.✓
- M.C.3. Employer's Certificate of Current Employment.
- M.C.4. Record of Employment.
- M.C.5. Record of Attendance at Dispensary and Period of Entitlement to Medical Care.
- M.C.6. Medical Case History.
- M.C.6A. Medical Record.
- M.C.7. Application to Another Dispensary for Medical Papers.
- M.C.8. Transfer of Medical Papers to Another Dispensary.
- M.C.9. Request to Record Section for Form M.C.1.
- M.C.10. Action Sheet for "No Identity Card" Case.
- M.C.11. Instructions to Insured Person as to Date of Next Examination.
- M.C.12. First Certificate of Incapacity.
- M.C.12A. Intermediate Certificate of Incapacity.
- M.C.12B. Final Certificate of Incapacity.
- M.C.13. Reference of Insured Person to Hospital.
- M.C.13A. X-Ray or Other Laboratory Examination.
- M.C.14. Prescription Form.
- M.C.15. Medical Stores Stock Sheet.
- M.C.15A. Medical Stores Stock Sheet - Dispensary.
- M.C.16. Order for Medical Stores.
- M.C.17. Requisition for Medical Stores - Dispensary.

Social Insurance Act

Name of insured person Dispensary

Address Insurance
Number

--	--	--	--	--	--	--	--

.....

Date of birth

--	--	--

Sex

M / F

Date of commencement
of insurance

Married
Single
Widow
Wid ower

Form M.C.1

Attendances at Dispensary		
Commenced	Subsequent attendances	Doctor who examined him

Form M.C.1.

[Suggested size 10 x 15 cms.]

Social Insurance Act

Certificate of Employment

(to be given to employee when he leaves
work in order to attend at the dis-
pensary to receive medical care)

To the Dispensary

This is to certify that
Insurance Number has been employed and insured in
this establishment continuously since and is still
employed there. His rate of pay is per week/month.

x / Insert here A or B as below according to method of payment
of contributions. 7

Signed
(or stamp of firm)

Employers' Registration No.

Date

-
- x / A. Where contributions are paid by means of stamps affixed to
contribution cards insert "His current contribution card
has been stamped for the period to"
- B. Where contributions are paid under the pay roll system
insert "The last payment of contributions which included
this employee was made on and the contribution
roll which accompanied the payment covered the period
..... to"

Suggested size of form 15 x 15 cms. 7

Social Insurance Act

Application for Medical Care

Name of insured person Insurance number

--	--	--	--	--	--	--	--

Date of first application for medical care during present illness

Record of employment within last 26 weeks

(a) as shown on Identity Card (Form R.6)

From	To	Employers' Registration No.

(b) as shown on Form M.C.3

Employed by Registration No.
from

Rate of pay per week/month

(c) as furnished by Applicant (or his representative)

From	To	Rate of pay	Employer's name	Registration No.

Completed by

Reception clerk

..... Dispensary

Date

Social Insurance Act

Period of entitlement to medical care

Name of insured person Insurance
Number

--	--	--	--	--	--	--	--	--	--

Name of Doctor providing treatment

Date of commence- ment of treatment (1)	Date up to which person is entitled to receive treatment (2)	Remarks (3)

Medical Case History

Name of Insured Person

Dispensary

Date of Birth

Insurance
Number

--	--	--	--	--	--	--	--

Name of Doctor	Period of Treatment		Diagnosis	Incapable of work		General remarks
	From	To		From	To	

✓ Note. This form should be printed on a stiff paper or thin cardboard as a pouch to hold other forms relative to the insured person's medical treatment.

Form M.C.6 (woman) should be the same as Form M.C.6 (man) but should make provision for recording the dates of confinement.

[Suggested size of pouch 25 x 20 cms]

Social Insurance Act

Medical Record

Name of Insured Person Insurance
Number

--	--	--	--	--	--	--	--	--	--

Date of Birth Dispensary

..... Date of first
examination

For completion by nurse

Height /Other data as
Weight necessary/.....
Occupation
Temperature
Pulse rate
Dates of subsequent examinations,

For completion by doctor

Diagnosis of morbid Whether morbid condition
condition due to accident

Whether capable or If incapable, dates of
incapable of work certificates of
incapacity issued

In the case of a pregnant
woman expected date
of confinement
date of
confinement

	Initially	Subsequently (with dates)		
Treatment recommended				
Pharmaceutical products prescribed				

General remarks (e.g. specialist examination, or hospital in-
patient treatment advised, changes in diagnosis, etc.)

Social Insurance Act

To Dispensary

re

Address

Insurance
Number

--	--	--	--	--	--	--	--	--	--

This insured person is receiving medical care at this dispensary at present, but the name of your dispensary is shown on his identity card. Will you please be good enough to forward Form M.C.1 and any other medical papers which may be in your possession relative to him.

Signed

..... Dispensary

Date

To Dispensary

Form M.C.1 and other medical papers herewith.

Signed

.....Dispensary

Date

[Suggested size 20 x 15 cms]

Form M.C.7.

Social Insurance Act

To Dispensary

re

Insurance
Number

--	--	--	--	--	--	--	--	--	--

The attached medical papers relate to emergency medical treatment given to the above-named insured person, who is understood to have been assigned to your dispensary. The insured person has been advised to attend at your dispensary for any further treatment which he may need.

Signed

.....Dispensary

Date

[Suggested size 15 x 15 cms]

Social Insurance Act

Re

Insurance Number

--	--	--	--	--	--	--	--

Record Section.

The above named person, who has applied here for medical care, has produced his identity card showing that he has been assigned to this dispensary, but we have no trace of the receipt of Form M.C.1 in respect of him.

Will you please forward Form M.C.1 for him accordingly.

Signed
..... Dispensary
Date

To Dispensary

Form M.C.1 herewith.

Signed
Record Section
Date

⌈ Suggested size 15 x 15 cms ⌋

Form M.C.9.

Social Insurance Act

Applicant for Medical Care without Identity Card

Full Name of Applicant Dispensary
Address Insurance Number, if
..... quoted on Form M.C.3

--	--	--	--	--	--	--	--

Date of Birth Name of Employer
Particulars of current Employer's
or last employment. From to Registration Number
Form R.4 attached/not attached (delete as necessary)

A. Index Section Will you please refer to the insured person's index and either confirm the insurance number quoted above, or trace the correct number and complete Part B. If there is no trace, please complete Part C and delete Part B.
Signed
..... Dispensary
Date

B. Record Section Insurance Number

--	--	--	--	--	--	--	--

 refers.
Dispensary shown on Index Slip, Form R.8.
Will you please prepare and attach Form M.C.1 and Form R.6, delete Part C and D and pass this form to the Dispensary.
Signed
Index Section
Date

C. Registration Section No trace in Insured Person's Index.
Will you please register, and prepare the usual Forms R.6, R.8, R.9 and M.C.1.
Form R.8 should be sent to this Section but the other form should be left attached to this form.
Signed
Index Section
Date

D. Record Section Insurance Number

--	--	--	--	--	--	--	--

 allotted.
Forms R.4 and R.9 should be detached for normal action.
Forms R.6 and M.C.1 should be left attached to this form.
Signed
Registration Section
Date

E. Dispensary Insurance Number

--	--	--	--	--	--	--	--

 refers Forms M.C.1 and R.6 herewith allotted
Signed
Records Section
Date

F. Inspector Will you please see the employer and advise him of the insurance (in new number and at the same time check that compliance is in order. registra-
tion cases)
Signed
..... Dispensary
Form M.C.10. Date

Social Insurance Act

To

Insurance
Number

--	--	--	--	--	--	--	--	--	--

..... Dispensary

You should attend this dispensary for further medical
examination on

Signed

Date

Form M.C.11.

[Suggested size 10 x 15 cms.]

First Medical Certificate of Incapacity for Work

To Mr. Insurance
Mrs. Number []
Miss

I certify that I have examined you today and that in my
opinion you are incapable of work by reason of

*In my opinion you will be fit to resume work today/tomorrow/
on

Doctor's signature

Date

Any other remarks by Doctor:-

*To be deleted if incapacity is likely to continue for at least a week.

Form M.C.12.

[Suggested Size 15 x 15 cms.]

Note. This form might be combined with Form S.17

SOCIAL INSURANCE ACT

Serial Number

--

Intermediate Medical Certificate
of Incapacity for Work*

Mr. Insurance
To Mrs. Number

--	--	--	--	--	--	--	--

Miss

I certify that I have examined you today and that in my
opinion you are incapable of work by reason of
.....
and have remained so incapable since the date of the last certi-
ficate of incapacity which was given to you.

Doctor's signature

Date

Any other remarks by Doctor:-

.....
.....

*If insured person will be fit for work within a week this
certificate should not be used, but a Final Certificate (Form
M.C.12.B) should be given to him.

Form M.C.12.A

[Suggested size 15 x 15 cms.]

[Note. This form and Form S.1A might be combined]

SOCIAL INSURANCE ACT

Serial Number

--

Final Medical Certificate of Incapacity for Work

Mr. Insurance
To Mrs. Number

--	--	--	--	--	--	--	--	--	--

Miss

I certify that I have examined you today and that in my
opinion you are incapable of work by reason of
.....
and have remained so incapable since the date of the last
certificate of incapacity which was given to you.

In my opinion you will be fit to resume work today/
tomorrow/ on *

Doctor's signature

Date

Any other remarks by doctor:-

.....
.....

* The date to be entered here must not be more than six days
after the date of examination.

Form M.C.12.B. [Suggested size 15 x 15 cms.]

[Note. This form and Form S.1A might be combined]

Social Insurance Act

Reference of Insured Person to a Hospital
for Examination and Treatment

Insured person..... Insurance number

--	--	--	--	--	--	--	--	--	--

I. To the Hospital.

I have seen the insured person named above and in my view he needs:

(a) to be examined and treated by a specialist*;

(b) to receive in-patient treatment*;

for the following reason

.....
.....
.....

I shall be glad to have a report as to the action taken.

Signature of Doctor.....

..... Dispensary

Date.....

* Delete whichever is inapplicable

II. To Dr.....

.....Dispensary

The insured person named above has been seen and

*(a) has been found to be suffering from.....
and instructed to return to your Dispensary for treatment accordingly;

*(b) is receiving treatment at this hospital as an out-patient for
.....; he appears to be capable* of work;
incapable

*(c) has been admitted for treatment as an in-patient of this hospital
suffering from.....: I will notify you of the date
of his leaving hospital as soon as he is discharged.

Signed.....

* Delete whichever is
inapplicable

For the.....Hospital.

Form M.C.13.

Date.....

Social Insurance Act

X-Ray or other Laboratory Examination

Name of insured Insurance
person Number 

Please arrange for the above-named person or the attached
specimen, to be examined as follows:

.....

.....

.....

Signature of Medical Officer

Date

Laboratory Report

Signed

Date

SOCIAL INSURANCE ACT

Prescription Form

Serial Number

.....Dispensary

Name of

Insured person

Insurance

Number

I Prescription

For Record Purposes Only

Signature of Doctor

Date

II. Prescription dispensed

Signature of Dispenser

Date

Social Insurance Act

Medical Stores Stock Sheet

Dispensary

Item Serial Number
in Drug List

MINIMUM LEVEL OF STOCK

Receipts		Stock in Hand			Consumption	
Quantity received	Date of receipt	Quantity at end of month	Date	Supply requisitioned serial No.	Quantity	During month of

Social Insurance Act

Serial Number
of Order

Order for Medical Stores
(To be completed in triplicate)

To: From: Central Medical Store
..... Social Insurance Board
.....

I. Please supply drugs as listed below according to the Standard Drug List.

Signed
Stores Clerk

Countersigned
Medical Officer
in charge of stores

Date

Item No. in Drug List	Quantity required	Item No. in Drug List	Quantity required	Item No. in Drug List	Quantity required

II. Drugs as ordered supplied herewith.

Signed

Date

III. Drugs received.

Signed

Medical Officer
in charge of stores

Date

IV. Accounts Division,

For necessary action.

Social Insurance Act

Requisition for Medical Stores
(To be completed in duplicate)

..... Dispensary

Serial Number
of Requisition

I. To the Central Medical Store

Will you please supply this dispensary with drugs as listed below.

Signed
Dispenser

Countersigned
Medical Officer
in charge of dispensary

Date

Item No. in Drug List	Quantity required	Item No. in Drug List	Quantity required	Item No. in Drug List	Quantity required

II. Drugs as requisitioned herewith.

Signed
Stores Clerk

Date

III. Drugs received.

Signed
Medical Officer
in charge of dispensary

Date

Part VI

Section C.2.

Sickness Benefit Forms

- S.1. Claim for Sickness Benefit - First Certificate.
- S.1A. Claim for Sickness Benefit - Intermediate or Final Certificate.
- ✓S.2. Claim for Increase of Benefit in Respect of Dependants.✓
- S.3. Certificate by Employer in Support of Benefit Claim by Employee.
- S.3A. Certificate by Employer of Return to Work of Employee.
- S.4. Reference for Independent Medical Examination.
- S.4A. Report on Independent Medical Examination.
- S.5. Sickness Benefit Claim - Action Sheet.
- S.5A. Sickness Benefit - Continuing Claim.
- S.6. Sickness Benefit - Hospital Treatment Case.
- S.7. Notification to Dispensary of Approaching Termination of Title to Cash Benefit.
- S.8. Cash Benefit History Sheet (MAN).
- S.8A. Cash Benefit History Sheet (WOMAN).
- S.9. Local Office Action Sheet.
- S.10. Notification to Record Section of Award of Cash Benefit.
- S.10A. Notification to Record Section of Termination of Cash Benefit.
- S.11. Notification of Reduction in Rate of Benefit.
- S.12. Cash Benefit Index Slip.
- S.13. Cash Benefit File.
- S.13A. Request to Another Local Office for Benefit File.
- S.14. Cash Benefit Payment Schedule.
- S.14A. Suspense Schedule.
- S.15. Authorisation to Cashier to Pay Benefit.
- S.16. Authorisation of Insured Person to Pay a Representative.
- S.17. Sickness Visitor's Report.
- S.18. Notification of Decision on Appeal - Disallowed.
- S.18A. Notification of Decision on Appeal - Allowed.

SOCIAL INSURANCE ACT

Claim for Sickness Benefit

First Medical Certificate

Insurance
Number

--	--	--	--	--	--	--	--	--	--

I residing at
(Name in full)
hereby state that I was certified on to be incapable
of work and I claim sickness benefit accordingly.

I was last employed as at the establishment
of and finished work there
(Name of Firm)
at a.m./p.m. on

I declare that the information given above is true to the best
of my knowledge and belief.

Signature of
Insured Person

Date

Impression of
Right Thumb

--

Form S.1.

[Suggested size 15 x 15 Cms]

[Note. This form might be combined with Form M.C.12]

SOCIAL INSURANCE ACT

Claim for Sickness Benefit

Intermediate or Final Medical Certificate

Insurance
Number

--	--	--	--	--	--	--	--	--	--

Iresiding at.....
(Name in full)

hereby declare that, because of incapacity for work, I have not
worked since the date of my last claim for benefit, and I now
claim benefit accordingly.

Signature of
Insured Person

Date

Impression of
Right Thumb

--

/Suggested size 10 x 15 Cms/

Form S.1A.

/Note. This form might be combined with Form M.C. 12A and with
Form M.C. 12B/

SOCIAL INSURANCE ACT

Claim for Dependant's Benefit

Insurance
Number

--	--	--	--	--	--	--	--

I residing at
who have claimed benefit, hereby apply
for an increase of benefit in respect of the following persons:

	Name in Full (Block Capitals)	Residing at	Place of Birth	Date of Birth		
				Day	Month	Year
Wife						
Children 1.						
2.						
3.						
4.						

Date of Marriage

Place of Marriage

I hereby declare that the information given above relates to
my wife and children who live with me and are dependent on me for
their support. This information is true to the best of my know-
ledge and belief.

Signature of Insured Person

Date

Impression of
Right Thumb

--

[Note. This form will not be needed unless
specific increases of benefit are to be
provided for dependants.]

Social Insurance Act.....

Certificate by Employer in Support of Benefit
Claim by Employee

To:(Name of Firm) From:
.....
.....(Address) Office of Social
Insurance Board

Employer's Registration No. Date

Will you please furnish the information requested below with regard to the
employment of
address

Insurance number

--	--	--	--	--	--	--	--

who has claimed benefit and is understood to
have been employed in your establishment up to
as

Signed:.....

Social Insurance Board

To the Social Insurance Board

This is to certify that the insured person named above:

- (a) has been employed in this establishment continuously from
to a week; during which he was paid wages at
- (b) has been absent from work on account of incapacity
pregnancy continuously since the
latter date;
- (c) has been or will be paid wages at the rate of a week during
the period of absence from work up to and including (insert
the last date for which wages will be paid if absence continues); and
- (d) has had contributions paid in respect of him since the
last monthly period for which a monthly contribution roll was forwarded
by me.

I certify that the above statements are true to the best of my knowledge
and belief and I assume full responsibility as to their correctness. I also
undertake to notify the Social Insurance Board within 24 hours on Form S.3A of
the return of the employee to my employment.

IMPORTANT. Employers who furnish
incorrect information with regard
to their employees render them-
selves liable to serious penalties.

Form S.3.

Signed.....
Designation.....
Employer's Stamp.....
Date.....

To the Social Insurance Board From (Name of
firm)

..... (Address)

• • • • •

..... (Employer's
Registration
No.)

Name of insured person

Insurance number

With reference to Form S.3 completed by me on

I hereby inform you that the above-named employee returned to his employment with this firm on 196 ..

Signed

Resignation

Stamp of firm

Date

IMPORTANT: Employers who furnish incorrect information with regard to their employees render themselves liable to serious penalties.

SOCIAL INSURANCE ACT

Reference for Independent Medical Examination

Reference by Dr.....Dispensary
..... Social Insurance Office
(Delete whichever is not appropriate)

Particulars of Case: Insured Person's Insurance
Name Number

--	--	--	--	--	--	--	--	--	--

Address
.....

Date of Birth Nature of Occupation

Certified to be incapable of work by reason of
.....

during period from Date of last
certificate

Particulars of earlier periods of incapacity within last 12 months.	From	To	Cause of incapacity
	1.		
	2.		
	3.		

Any other relevant
details including
reason for refe-
rence,

To Dr.

You are requested to examine the above-named patient and to
furnish a report on Form S.4A. as to his capacity for work.

Signed..... }
.....Dispensary. } Delete
.....Social In- } as
 surance Office } nece-
 sary.

SOCIAL INSURANCE ACT

Report on Independent Medical Examination

Dr....., Dispensary
To.....
.....Social Insurance Office
(delete as necessary)

Name of Insured Person Insurance
Date of Examination Number

--	--	--	--	--	--	--	--	--	--

I have examined the above named person and in my opinion
.....*

Add any further remarks (e.g. as to diagnosis, further medical
examination - this would apply chiefly to references by Medical
Officers)
.....

A copy of this report has been sent to the Social Insurance
Office/Dispensary.

Signed
Date

Form S.4A.

*NOTE: The report should be framed as far as possible in
standard terms so that there should be no
misunderstanding as to its meaning, e.g.:

- (a) He is incapable of work.
- (b) He is not incapable of work.
- (c) He is incapable of work at present, but I
should like to see him again in weeks
time, if he has not before then been certified
to be fit for work.
- (d) He is incapable of performing his normal
occupation but I think that in view of his age
and experience he is capable of work as a
..... at once/after a period
of training.
- (e) He did not attend for examination for the
following reason (if any is given).....
..... - if no reason is given, insert
"NONE".

If this is done it will help in the preparation of
statistics as to the general results of the examination
arrangements as well as indicating the course of
future action/

[Suggested size 15 x 20 Cms)]

Social Insurance Act

Sickness Benefit Claim - Action Sheet

Name of Insured Person Insurance Number

--	--	--	--	--	--	--	--	--	--

Date of Birth

Date of commencement of incapacity

I. Record Section

Attached for consideration is a claim for sickness benefit on Form S.1. made by the above-named insured person. Forms are also attached.

Form S.3. has been sent to the insured person's last employer.

Signed

..... Dispensary

Date

II. Social Insurance Office

- A. It has been confirmed that this person had satisfied the contribution condition for the receipt of sickness benefit at the date of commencement of incapacity as shown above.
- B. It has not been confirmed that this person has satisfied the contribution condition for the receipt of sickness benefit. According to the information received he was only employed in insurable employment during weeks within the 26 weeks immediately preceding the date of commencement of incapacity as shown above.

Signed

Record Section

Date

Delete A or B whichever
does not apply

/Suggested size 20 x 15 cms.7

Form S.5.

Social Insurance Act

Sickness Benefit - Continuation Claim

Name of Insured Person Insurance Number

--	--	--	--	--	--	--	--	--	--

To Social Insurance Office

Attached for consideration is a continuing claim for sickness benefit on Form S.1A. made by the above-named insured person.

The person has been instructed to apply to your office for payment on

Signed

..... Dispensary

Date

[Suggested size 10 x 15 cms]

Form S.5A.

Social Insurance Act

Sickness Benefit - Hospital Treatment Case

I. To the Hospital
Re. (Insured Person)
Insurance Number

--	--	--	--	--	--	--	--	--	--

Home Address

Delete (a) or
(b) whichever is
inapplicable

With reference to Form M.C.13 completed by Dr.
on In respect of the above-named person, it is noted that the
insured person (a) is receiving treatment as an out-patient at the hospital and appears
to be incapable of work; (b) has been admitted for treatment as an in-patient.

As no claim for sickness benefit has yet been made by the insured person, will you
please be so good as to arrange for him to complete the enclosed Form S.1 and return
the form to this office as early as possible.

This claim will in due course be referred to the local Social Insurance Office at
..... and, if the person will be unable to attend at
that office to receive payment of benefit, will you please ask him whether he wishes to
nominate a relative to attend there to receive payment on his behalf.

Signed
..... Dispensary
Date

II. To the Dispensary
Form S.1 completed herewith.

Delete the two which
are not appropriate

- A. The patient will be able to attend the local office to receive payment of benefit.
- B. The patient will not be able to attend the local office to receive payment, and he
does not wish his benefit to be paid to any other person.
- C. The patient will not be able to attend the local office and he desires payment of the
benefit to be made to

..... of
(Name) (Address)

who is his
(Relationship to insured person)

Signed
..... Hospital
Date

Social Insurance Act

Notification of Terminal Date of Cash Benefit

Name of Insured Person Insurance Number

--	--	--	--	--	--	--	--	--	--

To Dispensary

The above-named insured person is at present in receipt of
sickness benefit.
maternity

His title to this benefit will, in the absence of unfore-
Her seen circumstances, end on

Signed

..... Local Insurance Office

Date

/Suggested size 10 x 15 cms7

Form S. 7

Social Insurance Act

Cash Benefit History Sheet (MAN)

I. Name of Insured Person

Insurance
Number

--	--	--	--	--	--	--	--	--	--

Date of Birth

II.

Sickness Benefit Periods

Began	Ended	Nature of Incapacity	Duration		Special Notes
			Weeks	Days	

III. Funeral Grant Paid. Date of Death

[Suggested size 15 x 15 cms]

Form S.8.

[Note. In view of the extent of the use to which this form will be subject, it should be printed on fairly stout paper.]

IV.

Employment Injuries

A.

Injury Benefit Periods					Disablement Pensions		
Began	Ended	Duration		Special Notes	Percentage Disability	From	Special Notes
		Weeks	Days				

B.

Survivors' Pensions			
Date of death	Changes in Dependency		
	Date	Addition	Deduction
Pension awarded from			
For			
.....			
.....			
.....			

Social Insurance Act

Cash Benefit History Sheet (WOMAN)

I. Name of Insured Person Insurance

Number

--	--	--	--	--	--

Date of Birth

II.

Sickness Benefit Periods

Began	Ended	Nature of Incapacity	Duration		Special Notes
			Weeks	Days	

III.

Maternity Benefit

Date of Expected Confinement	Actual Date of Confinement	Benefit Paid			
		From	To	Duration	
				Weeks	Days

IV. Funeral Grant paid. Date of death

[Suggested size 15 x 15 cms]

[Note. This form should be a different colour from the Man's Form S.8. See also note on Form S.8 as to material].

Form S.8A.

Social Insurance Act

Sickness Benefit

Local Office Action Sheet

Insurance Number

--	--	--	--	--	--	--	--	--	--

Name of (Mr. _____
insured (Mrs. _____ Local Social
person (Miss _____ Insurance Office

Date of Birth

1. Date of commencement of incapacity
2. Cause of incapacity
Has Form E.2 been received? /Enter Yes or No
3. Date of receipt of claim
4. (a) Normal rate of wages or wage group /per week
(as shown on Form S.5) per month
- (b) Wages paid during absence from work /per week from
(as shown on Form S.3) per month to
5. Contribution condition satisfied /Enter Yes or No
 If not, number of weeks of employment in the
 qualifying period?
 Claim disallowed. Form A.8A sent on
6. If incapacity commenced before date of claim is explanation for delay
 in claiming satisfactory? /Enter Yes or No
7. Claim allowed as from
 after allowing for waiting period to
 Record Section notified on Form S.10 on
8. Rate of Benefit allowed.

* If the rate of wages paid exceeds the full rate of benefit otherwise payable, no payment of benefit will be due and Form A.10A should be issued.

Full weekly rate as determined on rate of wages	
Less: weekly rate of wages paid during sickness* Adjustment during hospital period	
Net rate of benefit due	

Prepared by Date

Checked by Date

9. Date of termination of title to sickness benefit

10. Record of Payments

Period of Benefit				Weekly rate of Benefit	Amount Payable	Prepared by	Checked by	Entered on Benefit Schedule Number
From	To	Weeks	Days					

11. Particulars of any changes affecting title to or rate of benefit, [e.g. cessation of period of entitlement, considered to be no longer incapable of work, disqualified under the rules for receiving benefit for a certain period, person enters or leaves hospital, or payment of wages by employer discontinued.]

.....

Delete as necessary { New rate of benefit a week
 { Disqualified for period to
 { Claim disallowed as from
 { termination of entitlement on

Form S.11, A.10, A.10A or A.10B sent
 (delete three not appropriate)

12. Record Section notified on Form S.10A of termination of benefit, including cases where person becomes capable of work before entitlement ends.

Signed

Checked.....

Date

Social Insurance Act

Notification of Allowance of Cash Benefit

Name of Insured Person Insurance
Number

--	--	--	--	--	--

Record Section

Benefit has been allowed in the case of this person
as follows:-

Delete
as
Necessary {
 { Sickness Benefit as from
 { (Waiting daysto)
 { Maternity Benefit as from
 { Funeral Grant. Date of Death

Signed

.....Local Office

Date

Form R.9. noted

.....

Record Section

Date

[Suggested size 15 x 15 cms]

Form S.10.

Social Insurance Act

Notification of Termination of Cash Benefit

Name of Insured Person Insurance
Number

--	--	--	--	--	--	--	--	--	--

Record Section

With reference to Form S.10 sent on, title to
benefit ended on for the following reason.

.....
In sickness cases, nature of incapacity.....
Code number

signed

.....Local Office

Date

Form R.9. noted

.....

Record Section

Date

/Suggested size 10 x 15 cms/

Form S.10A.

Social Insurance Act

To Insurance
..... Number

--	--	--	--	--	--	--	--	--	--

With reference to your claim for benefit,
the full rate of benefit otherwise payable to you has been
reduced as from by a week because
.....

✓insert reason, e.g. you are in receipt from your
employer of a week during your absence from
work, or you have been under treatment in hospital
since that day✓.

(Signed)

for the Social Insurance Board

Date

✓Suggested size 15 x 15 cms✓

Form S.11.

Social Insurance Act

Cash Benefit Index Slip

Name of Insured Person Insurance
Number

--	--	--	--	--	--	--	--	--	--

Address Sex M/F
.....

Benefit file sent to Local Office
on

/Suggested size 10 x 15 cms/

To be folded
along this line

<u>Surname</u> (Block Capitals)	Mr Mrs Miss Insurance Number
Other Names (In full)	Stamp of Local Insurance Office
<p style="text-align: center;">[Suggested size <u>when folded</u> 15 x 20 cms]</p>	

Form S.13

[Note. This is the design of the outside of the benefit pouch referred to in the note following paragraph 673. On the inside of each half there should be a pocket to hold the benefit claim papers/

Social Insurance Act

Application for Benefit File

Name of Insured Person Insurance
Number

--	--	--	--	--	--	--	--	--	--

To Local Insurance Office

Will you please forward to this local office the Benefit
File in respect of the above-named person, from whom a benefit
claim has been received in this office.

(Signed).....

.....Local Insurance Office

Date

To Local Insurance Office

Benefit File herewith

(Signed)

..... Local Insurance Office

Date

✓Suggested size 15 x 15 cms✓

Social Insurance Act

Cash Benefit Payment Schedule.

..... Benefit

..... Local Office

Schedule

Number

Date of Preparation

of schedule

Number of Entry	Name of Insured Person	Insurance Number	Particulars of payment			Acknowledgment of Receipt of Amount Stated (Signature or thumbprint)	Remarks
			From	To	Amount		

Total

Payments issued as shown above

Signed.....

Cashier

Date

Suspense Schedule

..... Local Office

Schedule Number

Number of Entry	Name of Insured person	Insurance Number	Particulars of Payment			Acknowledgement of receipt (Signature or thumbprint)	Transferred from Schedule Number	Expiry date (8 weeks after date at A)	Remarks
			From	To (A)	Amount				
			Total paid			Payments made where specified above			

Date

Social Insurance Act

Note for cashier

Name of
Insured Person.....

Insurance
number

--	--	--	--	--	--	--	--	--	--

.....Benefit due

Amount

Schedule

Entry

Signed

Date

⌈Suggested size 10 x 15 cms⌋

Social Insurance Act

Authorisation to pay a Representative

Insurance Number

--	--	--	--	--	--	--	--

I hereby authorise you to make payment of
my benefit to
(name)
of
(address)
who is my
(state relationship)

Signature of
insured
person

Date

Impression of Right Thumb

Social Insurance Act

Sickness Visitor's Report

.....Local Insurance Office

Name of insured person

Insurance Number

--	--	--	--	--	--	--	--	--	--

Address

.....

Incapacity commenced

Cause of

Date of last certificate

incapacity

To the Sickness Visitor

It is desired that a sickness visit should be made to the above-named person for the following reasons:

.....
.....

Will you please furnish a report on the form below.

Signed

Date

Sickness Visitor's Report

Reply

1. Date and time of visit.
2. What was the insured person doing at the time
of the visit?
3. If he was working, what work was he doing?
4. What is his normal occupation?
5. When does he think he would be fit to resume work
for an employer?
6. Has he work to go to when he ceases to be
incapable of work?
7. (a) If he could not be seen because he was not at
home at the time of the visit, where was he?
- (b) Is there any reason to think that he was at
work at that time? If so, particulars of the
employment should be given, if known.
- (c) Is it possible that his absence from home might
retard or prejudice recovery?
8. Is he following the doctor's instructions as to
medicine, diet, rest, etc.?

Additional remarks as to the insured person's general condition:

.....
.....
.....

Signed

Sickness Visitor

Date

Social Insurance Act....

Notification of decision on appeal

To.....

Insurance
Number

--	--	--	--	--	--	--	--	--	--

Address

.....

.....

Enclosed herewith is a copy of the Local Tribunal's decision on your appeal, which, as you will see, has been disallowed.

Signed

.....Local Insurance
Office

Date

[Suggested size 10 x 15 cms]

Form S.18

Social Insurance Act....

Notification of decision on appeal

To.....

Insurance Number

--	--	--	--	--	--	--	--	--	--

Address

.....

.....

Enclosed herewith is a copy of the Local Tribunal's
decision on your appeal. As you will see your appeal has
been allowed to the extent.....
and accordingly you should.....
.....

Signed.....

..... Local Insurance
Office

Date.....

[Suggested size 15 x 15 cms]

Form S.18A

Section C.2.

Maternity Benefit Forms

- M.1 Certificate of Expectation of Confinement and Claim for Maternity Benefit.
- M.2 Certificate of Confinement.
- M.3 Maternity Benefit Claim - Action Sheet.
- M.4 Local Office Action Sheet.

Serial No.

Social Insurance Act

Certificate of Expectation of Confinement
and Claim for Maternity Benefit

To Insurance Number

--	--	--	--	--	--	--	--

I. I certify that I have examined you today and in my opinion you are pregnant and it is to be expected that your confinement will occur on day month year. In my opinion confinement care should be given in a maternity hospital*.

Any other observations by the
medical officer or midwife

Signature
Medical Officer/Midwife*

.....Dispensary

* delete as necessary

Date

II. I hereby claim maternity benefit in accordance with the certificate at I above.

I ceased work asat the establishment of on

I do not expect to receive any wages or salary from my employer in respect of the period for which benefit is claimed.

Signature
of claimant

Date

Impression of right thumb

Note: Maternity benefit cannot be paid for any period earlier than six weeks before the date of expected confinement as certified by the medical officer or midwife, nor can it be paid for any period prior to the date of the certificate at I above, or for any period during which you are working for an employer or for which you are in receipt of a wage or salary in excess of the rate of benefit to which you would otherwise be entitled.

Social Insurance Act

Certificate of Confinement

Serial No.

--

To Insurance Number

--	--	--	--	--	--	--	--	--	--

I certify that I assisted at your confinement which
occurred on

Signature

Medical Officer/Midwife

.....Dispensary

Date

Any other observations by the Medical Officer or Midwife

.....
.....
.....
.....

[Suggested size 20 x 15 cms.]

Social Insurance Act

Maternity Benefit Claim - Action Sheet

Name of Insured Person Insurance Number
Date of Birth
Expected date of Confinement
Claimant has been instructed to call at Local Office on
for payment.

I. Record Section

Attached for consideration is a claim for maternity benefit on Form M.1 made by the above-named insured person.

Form M.C.3 is also attached (delete as necessary).

Form S.3 has been sent to the insured person's last employer.

Signed

..... Dispensary

Date

II. Social Insurance Office

- Delete A or B which
ever does not apply
- A. It has been confirmed that this person will had have satisfied the contribution condition for the receipt of maternity benefit at the date six weeks before the expected date of confinement as shown above.
- B. It has not been confirmed that this person has satisfied the contribution condition for the receipt of maternity benefit. According to the information received she was only employed in insurable employment during weeks within the 52 weeks immediately preceding the date six weeks before the expected date of confinement as shown above.

Signed
(Records Section)

Date

Social Insurance Act

Maternity Benefit

Local Office Action Sheet

Insurance Number

--	--	--	--	--	--	--	--	--	--

Name of insured person Local Social
Insurance Office

Date of Birth

1. Expected date of confinement Actual date of
confinement

2. Date of cessation of work

3. Date of receipt of claim

4. (a) Normal rate of wages/per week
(as shown on Form S3) per month

(b) Wages paid during/per week
absence from work per month from to

5. Contribution condition satisfied/Enter Yes
or No

If not, number of weeks of employment
in the qualifying period

Claim disallowed. Form A.8B sent on

6. If benefit is claimed for period before date of
receipt of claim, is explanation for delay in
claiming satisfactory?/ Enter Yes
or No

7. Claim allowed for period from

Record Section notified on Form S.10 on

8. Rate of benefit
allowed

*If the rate of
wages paid exceeds
the full rate of
benefit otherwise
payable, no pay-
ment of benefit
will be due and
Form A.10A. should
be issued.

Full weekly rate as determined on rate of wages		Alteration during benefit period as from		
Less weekly rate of wages paid during absence from work* Adjustment dur- ing Hospital period				
Net rate of benefit due.				

Prepared Date

Form M.4.

Checked Date

9. Date of termination of title to maternity benefit
(to be inserted when actual date of confinement is known)

10. Record of payments

Period of Benefit				Weekly rate of Benefit	Amount Payable	Prepared by	Checked by	Entered on Benefit Schedule Number
From	To	Weeks	Days					

11. Particulars of any changes affecting title to or rate of benefit
[e.g. cessation of period of entitlement, disqualified under the
rules for receiving benefit for a certain period, person enters
or leaves hospital, or payment of wages by employer discontinued.]

.....
.....

Delete as necessary { (New rate of benefit a week
(Disqualified for period to
(Claim disallowed as from
(termination of entitlement on

Form S.11, A.10., A.10A. or A.10B. sent
(delete three not appropriate)

12. Record Section notified on Form S.10A of termination of benefit.

Signed

Checked

Date

Part VI

Section C.2

Employment Injury Benefit Forms

- E.1. Employer's Accident Book - Cover.
- E.1A. Employer's Accident Book - Page of Book.
- E.2. Employer's Report of Serious Accident.
- E.3. Employment Injury - Action Sheet.
- E.3A. Disability Pension - Action Sheet.
- E.3B. Survivor's Pension - Reference to Medical Tribunal
- E.4. Notification to Dispensary of Employment Injury Award.
- E.5. Application for Injury Benefit.
- E.6. Request for Medical Officer's Report.
- E.7. Disability Pension - Payment Schedule.
- E.8. Notification of Award of Disability Pension.
- E.8A. Notification of Award of Disability Gratuity.
- E.8B. Notification of Disallowance of Disability Pension Claim.
- E.8C. Notification of Disallowance of Survivor's Pension Claim.
- E.9. Instruction as to Subsequent Payment of Disability Pension.
- E.10. Claim for Survivors' Pension.
- E.11. Survivors' Pension - Payment Schedule.
- E.12. Notice of Awards of Survivors' Pension.
- E.12A. Instruction as to Subsequent Payment of Survivors' Pension.

Front of Book

Social Insurance Act ...

Employer's Accident Book

Note: In accordance with the Social Insurance Benefit Regulations each employer is required:

- (a) to keep an accident book in the form laid down by the Social Insurance Board, to enter therein particulars of each employment accident which occurs in his establishment, whether serious or not, as soon as practicable after the accident has occurred and, in token of the correctness of the particulars, to append his signature to the entry;
- (b) to preserve the accident book for a period of three years after the date of the last entry therein;
- (c) to submit in triplicate a notification to the Board on Form E.2 within 24 hours of each serious employment accident which occurs in his establishment, which causes either the death of an insured person, or an injury to an insured person as a result of which he is likely to be rendered incapable of work for a period of at least three days*; and
- (d) where an employment accident, although not immediately likely to render the injured insured person incapable of work for three days, subsequently renders him incapable of work for at least that period, to submit a notification of the accident to the Board as in (c) within 24 hours after it is clear that he has been or is likely to be rendered incapable of work thereby for at least three days.

* In cases of injury causing incapacity for work Form E.2 should be given to the insured person with Form M.3 so that he may present both forms together to the Social Insurance Dispensary. Where the insured person has died as a result of the injury Form E.2 should be sent direct to the Head Office of the Social Insurance Board.

IMPORTANT: Employers who do not comply fully with the requirements of the Rules with regard to the maintenance of accident books render themselves liable to serious penalties.

Form E.1

Page of Book

Social Insurance Act ...

Employer's Accident Book

Date	Time of Accident	Name of Injured Person	Social Insurance Number	Circumstances of accident	Serious (S) or non-serious (N.S.)	Date of Notification on Form E.2. to the Social Insurance Board	Signature of Employer

Form E.1.A

Social Insurance Act ...

Employer's Report of Serious Accident
to the Social Insurance Board

(To be sent in triplicate within 24 hours after the occurrence of each serious accident.)

[NOTE: Please read instructions on back of the Form.]

Name of Firm Employer's
Registration No. ...

Address

Telephone No.

I. (1) This is to certify that at a.m. on
p.m.
the day of 19

(name of employee) of
..... (address) Insurance number suffered
a serious employment injury as follows:
.....

(give brief description of nature and extent of injury)

(2) The circumstances of the accident were
.....

(give brief description as to how the accident occurred)

II. Employer's Observations
.....
.....

I certify that the above statements are true to the best of my knowledge and belief and I assume full responsibility as to their correctness.

Signature

Designation

Stamp of Firm

Date

Instructions as to Completion of Form E.2

1. A serious accident is defined as one which causes either the death of an insured person, or an injury to an insured person as a result of which he is likely to be rendered incapable of work for a period of at least three days. A form should also be sent if, although the insured person does not appear at first to have suffered a serious accident, it subsequently appears clear that he has been or is likely to be rendered incapable of work thereby for at least three days.
2. In cases of injury causing incapacity for work the form should be given to the insured person with Form M.3 so that he may present both forms together to the Social Insurance Dispensary. Where the insured person has died as a result of the injury the form should be sent direct to the head office of the Social Insurance Board.
3. A separate form should be completed in triplicate in respect of each insured person who was seriously injured as a result of the accident.
4. In Part II the following should be included:
 - (a) brief information on the cause of the accident (e.g. the machine by the operation of which the accident was caused);
 - (b) the names and addresses of witnesses; and
 - (c) in fatal cases, the date of death and any information available as to the dependants of the deceased person.

IMPORTANT: In signing the report the employer or his representative assumes full responsibility for the correctness of the information given therein. Employers who do not comply fully with the provisions with regard to the submission of accident reports or who furnish incorrect information in them render themselves liable to serious penalties.

Social Insurance Act

Employment Injury - Action Sheet

Name of Insured (Mr.

Person

(Mrs.....
(Miss

Insurance Number

--	--	--	--	--	--	--	--	--	--

Date of Birth Local Social Insurance Office

1. Date of commencement of incapacity

2. Cause of incapacity

3. Date of receipt of claim

4. (a) Normal rate of wages (as shown on Form S.5) per week
per month

(b) Wages paid during absence from work per week from to
(as shown on Form S.3) per month

5. Date of accident

(a) as shown on Form E.2) Any discrepancy between these

(b) as shown on Form E.5) dates must be investigated.

6. Is it agreed that (a) the insured person suffered an accident at work?)

(b) the work on which he was then engaged was insurable) answer

(c) the insured person's incapacity resulted from the accident) yes or no
at work?)

If the answer to any of these queries is "No" the claim should be refused and form A.10 should be issued.

7. Claim allowed as from

after allowing for waiting period to

Record Section notified on Form S.10 on

8. Rate of Benefit allowed

Full weekly rate as determined on rate of wages	
<u>Less</u> Weekly rate of wages paid during absence from work* Adjustment during hospital period	
Net rate of benefit due	

* If the rate of wages paid exceeds the full rate of benefit otherwise payable, no payment of benefit will be due and Form A.10A should be issued.

Prepared by Date

Checked by Date

- 9 (a) Date of termination of title to injury benefit
(b) Date ten weeks before date of termination

10. Record of Payments

Period of Benefit				Weekly Rate of benefit	Amount Payable	Prepared by	Checked by	Entered on Benefit Schedule No.
From	To	Weeks	Days					

11. Particulars of any changes affecting title to or rate of benefit, (e.g. cessation of period of entitlement, considered to be no longer incapable of work, disqualified under the rules for receiving benefit for a certain period, person enters or leaves hospital, or payment of wages by employer discontinued).

.....
.....

(New rate of benefita week

Delete as { Disqualified for periodto
necessary { Claim disallowed as from
(termination of entitlement on

Form S.11, A.10, A.10A, or A.10B sent (delete three not appropriate)

12. Record Section notified on Form S.10A of termination of benefit, including cases where person becomes capable of work before entitlement ends.

Signed
Checked
Date

Social Insurance Act
Disability Pension - Action Sheet

1. Name of Insured (Mr. Insurance
Person { Mrs. Number

--	--	--	--	--	--	--	--	--	--

(Miss

Date of Birth Local Social
Insurance Office

1. Date of Accident
2. Injury Benefit paid from to
3. Does Medical Certificate on Form E.6 indicate) answer
that insured person is still suffering } yes or
disability as a result of the accident? } no

II. Clerk to Medical Tribunal

Case submitted for consideration by Medical Tribunal of
claim for disability pension. Relative papers are attached.

Signed
.....Local Office. Date.....

III. Local Office

Medical Tribunal's decision on Form A.16 is attached.

Signed
(Clerk to Medical Tribunal)
Date.....

IV. Cash Benefits Section

Relative claim papers herewith for consideration.

Signed
.....Local Office. Date.....

V. Local Office

Delete the two items which are not applicable.

(A. Award of disability pension agreed.
(
(1) Pension should be paid at the rate of a month
from calculated as follows
.....
The case should be submitted to the Medical Tribunal again
on
(
(ii) Gratuity of should be paid to the insured person.
This amount has been calculated as follows
.....
(
(B. Disability pension claim should be disallowed on the ground that
(.....
(.....
(

Signed
Cash Benefits Section

Date

VI.

Delete the two items which are not applicable.

(A. Form E.7 prepared for payment of pension and Forms E.8 and S.16 sent to insured person.
(
(B. Form E.8A sent to insured person. Gratuity paid
(
(C. Form E.8B sent to insured person disallowing claim.

Signed

Checked

..... Local Insurance Office

Date

Social Insurance Act

Notification to Dispensary of Employment

Injury Award

Name of Insured

Person

Insurance Number

--	--	--	--	--	--	--	--	--	--

To.....Dispensary.

The above-named insured person has now been awarded employment injury benefit.

*Form S.7 sent to you on should therefore be cancelled.

Signed

..... Local Insurance Office

Date.....

[Suggested Size 15 x 15 Cms.]

Form E.4

* Delete this sentence if it is not appropriate.

Social Insurance Act

Application for Injury Benefit

Insurance Number

--	--	--	--	--	--	--	--

I residing at
(Name in full)

..... hereby state that

my incapacity is due to an accident which I suffered on

at $\frac{\text{a.m.}}{\text{p.m.}}$ in the following circumstances.....

when employed as by

.....
(name of Firm)

and I claim injury benefit accordingly.

I declare that the information given above is true to the best of my knowledge and belief.

Signature of insured
person

.....

Date

Impression
of right
thumb

Social Insurance Act

Request for Medical Officer's Report

Name of Insured

Person Insurance Number

--	--	--	--	--	--	--	--	--	--

To Dr.....,Dispensary FromSocial Insurance
Office

Date.....

This person has been certified by you to have been incapacitated
since by reason of
which has been accepted as having been due to an employment injury.
As his title to injury benefit has ended or will shortly come to an end
the question of his future title to disability pension is being considered.

Would you please be so good as to answer the following questions
with regard to the case, after you have next examined the insured person:

Question	Reply
In your opinion	
1. is the insured person's earning capacity at present affected as a result of the accident which happened on?	
2. if so, do you consider that his earning capacity is likely to be permanently so affected?	

Will you please add any general observations
which may have a bearing on the matter.

Signed
Medical Officer

Date

Social Insurance Act

Notice of Award of Disability Pension

To Insurance Number

--	--	--	--	--	--	--	--	--	--

.....

Sir,

Enclosed herewith is a copy of the Medical Tribunal's decision with regard to your claim for a disability pension.

In accordance with that award you will be entitled to receive a pension of with effect from..... payable monthly in advance. This amount is calculated as follows:

Will you please call at this office to receive the first payment on If you are unable to come to this office, the enclosed Form S.16 should be completed nominating some other person to receive the payment on your behalf.

You, or your nominee, must bring this form and your identity card (Form R.6) when application is made for payment.

Signed

.....Local Insurance Office

Date.....

[Suggested Size 20 x 15 Cms.]

Social Insurance Act

Notice of Award of Disability Gratuity

To
.....

Insurance Number

--	--	--	--	--	--	--	--	--	--

Sir,

Enclosed herewith is a copy of the Medical Tribunal's decision allowing your claim for a disability award.

As the degree of your loss of earning capacity has been assessed at less than 20 per cent., you are entitled to receive a disability gratuity of, in full settlement of your claim. This amount is calculated as follows:
.....

This sum will become payable to you on, and you should call at this office on that date to receive the payment.

You must bring your identity certificate (Form R.6) when you come to receive payment.

Signed

..... Local Insurance Office

Date

[Suggested Size 20 x 15 Cms.]

Form E.8A.

Social Insurance Act

Notice of Disallowance of Disability

Pension Claim

To Insurance Number

--	--	--	--	--	--	--	--	--	--

.....

Sir,

Enclosed herewith is a copy of the Medical Tribunal's
decision on your claim for a disability pension.

Your claim has been disallowed for the following reason

.....
.....

Signed.....

.....Local Insurance Office

Date

[Suggested Size 15 x 15 Cms.]

Social Insurance Act.....

Notice of Disallowance of Survivors'
Pension Claim

To
.....

Deceased Person's
Insurance Number

--	--	--	--	--	--	--	--	--	--

Your application for a survivors' pension cannot be allowed because the Medical Tribunal has decided that the death of was not the result of an employment injury.

A copy of the Medical Tribunal's decision is enclosed.

Signed

.....Local
Insurance Office

Date

[Suggested Size 15 x 15 cms.]

Social Insurance Act
Instruction as to Subsequent Payments of
Disability Pension

To Insurance Number

--	--	--	--	--	--	--	--	--	--

.....

Sir,

The next payment of your disability pension becomes due on Will you please call at this office to receive payment on that date, bringing with you this form and your identity certificate.

If you are unable to come yourself, you should complete Form S.16 nominating some other person to receive the payment on your behalf. He should bring this form, Form S.16 and your identity certificate with him.

Signed

..... Local Insurance Office

Date

[Suggested Size 20 x 15 Cms.]

Form E.9

Social Insurance Act

Claim for Survivor's Pension

Name of Deceased

Insured Person

Insurance Number

--	--	--	--	--	--	--	--

Date of Birth Date of Death

I. To the Social Insurance Board

* Delete the inappropriate alternative I declare that I am the widow/person having charge of the children of the above named insured person who died on as a result of an injury received on in the course of his employment by
He was* in receipt of injury benefit* prior to his death
was not disability pension

The following particulars relate to myself/to the children.

Description	Name	Father's Name	Mother's Name	Date of Birth	Place of Birth	Date of Marriage to Deceased
Widow*						
Children 1						-
2						-
3						-
4						-

* If the claim is made by the person having charge of the child, particulars of the wife, and the date of the decease (if known) should be given here.

I attach the following birth and marriage certificates:

.....
.....
.....
.....

I declare that the information given above is true to the best of my knowledge and belief and I claim survivor's pension accordingly.

Signed

Name in Full.....
(Block letters)

Full address

.....

Impression of
right thumb

--

Date

For Official Use Only

II. Information obtained with regard to the circumstances of the death of the insured person

Signed

.....Local Insurance Office

Date

III. Cash Benefit Section

Claim papers herewith for consideration of survivor's pension claim.

Signed

.....Local Insurance Office

Date

IV. Local Office

Decision on claim for survivor's pension.

A. Claim allowed. Pension of a month payable from
Rate calculated as follows

B. Claim disallowed following reference to Medical Tribunal on Form E.3A.

C. Claim disallowed for the following reason

Signed

Cash Benefit Section

Date

V. A. Form E.11 prepared for payment of pension and Form E.12 sent to applicant for pension.

B. Form E.8C sent to applicant with Form A.16A disallowing claim on

C. Form A.18 sent to applicant disallowing claim on

Signed

Checked

.....Local Insurance Office

Date

Social Insurance Act

Survivor's Pension - Payment Schedule

Name of Deceased

Insured Person Insurance Number

..... Local Insurance Office

Survivor's pension ofa month awarded with effect from
..... to of

Persons covered by award

Name	Date of birth	Relationship to deceased	Date when title will cease

Period of payment		Amount Payable	Checked	Receipt for payment (signature or thumbprint)	Date of payment	Remarks
From	To					
			Total of payments at end of 12 months			

Social Insurance Act

Notice of Award of Survivor's Pension

To Registered
..... Number
.....

Madam,

Your application for a Survivor's Pension has been
admitted and a pension of has
been awarded to you with effect from
payable monthly in advance.

This amount is calculated as follows
.....

Will you please call at this office on
to receive the first payment, bringing this form with
you.

Signed

.....Local Insurance Office

Date

[Suggested Size 20 x 15 Cms.]

Social Insurance Act
Instruction as to Subsequent Payments
of Survivor's Pension

To
.....

Registered
Number

Madam,

The next payment of your survivor's pension becomes
due on

Will you please call at this office to receive payment
on that date, bringing this form with you.

Signed

.....Local Insurance Office

Date

[Suggested Size 10 x 15 Cms.]

Section C 2

Funeral Grant Forms

- F.1 Claim for Funeral Grant
- F.2 Funeral Grant Claim - Action Sheet
- F.3 Notification to Record Section of
Death of Insured Person
- F.4 Record of Employment
- F.5 Notification to Record Section of
Allowance of Funeral Grant Claim
- F.6 Notice of Award of Funeral Grant

Social Insurance Act

Claim for Funeral Grant

Name of Deceased Insurance
Insured Person Number

--	--	--	--	--	--	--	--

Date of Birth Date of Death

To the Social Insurance Board

I declare that I am the deceased
(insert relationship, if any;
if none, insert "not related to")
insured person named above, and I have paid * am liable to pay the amount of
the funeral expenses.

- I attach herewith* (a) a copy of the certificate of the insured person's death;
(b) his identity card (Form R.6);
(c) a receipt for the amount of the funeral expenses which I have paid;
(d) details of the amount of the funeral expenses which have not yet been paid.

* Items which are not applicable should be deleted.

I claim funeral grant in respect of the insured person's death.

Signed

Name in full
(Block Letters)

Full address

.....

Date

Impression of Right Thumb

Note. If you have any difficulty, the local Social Insurance Office will help you to complete this form.

Social Insurance Act

Funeral Grant Claim - Action Sheet

Name of Insured (Mr.
Person (Mrs. Insurance
(Miss Number

--	--	--	--	--	--	--	--

Date of death

Name of Claimant

Address of Claimant

I. Record Section

Attached for consideration is a claim for Funeral Grant (Form F.1) completed in this dispensary, together with a copy of the certificate of death, the deceased person's identity card, and the following documents

.....

(any information relative to the claim which has been given by the applicant should also be noted here)

According to the records in this dispensary the deceased person was entitled to medical care up to the date of his death. (Delete any part of this statement which is not applicable.)

Signed

..... Dispensary

Date

II. Record Section

Please see Form F.4 attached. Will you please confirm that the insured person was entitled to medical care immediately prior to his death.

Signed

.....Social Insurance Office

Date

III. Social Insurance Office

- Delete A
or B,
whichever
does not
apply
- A. It has been confirmed that the contribution condition for entitlement to medical care immediately prior to death was satisfied.
- B. According to the information received the deceased person was only employed in insurable employment during weeks within the 26 weeks immediately preceding the date of death.

Signed

..... Record Section

Date

IV. For completion by the Local Office

- (a) Title to medical care satisfied/Enter Yes or No.
If not, number of weeks of
employment in qualifying period
Claim disallowed. Form A.8C sent on
- (b) Deceased person's identity card received
/Enter Yes or No.
If not, what reason was given for its absence?
.....
- (c) Copy of certificate of death received
/Enter Yes or No.
If not, what alternative evidence
of death was given?
- (d) Funeral Expenses amounting to
paid /Enter Yes or No.
If not paid, why not and what evidence has been
given as to the amount of the expenses?
.....
- (e) Claim allowed. Amount payable
Entered on Benefit Schedule Number F. ...
- (f) Form F.6 sent to claimant on
- (g) Form F.5 sent to Record Section on

Part IV

Completed by Date
Checked by Date

Social Insurance Act

Name of Insured

Person

Insurance

Number

--	--	--	--	--	--	--	--	--	--

Record Section

Please note that information has been received that
the insured person named above died on

Signed

..... Dispensary

Date

Form R.9 noted

.....

Record Section

Date

[Suggested size 20 x 15 cms.]

Form F.3

Social Insurance Act

Funeral Grant

Name of Deceased Insurance
Insured Person Number

--	--	--	--	--	--	--	--	--	--

Date of Death

Record of deceased person's employment within 26 weeks prior to death

(a) as shown on his identity card (Form R.6)

From	To	Employer's Registration Number

(b) As furnished by applicant

From	To	Rate of Pay	Employer's Name	Registra- tion No.

Date Completed by
..... Local Insurance Office

Social Insurance Act

Notification of Allowance of Funeral Grant

Name of
Insured
Person Insurance
Number

--	--	--	--	--	--	--	--

Date of Death

Record Section

Funeral Grant in respect of the death of the above named
person has been paid to

Address

Signed

..... Local Office

Date

Form R.9 noted

.....

Record Section

Date

[Suggested size 20 x 15 cms.]

Form F.5.

Social Insurance Act

Notice of Award of Funeral Grant

To
.....

Insurance Number
of Deceased
Person

--	--	--	--	--	--	--	--	--	--

Sir:

Your application for funeral grant in respect of the death
of has been allowed.

Will you please call at this office on
to receive payment of the grant, bringing this form with you?

Signed

..... Local Insurance Office

Date

[Suggested size 15 x 12 cms.]

Part VI

Section C.3

Contribution Forms

- C.1 Contribution Card.
- C.2 List of Employers in local office area.
- C.2A Advice as to number of employees recorded on Form C.2 and record of first issue of stamps.
- C.3 Local office record of employer (Procedure A).
- C.3A Local office record of employer (Procedure B).
- C.4 Notice to employer as to purchase of insurance stamps.
- C.5 Application by employer for insurance stamps.
- C.6 Schedule of stamp sales by local office.
- C.7 Return of contribution card when employment ceases.
- C.8 Request by new employer for contribution card.
- C.9 Issue of contribution card to new employer.
- C.10 Request to former employer for return of contribution card.
- C.11 Application by employer for credit for lost or spoilt insurance stamps and cards.
- C.11A Register of applications on Form C.11.
- C.11B Notification to employer of allowance in respect of unused stamps.
- C.11C Notification to local office of allowance as on Form C.11C.
- C.11D Notification to employer of credit in respect of stamped cards referred to on Form C.11.
- C.11E Notification to employer of disallowance of application on Form C.11.
- C.12 Reference to Inspector for inquiry of employer.
- C.13 Schedule of Contributions for the Month.
- C.14 Notification of missing insurance numbers in the schedule of contributions.
- C.15 Request to employer for balance of contributions due.
- C.16 Advice to employer of credit for contributions paid in excess.

Draft of Contribution Card

Back

Outside of Card

Front

This card is the property of the Social Insurance Board
General Instructions

1. This card is for payment of Social Insurance Contributions only.
2. No undertaking can be given that any allowances will be made for the value of stamps on a card which is lost or destroyed.
3. If this card is found it must be handed in at a Social Insurance Office.

Instructions to Employers

4. Buy stamps regularly and only from Social Insurance Office.
5. You must hold a card for each of your employees. If you have no card for an employee, apply to the Social Insurance Office for one.
6. When you receive a card enter your registration number and the date employment commenced in the space on the front of the card.
7. Affix a stamp to the card for each week (beginning Monday) or part of a week during which the insured person is employed, unless a stamp has already been affixed for that week.
8. Affix stamps before wages are paid. The insured person's contributions may then be deducted from the wages, but cannot be recovered from him later.
9. Each stamp must be cancelled immediately after it is affixed to the card, by writing across it in ink (or with a metal die) the date on which it is affixed.
10. If the insured person leaves your employment before the end of the period of the card, enter the date of his leaving on the front of the card, see that the card is stamped up to that date, and send it at once to the Social Insurance Office.
11. At the end of the period of the cards, send the cards of all your employees properly stamped to the Social Insurance Office in one packet. New cards for use during the next period will then be sent to you.

Form C.1.

SOCIAL INSURANCE
CARD

INSURANCE
NUMBER

--	--	--	--	--	--	--	--

Period to

SURNAME
(BLOCK LETTERS)

Other Names
in FULL

ADDRESS
.....

CONTRIBUTION RATES TO BE
ENTERED HERE

Registration number of Employer	EMPLOYMENT		NOTED IN Social Insurance Office
	COMMENCED	ENDED	

Form C.1.

Left

Inside of Card

Right

Name of Insured Person

Insurance Number

--	--	--	--	--	--

DATE CANCEL ALL STAMPS

WARNING. Do not remove a stamp from this card. Any person who does so, or who buys or sells an insurance card, or a used stamp, or affixes a used stamp to an insurance card, is liable to a heavy penalty.

1	2	3	4	5	6
7	8	9	10	11	12
13	14	15	16	17	18
19	20	21	22	23	24
25	26	FOR OFFICIAL USE			

27	28	29	30	31	32
33	34	35	36	37	38
39	40	41	42	43	44
45	46	47	48	49	50
51	52	53			

--

THIS CARD MUST BE SENT TO THE SOCIAL INSURANCE OFFICE TO
BE EXCHANGED FOR A NEW ONE IMMEDIATELY AFTER
AND NOT LATER THAN

Notes with regard to the Draft Contribution Card (Form C.1.)

1. The stamp should be of sufficient size to be easily handled; probably about the size of a normal postage stamp, approximately 2 cms. by 1.7 cms. As to its design, see paragraph 1254(a).
2. The card should be of sufficient size to take 52 stamps on one side only - so that they can all be seen at once without turning the card over. Approximate over-all dimensions if stamp is size suggested at 1.23 cm. by 16 cm.
3. The actual size may have to be determined in relation to employers' existing filing arrangements, e.g. for holding other documents in relation to their staffs.
4. The material of the card should be reasonably durable but at the same time capable of being folded in two to protect the stamps on the inner side. The gum on the stamps may dry, and the stamps may flake off if the cards rub against one another. (See also paragraph 1236.)
5. The arrangements of the weekly stamp spaces is capable of adjustment to suit any special circumstances, e.g. for the purposes of accounting. A provisional additional 53rd space is indicated for use in years which have 53 Mondays.
6. The stamp spaces are numbered on the draft, but it may be considered preferable to print the actual date of commencement of each week in its relative space. Other dates on the card have been left blank for completion when the cards are sent to print.
7. A "For Official Use" space has been provided, e.g. for entry of any necessary data, such as issue of new card, number of stamps affixed and noted in records.
8. The list and terms of instructions and the terms of the "Warning" note above the stamp spaces will depend on the provisions of the Contribution Regulations.
9. Although it means more work, it will be of assistance to the Social Insurance Office administration and to employers to have the name and insurance number entered on both sides of the card.
10. Note 7A Part V deals with certain matters relating to the exchange of cards which may affect their design.

Social Insurance Act

Local Office

Accounts Section

The total number of employees of the employers within the area of the local office named above is as follows:

..... employees in wage group
..... employees in wage group
..... employees in wage group.

Will you please send the necessary initial supply of insurance stamps to the local office accordingly.

signed

Contribution Section. Date

Stamps sent at
..... at
..... at

signed

Form C.2A

Accounts Section.

Date

[Suggested size 15 x 15 cms.]

Social Insurance Act

Record of Stamp Sales and Card Exchanges

Name of Firm

Local Office

Address

Registration No. of Employer

Telephone Number

Number of Employees as
shown on Form R.5

Nature of Business

(Where necessary provision should be made
for showing the number in each wage group)

Stamp Sales						Cards exchanged				
Date	Number	Amount	Date	Number	Amount	Date	Number	Amount	Date	Number
<p>[Note. This form should be printed as an index card or slip]</p>										

Form C.3

[Suggested size 15 x 20 cms.]

Social Insurance Act

Local Office Record of Employer

Name of Firm Local Office
Address Registration No. of Employer
Telephone No. Number of Employees as
shown on Form R.5
Nature of Business

Date of Inspector's Visit	Number of Employees	Notes with regard to Visit
<p>/Note. This form should be printed as an index card or slip/</p>		
<p>Form C.3A</p>		

/Suggested size 15 x 20 cms/

Social Insurance Act

To From
(Name of Firm)
(Address) Local Social Insurance Office
Date

I understand from the head office of the Social Insurance Board that your firm has been registered under the above-mentioned number.

As from....., when the Social Insurance Act comes into force, you will become liable to pay contributions in respect of your employees, by affixing insurance stamps to the contribution cards which have been issued to you.

Application for the insurance stamps should be made in duplicate on the enclosed Forms C.5 as and when you require them. When the form has been completed the two copies should be brought, together with the necessary money or cheque for the value of the stamps requisitioned, to this Office, where the stamps will be supplied and one copy of the form will be receipted and returned to you.

Further copies of the Form C.5 will be supplied to you on request.

I also enclose for your information a copy of Leaflet 3 which explains the duties of employers under the Social Insurance Act.

(Signed).....

for Social Insurance Board.

Form C.4.

/ Suggested size 15 x 12 cms /

Social Insurance Act

Application for Insurance Stamps
(to be completed in duplicate)

Date.....

Employer's Reference

To the Social Insurance Board

Will you please supply to the bearer insurance stamps as set out below:-

..... stamps at Total value

..... stamps at Total value

..... stamps at Total value

In return for which the bearer will furnish cash * for the amount
cheque
of

Signed.....

Name of Firm.....

Registration No.....

* Delete whichever is inapplicable

For official use only

I acknowledge the receipt of cash * to the value of
cheque

.....
for Social Insurance Board

Form C.5.

/ Suggested Size 15 x 12 cms /

Social Insurance Act

Amounts received in payment for insurance stamps

..... Local Office. Date

	Registration Number of Employer	Amount received
1.		
2.		
3.		
4.		
5.		
6.		
etc.		
	Total amount received	

Total agreed with value of stamps issued.

Signed Cashier.

Form C.6

[Suggested Size 25 x 15 cms]

Social Insurance Act.....

To the Social Insurance Board Local Office

.....

The enclosed contribution card for.....
.....Insurance Number

--	--	--	--	--	--	--	--	--	--

is returned as he left my employment on.....
His rate of wages at that date was.....a week

Signed.....

Name of Firm.....

Registration Number.....

Date

For Official Use only

Insurance card filed.

Intls.....Date.....

Form C.7.

[Suggested Size 15 x 10 cms]

Social Insurance Act

Request for Insurance Card

Date

To the Social Insurance Board Local Office Employer's Reference.....

•••••

Will you please send me the Insurance Card of.....
Insurance Number

--	--	--	--	--	--	--	--	--	--

 who entered my employment on.....
 His rate of wages is.....a week.

According to his Identity Card he was last employed by the employer whose Registration No. is.....on....."

Signed.....

Name of Firm.....

Registration No.

✓ This form should not be used if the employee has no Identity Card and cannot quote his Insurance Number. Instead he should be asked to complete Form R.4 which should be sent to the Social Insurance Board.

*If no date has been entered in the Identity Card enter "Date not shown".

Form C.8.

P.T.O.

[Suggested size 15 x 12 cms]

For Official Use only

Action	Intls.	Date
Contribution card traced and sent to new employer with Form C.9.		
Contribution card not traced, Form C.10 sent to former employer		
Contribution card received, and sent to new employer with Form C.9.		
Form C.8.		

Social Insurance Act

To Name of Firm..... From.....Local Office

Address.....

Registration Number..... Date

Your reference.

In reply to your request of.....I enclose
herewith the contribution card of.....

.....Insurance Number

--	--	--	--	--	--	--	--	--	--

Signed.....
for Social Insurance Board

Form C.9.

/Suggested size 15 x 10 cms/

Social Insurance Act

To Name of Firm..... From.....Local Office

Address.....

Registration Number..... Date

re.....

.....

..... Insurance Number

--	--	--	--	--	--	--	--	--	--

This insured person is understood to have left your employment on
.....but there is no trace of the receipt
of his insurance card in this office.

If the contribution card is still in your possession will you please
forward it with Form C.7.

Signed.....
for Social Insurance Board

Form C.10.

/Suggested Size 15 x 10 cms/

For Official Registered
Use Only Number of
Application

Social Insurance Act

Notice of Loss or Destruction of, or Damage to Contribution
Card, or Damage to Insurance Stamps

From: Name of Employer To the Social Insurance Board
Address

Registration Number

Reference

(delete parts which are not appropriate)

Part A

I give notice that on, the contribution cards for the
employees named in Part D below were lost, destroyed or damaged in the
following circumstances, while in my custody:

.....
.....

Part B

I give notice that on, insurance stamps
each of value were spoiled or rendered unfit for use
in the following circumstances, while in my possession:

.....

Part C

I enclose (enter number of stamped contribution
cards or insurance stamps enclosed) and I apply for credit to be allowed in
respect of insurance stamps as follows:

.....

I declare that the particulars I have given in Parts A, B and D of this
form are true to the best of my knowledge and belief.

Signed:

Employer

Date

Part D

Name of Employee	Insurance Number	Number and rate of insurance stamps affixed to card

Part E

For Official Use Only

Registered Number	Date	Name of Employer	Registration Number of Employer	Date (if any) of Reference to Inspector	Date of Settlement of Application	Remarks
1						
2						
3						
4						
5						
6						

Social Insurance Act

Registered
Number of
Application.....

To.....(Name of Employer) From the Social Insurance Board

.....(Address)

.....(Registration No.)

Your Reference.....

Date

Your application dated.....for credit in respect of spoilt
insurance stamps has been allowed and the local office at.....
has been authorised to issue to you on production of this form and without
payment.....insurance stamps of.....value.

Signed.....

Stamp of the
Social Insurance Board

/Suggested Size 15 x 12 cms/

Form C.11B.

Social Insurance Act

Registered
Number of
Application.....

To the Social Insurance
Local Office at.....

.....

Date

An application made by....., Registration No.....,
for credit in respect of spoilt insurance stamps has been allowed and the
employer has been advised to apply to you for the issue of.....
insurance stamps of.....Value.

You are accordingly authorised, on the production to you of Form C.11B,
to issue such stamps to the employer without payment.

After the stamps have been issued this form should be signed and filed
under the employer's Registration Number.

Signed.....

Stamp of the
Social Insurance Board

Stamps issued

Signed.....

.....Local Office

Form C.11C.

/Suggested Size 15 x 12 cms/

Social Insurance Act

Registered
Number of
Application

To (Name of Employer) From the Social Insurance Board

..... (Address)

..... (Registration No.)

Your reference

Date as postmark

Your application dated for credit in respect of lost or damaged contribution cards has been allowed to the extent shown in the schedule overleaf, and the individual record of each employee named therein has been noted accordingly. You will, of course, be liable for payment of contributions in respect of any periods of employment other than those quoted in the schedule.

This form should be retained by you for production on request.

Signed

Stamp of the
Social Insurance Board

Form C.11D

(Suggested size 20 x 20 cms)

Name of Employee	Insurance Number	Period		Contributions Credit	
		From	To	Number	Value

Form C.11D

Social Insurance Act

Registered
Number of
Application.....

To.....(Name of Employer) From the Social Insurance Board

.....(Address)

.....(Registration No.)

Your reference..... Date

Your application dated.....for credit in respect of.....
.....has received careful considera-
tion, but it is regretted that it has not been found possible to allow your
application.

Signed.....

Stamp of the
Social Insurance Board

Form C.11E.

Suggested Size 15 x 10 cms

Social Insurance Act

Reference to Inspector

Employer's Name Registration No.

Address

Telephone No.

To the Inspector

From Division

..... Local Office

(delete as necessary)

You are requested to visit the above-named employer and make enquiries and report to me with regard to the following matters:

/Add particulars on which enquiry is to be made, e.g.

1. The circumstances relating to the loss, damage or destruction of contribution cards or insurance stamps referred to on the attached Form C.11 and particularly in regard to
2. The failure of the employer to return his employees' contribution cards for the period ended, and to obtain new cards for use during the present period.
3. The failure of the employer to apply for any insurance stamps since7

Signed

Date

Social Insurance Act.....

Schedule of Contributions for the Month.....
(Period between..... and.....)

.....(Name of Employer) Registration No.

.....(Address)

Reference

I certify that the following is a full schedule of the ,
persons employed by this firm on....., and that the
information given with regard to their employment and wages is
correct.

Signature of employer
or stamp of firm

Date

Serial No.	Insurance Number	Name of Employee	Insured Wage	Employment Comm- enced	Ended	Remarks
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						

A: TOTAL OF INSURED SALARIES:
B: EMPLOYEES' CONTRIBUTIONS (% of A)
C: EMPLOYER'S CONTRIBUTION (% of A)
D: TOTAL AMOUNT OF CONTRIBUTIONS DUE
(B+C)

NUMBER OF EMPLOYEES
in respect of whom con-
tributions are being
paid according to this
form

Instructions for Completing the Schedule of Contributions
(Form C.13)

THE SCHEDULE SHOULD BE COMPLETED IN TRIPLICATE, IF POSSIBLE IT SHOULD BE TYPED; OTHERWISE IT SHOULD BE COMPLETED IN INK IN LEGIBLE WRITING. THE SECOND COPY WILL BE RETURNED TO THE EMPLOYER AND WILL SERVE AS A RECEIPT.

THE MONEY CORRESPONDING TO THE CONTRIBUTIONS DUE SHOULD BE SUBMITTED WITH THE SCHEDULE.

CONTRIBUTION PERIOD: STATE CLEARLY IN THE HEADING OF THE SCHEDULE THE CONTRIBUTION PERIOD COVERED. If wages are paid weekly, it is necessary to submit only one schedule for a period of four to five weeks in accordance with the standard calendar instructions issued by the Board.

IF MORE THAN THE FIRST PAGE IS NEEDED TO LIST ALL THE INSURED WORKERS, CONTINUATION SHEETS, DULY NUMBERED, SHOULD BE USED.

IF CONTRIBUTIONS IN RESPECT OF MORE THAN ONE CONTRIBUTION PERIOD ARE PAID AT THE SAME TIME, A SEPARATE SCHEDULE FOR EACH CONTRIBUTION PERIOD SHOULD BE COMPLETED.

DATA CONCERNING THE EMPLOYER: The name of the employer and his registration number should be clearly entered.

DATA CONCERNING THE EMPLOYEE: The names of the employees should be listed in the same order as that followed in the previous schedule, omitting the names of employees who have left insurable employment and adding at the end the names of employees whose employment commenced during the month. As regards the new employees please enter the date of commencement of employment in the appropriate column.

If an employee included in the schedule leaves his employment during the contribution month, insert the date of departure in the appropriate space. If an employee left his employment during the preceding month and no notification to this effect was included in the relevant schedule, his name should be repeated at the end of the present schedule, together with the date of termination of employment, without any mention of salary.

The insurance number of the employee should be accurately stated. When an employee enters employment without being able to present his insurance card he should be registered with the Board by means of Forms R.4 and R.5. If such forms have not been completed in respect of a worker who is listed in this schedule and whose insurance number is not known, they should be completed forthwith and attached to the schedule.

Enter carefully the total sum of insured wages in respect of employees included in the schedule and calculate the total employees' and employer's contributions by applying percentages ... and ... respectively to the total sum of insured wages.

ANY REMARKS OR ANY QUERIES AS TO THE WAY IN WHICH THIS SCHEDULE SHOULD BE FILLED SHOULD BE NOTED IN THE COLUMN RESERVED FOR "REMARKS".

(The most important statutory provisions concerning the collection of contributions, penalties, sanctions, etc., may also be reproduced on this form.)

1. The first part of the paper is devoted to a general discussion of the problem.

2. The second part is devoted to a detailed analysis of the results.

3. The third part is devoted to a discussion of the results in the context of the existing literature.

4. The fourth part is devoted to a discussion of the results in the context of the existing literature.

5. The fifth part is devoted to a discussion of the results in the context of the existing literature.

6. The sixth part is devoted to a discussion of the results in the context of the existing literature.

7. The seventh part is devoted to a discussion of the results in the context of the existing literature.

8. The eighth part is devoted to a discussion of the results in the context of the existing literature.

9. The ninth part is devoted to a discussion of the results in the context of the existing literature.

10. The tenth part is devoted to a discussion of the results in the context of the existing literature.

11. The eleventh part is devoted to a discussion of the results in the context of the existing literature.

12. The twelfth part is devoted to a discussion of the results in the context of the existing literature.

13. The thirteenth part is devoted to a discussion of the results in the context of the existing literature.

14. The fourteenth part is devoted to a discussion of the results in the context of the existing literature.

15. The fifteenth part is devoted to a discussion of the results in the context of the existing literature.

16. The sixteenth part is devoted to a discussion of the results in the context of the existing literature.

17. The seventeenth part is devoted to a discussion of the results in the context of the existing literature.

Social Insurance Act

To(Name of Employer) From the Social Insurance Board
.....(Address) Date
.....(Registration No.)
Your Reference

In the Contribution Schedule (Form C.13) for the month of
..... the social insurance number of the following
employees is missing:

Name of Employee	Social Insurance Number to be Stated by Employer
.....
.....
.....
.....
.....
.....
.....
.....
.....

Please return this form within a fortnight, duly completed with
the insurance numbers required. If these are not known please attach
the registration forms (Form R.4 and Form R.5) of those employees who
are unable to show their social insurance identity card.

(Signed)
for the Social Insurance Board

THE UNIVERSITY OF CHICAGO

PHYSICS DEPARTMENT

1963-1964

PHYSICS 201

LECTURE NOTES

BY

ROBERT A. FAY

AND

JOHN D. JOHNSON

CHICAGO, ILLINOIS

1964

CHICAGO, ILLINOIS

CHICAGO, ILLINOIS

Social Insurance Act ...

To (Name of Employer) From the Social Insurance Board
 (Address)
 Registration No. Date
 Your reference

From the information furnished by you on Form C.13, it appears that the total amount of contributions due from you for the period ended was

As, however, the total of the monthly payments made by you for that period only amounted to, I shall be glad if you will forward to this office a cheque for the balance of

The cheque should be crossed and made payable to the Social Insurance Board.

(Signed)
for the Social Insurance Board

Form C.15

[Suggested Size 15 x 15 cms]

[Suggested Size 15 x 15 cms]

Part VI

Section C.4.

Appeal Forms

Insurability Questions

- A.1. Application for decision by Social Insurance Board.
- A.2. Index record of application on Form A.1.
- A.3. Request for comment by interested persons on summary of the case.
- A.4. Certificate of appointment by the Social Insurance Board of person to hold an inquiry in regard to the application for decision.
- A.5. Notice of proposed hearing in regard to the application for decision.
- A.6. Notice that a question of law is to be referred to the Court.
- A.7. Covering letter accompanying the copy of the decision of the Social Insurance Board.

Benefit Questions

- A.8. Decision by Social Insurance Board on title to medical care.
- A.8A. Decision by Social Insurance Board - Contribution Condition for sickness benefit not satisfied.
- A.8B. Decision by Social Insurance Board - Contribution Condition for maternity benefit not satisfied.
- A.8C. Decision by Social Insurance Board - Contribution Condition for funeral grant not satisfied.
- A.9. Decision by Social Insurance Board as to cessation of entitlement to medical care.
- A.10. Disallowance by Social Insurance Board of claims for cash benefits, when period of entitlement ends.
- A.10A. Disallowance of claim by reason of receipt of wages.
- A.10B. Notice of disqualification because of breach of rules.

- A.11. Reference to Medical Tribunal of complaint about medical treatment.
- A.12. Insured person - appeal against decision on a benefit claim.
- A.13. Application for dispensary papers in connection with a medical care appeal.
- A.14. Notice of Tribunal Meeting to Chairman of Tribunal.
- A.14A. Notice of Tribunal Meeting to applicant for disability pension.
- A.14B. Notice of Tribunal Meeting to complainant about medical treatment.
- A.14C. Notice of Tribunal Meeting to medical officer.
- A.14D. Notice of Tribunal Meeting to medical member of Tribunal.
- A.14E. Notice of Tribunal Meeting to panel member of Tribunal.
- A.14F. Notice of Tribunal Meeting to appellant.
- A.14G. Notice to Social Insurance Board of hearing of appeal.
- A.14H. Notice of Local Tribunal Meeting to an interested person.
- A.15. List of cases for consideration at Tribunal Meeting.
- A.16. Decision of Medical Tribunal on disability pension question.
- A.16A. Decision of Medical Tribunal on survivor's pension question.
- A.17. Decision of Local Tribunal on an appeal.
- A.18. Disallowance of Survivor's Pension Application.

Social Insurance Act ...

For Official Use Only Registration No.
--

Form of Application for the Decision by the
Social Insurance Board of an Insurability Question

Important Note

Any person who desires to obtain the decision of the Social Insurance Board on any question as to -

- (a) whether the Social Insurance Act should be applicable to a particular establishment;
- (b) whether a certain person is or was employed under a contract of service as an employee or apprentice, or is to be treated as so employed;
- (c) who is or was liable for the payment of contributions as the employer of a certain insured person; or
- (d) at what rate contributions are or were payable by or in respect of an insured person;

must complete carefully Part A, B, C or D respectively of this form and also give in Part E any additional information relevant to the question, and send the form to the Social Insurance Board at

Part A Name of Establishment Employer's
Registration No. (if any)
Full Address of Establishment
.....
Number of persons employed in the establishment

I hereby apply for a decision as to whether the establishment named above should be an establishment to which the Social Insurance Act is applicable.

(signed)

Stamp of Firm

Date

Part B Name of person Insurance
No. (if any)

--	--	--	--	--	--	--	--	--	--

Address of person Date of birth
Name and address of Establishment at which he works

.....
Nature of work
By whom is work controlled
Date of commencement of work Date of end of work,
if terminated

I hereby apply for a decision as to whether the person named above was employed under a contract of service as an employee or apprentice, or is to be treated in accordance with the Contributions Regulations as so employed, since, or during the period to, while working at the establishment named.

(signed)

Address

Date

Part C Name of insured personInsurance

No.

--	--	--	--	--	--	--	--

Employed as at

.....(give name and address of place of work)

from to(if employment has ended)

Name of person by whom wages are paid

I hereby apply for a decision as to who is or was liable for the payment of contributions as the employer of the above-named insured person for the period since, or from to.....

(signed)

Address

Date

Part D Name of insured personInsurance

No.

--	--	--	--	--	--	--	--

Employed as by

.....(give name and address of establishment)

from to (if employment has ended)

Rate of wages.....

I hereby apply for a decision as to the rate of contribution payable in respect of the above-named insured person for the period since, or from to

(signed)

Address

Date

Part E To be completed in all cases

Please enter here any other details relating to the matter on which a decision is requested, and indicate particularly on what grounds it is considered that the advice already given to you may have been incorrect.

I declare that all the information given by me on this application is true to the best of my knowledge and belief.

(signed)

Form A.1.

Date

Social Insurance Act ...

Registration
No. of
Application

Application for Decision of Social Insurance Board

Application made by

Address

.....

Subject of question raised

.....

.....

Summary of Decision

.....

Form A.2. [Suggested size of Form 15 x 15 cms]

Social Insurance Act ...

Registration
No. of
Application

Application for Decision of Social Insurance Board

To From the Social Insurance Board
..... Date as postmark
.....

In the matter of an application made by
for a decision of the Social Insurance Board, with regard to
.....
the enclosed is a summary of the information which has so far been
furnished with regard to this matter:

As it appears that you are a person who is or may be
interested in this matter the Board would be glad if you would
furnish below your comments as to the correctness or otherwise
of this summary and any further information which you may be able
to give relative to the subject.

(signed)
for the Social Insurance Board

Comments and further information

I declare that all the information
given by me above is true to the best
of my knowledge and belief

(signed)

Date

Social Insurance Act ...

Registration
No. of
Application

Application for Decision of Social Insurance Board

..... is hereby appointed
in accordance with the Social Insurance Adjudication Regulations to
hold an inquiry into the question raised by
..... on

(Signed)

A person authorised to
sign on behalf of the
Social Insurance Board

Date

[Suggested size of Form 15 x 20 cms]

Form A.4

Social Insurance Act ...

Registration
No. of
Application

Application for Decision of Social Insurance Board

To
.....
.....

In accordance with the Social Insurance Adjudication Regulations, the Social Insurance Board has appointed
..... to hold an inquiry into the question raised by and this is to inform you that he proposes to hold a hearing with regard to the matter at on the day of, at

You should be present at the hearing and bring with you the following documents

.....
.....

(Signed)
for the Social Insurance Board

Date

[Suggested size of Form 20 x 20 cms]

Form A.5

Social Insurance Act ...

Registration
No. of
Application

Application for Decision by Social Insurance Board

To From the Social Insurance Board
..... Date as postmark
.....

In the matter of an application made by
for a decision of the Social Insurance Board, you are informed
that a question of law has arisen in connection therewith and
the Board have decided in accordance with the Social Insurance
Adjudication Regulations to refer the question to the Court for
decision.

(Signed)
for the Social Insurance Board

[Suggested size 15 x 20 cms]

Form A.6

Social Insurance Act ...

Registration
No. of
Application

Application for Decision of Social Insurance Board

To
.....
.....

Enclosed herewith is a copy of the decision of the Social Insurance Board with regard to the application made on
.....

If you are dissatisfied with the decision so far as it relates to any question of law, it is open to you, within 30 days of the date mentioned hereunder, to appeal against it to the Court. In all other respects the decision of the Social Insurance Board is final.

If you are in doubt as to whether any question of law arises in relation to this decision, you are entitled to ask to be supplied with a statement of the grounds of the decision.

(signed)

for the Social Insurance Board

Date

[Suggested size 15 x 20 cms]

Form A.7.

Social Insurance Act ...

To
.....

Insurance
Number

--	--	--	--	--	--	--	--

With reference to your application on for medical care, you are informed that you are not entitled to receive such care under the Social Insurance Act because you had not on that date been insurably employed during at least 13 weeks within the 26 weeks immediately preceding the date of your application and accordingly did not satisfy the condition for entitlement laid down in the Social Insurance Benefit Regulations.

(Signed)
for the Social Insurance Board

Date

[Suggested size 15 x 15 cms]

Form A.8

Social Insurance Act

To
.....

Insurance
Number

--	--	--	--	--	--	--	--

With reference to your application for sickness benefit as from you are informed that you are not entitled to receive such benefit under the Social Insurance Act because you had not been insurably employed during at least 13 weeks within the 26 weeks immediately preceding that date and accordingly did not satisfy the condition for entitlement laid down in the Social Insurance Benefit Regulations.

(Signed)
for the Social Insurance Board

Date

[Suggested size 15 x 15 cms]

Form A.8A

Social Insurance Act

To Insurance
..... Number

--	--	--	--	--	--	--	--	--	--

With reference to your application for maternity benefit as fromyou are informed that you are not entitled to receive such benefit under the Social Insurance Act because you had not been insurably employed during at least 26 weeks within the 52 weeks immediately preceding that date, and accordingly did not satisfy the condition for entitlement laid down in the Social Insurance Benefit Regulations.

(Signed)
for the Social Insurance Board

Date

[Suggested size 15 x 15 cms]

Form A.8B

Social Insurance Act

To Insurance)
..... Number of)

--	--	--	--	--	--	--	--	--	--

..... Deceased person)

With reference to your application for a funeral grant in respect of the death of you are informed that you are not entitled to receive such a grant under the Social Insurance Act because that person was not immediately prior to his death qualified to receive medical care under that Act and accordingly the condition for entitlement laid down in the Social Insurance Benefit Regulations is not satisfied in your case.

(Signed)
for the Social Insurance Board

Date

[Suggested size 15 x 15 cms]

Form A.8C

1. The first part of the document is a list of the names of the persons who were present at the meeting.

2. The second part of the document is a list of the names of the persons who were absent from the meeting.

3. The third part of the document is a list of the names of the persons who were present at the meeting, but who were not present at the previous meeting.

4. The fourth part of the document is a list of the names of the persons who were present at the meeting, but who were not present at the previous meeting.

5. The fifth part of the document is a list of the names of the persons who were present at the meeting, but who were not present at the previous meeting.

6. The sixth part of the document is a list of the names of the persons who were present at the meeting, but who were not present at the previous meeting.

7. The seventh part of the document is a list of the names of the persons who were present at the meeting, but who were not present at the previous meeting.

8. The eighth part of the document is a list of the names of the persons who were present at the meeting, but who were not present at the previous meeting.

9. The ninth part of the document is a list of the names of the persons who were present at the meeting, but who were not present at the previous meeting.

10. The tenth part of the document is a list of the names of the persons who were present at the meeting, but who were not present at the previous meeting.

Social Insurance Act ...

To

Insurance Number

--	--	--	--	--	--	--	--	--	--

.....

With reference to your application for medical care, you are informed that your title to receive such care under the Social Insurance Act will cease on

If you are of the opinion that this decision is wrong, it is open to you to appeal against the decision to the Local Appeal Tribunal at Any such appeal must be made in writing and should explain for what reasons you consider that the decision is wrong.

(signed)

for the Social Insurance Board

Date

[Suggested size 15 x 15 cms.]

Form A.9.

Social Insurance Act

To Insurance
..... Number

--	--	--	--	--	--	--	--	--	--

With reference to your claim for benefit, you are
informed that you are not entitled to receive such benefit beyond
to which date benefit has been paid, because
.....

/Insert reason, e.g. by that date you had received sickness benefit for 13 weeks,
or you had received maternity benefit for six weeks from the date of your
confinement, or as you returned to work on the following day, or after enquiry
it is considered that you are no longer incapable of work./

If you are of opinion that this decision is wrong, it is open to you to
appeal against the decision to the Local Appeal Tribunal at
Any such appeal must be in writing and should explain for what reasons you
consider that the decision is wrong.

(Signed)
for the Social Insurance Board

Date

Form A.10

/Suggested size 20 x 15 cms./

Social Insurance Act

To Insurance
..... Number

--	--	--	--	--	--	--	--

With reference to your claim for benefit, no payment of bonofit can be made to you at present as it is understood that your employer is paying you wages during the period of your absence from work at a rate which is not less than the rate of benefit to which you would otherwise be entitled.

If you are of opinion that this decision is wrong, it is open to you to appeal against the decision to the Local Appeal Tribunal at Any such appeal must be in writing and should explain for what reasons you consider that the decision is wrong.

(Signed)
for the Social Insurance Board

Date

Suggested size 15 x 15 cms.

Form A.10A

Social Insurance Act

To

Insurance Number

--	--	--	--	--	--	--	--	--	--

.....

With reference to your claim for benefit, it is considered that in accordance with the Social Insurance Benefit Regulations, payment of benefit must be suspended for a period ofweeks fromfor the following reason:-

Insert reason, e.g. you were engaged in remunerative work during the periodtofor which you claimed and received benefit, or you failed to submit yourself for medical examination when required to do so.

If you are of opinion that this decision is wrong, it is open to you to appeal against the decision to the Local Appeal Tribunal at Any such appeal must be made in writing and should explain for what reasons you consider that the decision is wrong.

(Signed)
for the Social Insurance Board

Date

Suggested size 20 x 15 cms

Form A.10B

THEORY OF THE EARTH

1.

The first part of the theory of the earth is the study of the origin and development of the earth.

The second part of the theory of the earth is the study of the structure of the earth.

The third part of the theory of the earth is the study of the distribution of the earth's resources.

The fourth part of the theory of the earth is the study of the history of the earth.

The fifth part of the theory of the earth is the study of the future of the earth.

The sixth part of the theory of the earth is the study of the present of the earth.

The seventh part of the theory of the earth is the study of the past of the earth.

The eighth part of the theory of the earth is the study of the future of the earth.

The ninth part of the theory of the earth is the study of the present of the earth.

The tenth part of the theory of the earth is the study of the past of the earth.

The eleventh part of the theory of the earth is the study of the future of the earth.

The twelfth part of the theory of the earth is the study of the present of the earth.

The thirteenth part of the theory of the earth is the study of the future of the earth.

The fourteenth part of the theory of the earth is the study of the present of the earth.

Case Number

Social Insurance Act

Complaint regarding Medical Treatment

Name of Insured Person

Insurance
Number

--	--	--	--	--	--	--	--	--	--

I. To the Clerk

..... Medical Tribunal

Will you please submit to the Tribunal for their consideration the attached papers relative to the complaint of the above-named insured person.

Signed

Appeals Section

Date

II. Appeals Section

This complaint has been considered by the Medical Tribunal and their findings thereon are as follows:

.....
.....
.....

Signed Chairman

..... (Medical Members

..... (of the Tribunal

Date

Form A.11

Suggested size 25 x 15 cms.

Social Insurance Act
Appeal Against Decision on Benefit Claim

To Name of Insured Person Insurance
Number

--	--	--	--	--	--	--	--

Address
.....

If you wish to appeal against the decision notified to you on Form
with regard to your claim for benefit, you should
complete the following statement, setting out clearly the grounds on which you
consider that the decision was wrong. A notice will be sent to you in due
course telling you when your appeal will be heard by the Local Tribunal.

Signed
for the Social Insurance Board

Date

To the Local Tribunal

I hereby give notice of appeal against the decision referred to above, because I
consider that it is wrong for the following reasons:

.....
.....

Signature of
Insured Person
Date

Impression of Right Thumb

Form A.12

[Suggested size 25 x 15 cms.]

Case Number

Social Insurance Act

Application for Dispensary Papers

Name of Insured Person Insurance
Number

--	--	--	--	--	--	--	--	--	--

To the Dispensary

The above-named insured person has stated that he wishes to appeal against the decision notified to him by you on Form A.9 that he is no longer entitled to receive medical care under the Social Insurance Act. Will you please be good enough to forward your papers with regard to the case (including Form M.C.5) showing for what periods he has been in receipt of medical care. The papers will be returned to you in due course.

Signed

Clerk to the Local Tribunal

Date

To the Local Tribunal

Relevant dispensary papers herewith.

Signed

..... Dispensary

Date

To the Dispensary

Papers returned herewith together with a copy of the Tribunal's decision for any necessary action.

Signed

Clerk to the Local Tribunal

Form A.13

Date

[Suggested size 20 x 15 cms.]

Social Insurance Act

Notice of Tribunal Meeting to Chairman of Tribunal

Sir,

As agreed I have issued notices of a meeting of the
Tribunal to be held on at a.m.
..... p.m.

I enclose herewith a list of the cases which are to be considered at the
meeting, and copies of the relevant papers.

Signed
Clerk to the Tribunal

Date

[Suggested size 15 x 12 cms.]

Form A.14

Social Insurance Act

Notice of Medical Tribunal Meeting

Mr.)
To Mrs.) Case Number
Miss)

This is to notify you that your application for disability^x pension has been
submitted by the Social Insurance Board to the
Medical Tribunal at and will be considered by that
Tribunal at a.m. on
p.m.

Will you please attend the meeting of that Tribunal a quarter of an hour
before that time and bring this form with you.

If for any reason you find that you will not be able to attend at that time
will you please notify me at once on the form below and let me know whether you
consent to the Tribunal dealing with your claim in your absence.

Signed

Clerk to the Tribunal

x Delete whichever does not refer

Date

To the Medical Tribunal

I shall not be able to attend the meeting at the time stated on this form
and I consent
do not consent to my claim being dealt with in my absence.

Signed

Date

[Suggested size 20 x 15 cms.]

Form A.14A

Social Insurance Act

Notice of Medical Tribunal Meeting

Mr.)
To Mrs.) Case Number
Miss)

This is to notify you that your complaint with regard to the medical treatment received by you will be considered by the Medical Tribunal sitting at on at a.m.
p.m.

Will you please attend the meeting of that Tribunal a quarter of an hour before that time and bring this form with you. If for any reason you find that you will not be able to attend at that time will you please notify me at once on the form below, giving your reasons.

The Tribunal is empowered to consider your complaint even if you are not present at the hearing, unless you have given them a reasonable explanation for your absence.

Signed
Clerk to the Tribunal

Date

To the Medical Tribunal

I shall not be able to attend the meeting of the Tribunal at the time stated on this form for the following reason:

.....
.....

Signed

Date

Form A.14B

Suggested size 20 x 15 cms.

Social Insurance Act

Notice of Medical Tribunal Meeting

To Dr. Dispensary Case Number

Sir,

A complaint which has been received from
Insurance Number [] [] [] [] [] [] [] [] with regard to medical treatment given by
you, is to be considered by the Medical Tribunal sitting
at on at a.m.
p.m.

A copy of the complaint is attached.

It would be of assistance to the Tribunal if you could attend the Tribunal meeting at that time in order to furnish them with your observations with regard to the complaint. If you will not be able to attend will you please sign the statement below and furnish any remarks which you may wish to make in the matter.

Signed
Clerk to the Tribunal

Date

To the Medical Tribunal

I shall not be able to attend the meeting of the Tribunal at the time stated on this form. My further remarks are as follows;

.....

.....

Signed
Medical Officer

Form A-14C

Date

[Suggested size 20 x 15 cms.]

Social Insurance Act

Notice of Medical Tribunal Meeting

Sir,

This is to notify you that a meeting of the Medical Tribunal will be held at on commencing promptly at
a.m.
p.m.

I enclose herewith a list of the cases which are to be considered at that meeting. Copies of the relevant papers will be available at the meeting.

If for any reason you find that you will not be able to attend, will you please notify me accordingly as early as possible in order that I may get someone else to take your place on the Tribunal.

Signed
Clerk to the Tribunal

Date

[Suggested size 15 x 12 cms.]

Form A.14D

[Suggested size 20 x 15 cms.]

Social Insurance Act

Notice of Local Tribunal Meeting

Mr.)
To Mrs.) Case Number
Miss)

This is to notify you that your appeal against the decision of the Social Insurance Board with regard to your title to benefit will be dealt with by the Local Tribunal sitting at on at ^{a.m.}
p.m.

Will you please attend at that address a quarter of an hour before that time and bring this form with you. You may, if you wish, be represented at the hearing by any other person not being a lawyer.

If for any reason you find that you will not be able to attend at that time will you please notify me at once on the form below, giving your reasons.

The Tribunal is empowered to determine your case even if you are not present at the hearing, unless you have given them a reasonable explanation for your absence.

Signed
Clerk to the Tribunal

Date

To the Local Tribunal

I shall not be able to attend the meeting of the Tribunal at the time stated on this form for the following reason:

.....
.....

Signed

Form A.14F

Date

[Suggested size 20 x 15 cms.]

Social Insurance Act

Notice to Social Insurance Board of
Hearing of Appeal

Case
Number

Sir,

The appeal of Insurance Number
is to be considered by the Local Tribunal sitting at
on at a.m.
p.m.

If you propose to be represented at the hearing will you please advise your representative, who should not be a lawyer, to attend at that address a quarter of an hour before the time stated above.

Signed
Clerk to the Tribunal

Date

Form A.14G

[Suggested size 15 x 12 cms.]

Social Insurance Act

Notice of Hearing of Appeal

Case Number

Sir,

As it appears to the Chairman of the Local
Tribunal that you may be interested in the case of
Insurance Number Address
he has asked me to let you know that the appeal is to be considered by the
Tribunal sitting at on
at a.m.
 p.m.

If you intend to be present at the hearing you should attend at that address a quarter of an hour before the time stated above.

Signed
Clerk to the Tribunal

Date

Social Insurance Act

List of Cases for Consideration

at Tribunal Meeting on

Name of insured person	Insurance number	Case number	Nature of benefit involved	Time fixed for hearing	Special notes

Social Insurance Act
Decision of Medical Tribunal

Case
Number

In regard to the claim for disability pension made by

..... Insurance Number

--	--	--	--	--	--	--	--	--	--

we have examined and questioned him and we find that } insert findings of
..... } fact material to
..... } the decision
..... }

and that (a) he has * suffered a loss of earning capacity as a result of an
has not employment injury;
(If the decision on (a) is "has not" the rest of the decision
should be deleted)

(b) that loss is * likely to be permanent;
is not

(c) the loss of earning capacity is assessed at per cent.;

(d) *this decision is final

*this decision is provisional and should be reviewed inmonths.

* Delete whichever is inapplicable.

Signed Chairman

.....(Medical Members

.....(of Tribunal

Date

Form A.16

Suggested size 20 x 15 cms.

