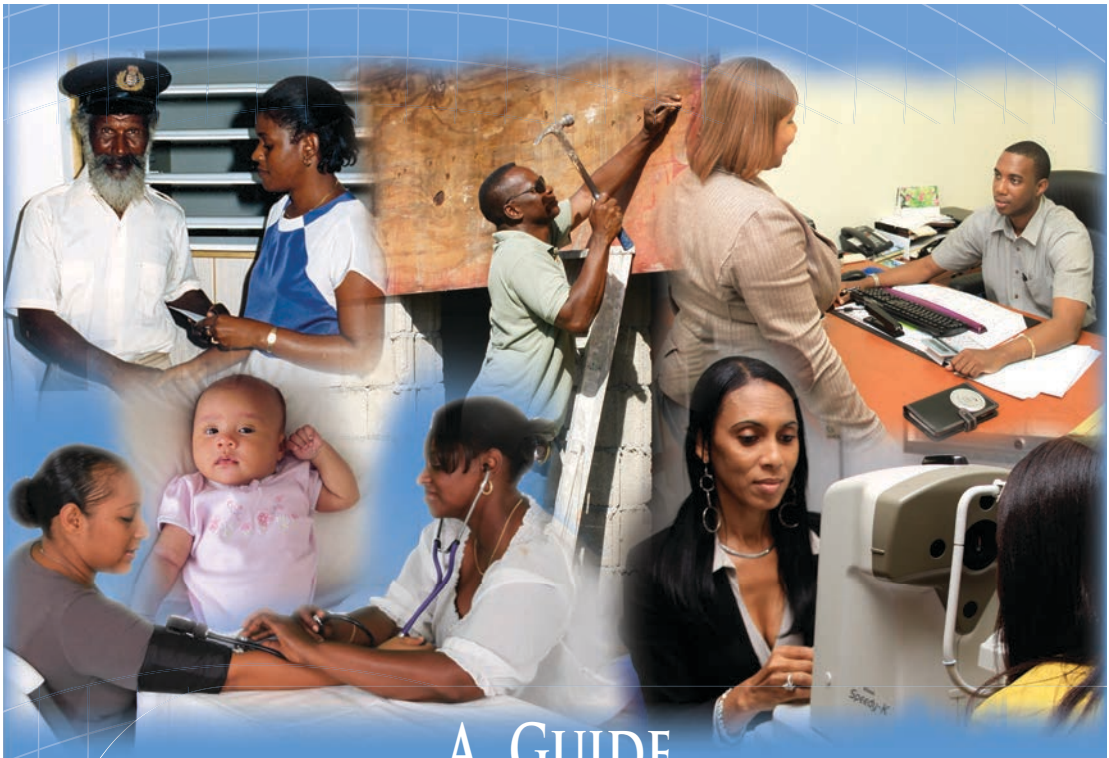

A Guide
for
Employers, Employees
and
The Self-Employed in Anguilla

ANGUILLA SOCIAL SECURITY BOARD

Improving The Quality Of Life For All

30th Anniversary Edition

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VISION:

The ASSB is an excellent, sustainable organization which has improved the quality of life for all through universal social security coverage.

MISSION:

The ASSB exist to improve the quality of life in Anguilla by providing meaningful social security to workers & beneficiaries and socio-economic development for our community.

We will achieve this by being customer-oriented, strategy-focused and technology-driven; with competent and committed staff, high standards of corporate governance and prudent financial management.

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INTRODUCTION

Social Security Board, Management and Staff

Improving the Quality of Life for All

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INTRODUCTION

Social Security in Anguilla is a compulsory insurance plan to which employers, employees and self-employed persons contribute. Social Security is designed to protect insured persons from financial distress by providing partial income replacement when insurable circumstances occur.

All employed persons between the ages of fifteen (15) and sixty five (65) years must be registered with, and contributing to, the Social Security Board. In return, employees and their families receive financial help when the following circumstances arise: Sickness, Maternity, Invalidity, Old Age, Funeral and Survivorship.

Social Security is everybody's business. It affects our daily life. Universally recognised as a basic human right, it makes a decisive contribution to establishing greater social justice, without which no lasting peace would be possible.

This booklet is intended as a general guideline for employers, their employees and the self-employed. While this booklet provides general guidelines, individual cases may vary. It does not seek to replace and is subject to the provisions of the Social Security Act (R.S.A. c. 545 and any Regulations made there under. If you have any further questions or need clarification on a matter that concerns you, please feel free to visit us at the Social Security Office.

Amendments to the Social Security Act have been passed to expand coverage to the self-employed. These changes came about as a result of requests from the self-employed public who wanted coverage under Social Security.

All forms referred to in this booklet can be acquired from the Social Security Office. All Benefit and Contribution Ceilings are as of date of publication. Please check with Social Security Office for any updates.

The booklet provides general guidance only and should not be treated as a statement of the law.

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Registration

Always quote your Social Security number in correspondence with the Social Security Office. This speeds identification.

If you change your name be sure to notify the Social Security Office. Quote your Social Security number and old and new names.

Make sure you claim your benefit within the times set out in Regulations, otherwise you may lose some or all of it.

If you lose this card you may have to pay to get another.

If lost or stolen contact the:
Social Security Office - Telephone: (264) 497-2201

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WHO IS AN EMPLOYER?

A person or body corporate with whom an employee has entered into a contract or service or apprenticeship expressed or implied whereby such person or body corporate is liable to pay salary, wages and other remuneration for services performed by the employee.

EMPLOYER REGISTRATION

The Social Security Law requires that Employers register and pay contributions on behalf of all employees, even if they employ one person on a part time basis only.

SOCIAL SECURITY ACT 1980

REGISTRATION OF EMPLOYER

NAME OF EMPLOYER .....

NAME OF BUSINESS .....

MAILING ADDRESS .....

TELEPHONE NO. (IF AVAILABLE) .....

LOCATION OF BUSINESS .....

NATURE OF BUSINESS .....

DATE OF FIRST EMPLOYMENT OF WORKER (S) .....

NUMBER OF INSURABLE PERSONS BETWEEN AGES 15 TO 65 .....

MALE ..... FEMALE .....

EMPLOYEES ARE PAID WEEKLY OR MONTHLY (CIRCLE APPROPRIATE ONE)

I DECLARE THAT THE INFORMATION GIVEN IS CORRECT.

SIGNATURE OF EMPLOYER ..... DATE .....

NOTES:

1. Every employer to whom Social Security Act and Regulations apply is required to register with the Director of Social Security within fourteen (14) days of the date on which he becomes, or again becomes, an employer.
2. Every person who subsequently ceases to be an employer, or changes his business address, must forthwith notify the director thereof.
3. Every employer must, as soon as he engages any person, ensure that the worker completes an application form (R3) for registration as an insured person unless the worker produces evidence that he is already registered.

R6 REVISED 2003

OFFICE USE ONLY

REGISTRATION NO. .....

SIGNATURE OF ASSIGNING OFFICER ..... DATE .....

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WHO IS AN EMPLOYEE?

A person who performs services under a contract of service or apprenticeship with an employer.

EMPLOYEE REGISTRATION

To register, an employee must submit his or her passport, birth/marriage certificate and all other relevant supporting documents where necessary (affidavit, deed poll, proof of citizenship. etc.) All documents presented must be original.

CONTRACT OF SERVICE

To determine the nature of any contractual relationship, the following factors must be examined.

1. Who is in control? That is who decides the things to be done, the means to be used to get it done; the time when and the place where it is to be done.
2. Who owns the tools or equipment?
3. Who has the chance to make a profit or a loss;
4. Whether or not the worker has a duty of fidelity, confidentiality and obedience to instructions;
5. How integral the worker's work is to the business; whether or not his work is part of the business (particularly for technical and professional workers.

A contract of service exists if someone agrees that in consideration for wages or other remuneration, he will provide his own work and skill in the performance of some service for another person. By so doing, he agrees expressly or implied, that in the performance of that service he will be subject to that person's control.

In the circumstances outlined above, a combination of these conditions normally exist:

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CONTRACT FOR SERVICE

1. The person (employee) is subject to the command of his employer as to the manner in which he does his work;
2. He/she personally has to provide the service;
3. He/she does not own the tools or equipment used (or only insignificant tools);
4. He/she has fixed hours of work;
5. He/she has a regular salary or regular commission;
6. He/she has no possibility of making a profit or loss;
7. He/she performs tasks that are integral to the operation of the business.

It should therefore be noted that a person who enters into a contract for a fixed time or a specific task may still be regarded as an employee once the previous conditions exist.

In the case where one or more of the above conditions do not hold in the contractual arrangement you may be considered as an independent contractor providing a service at a cost.

Independent contractors are obligated to register with the SSB as a self-employed person and make contributions on their own behalf.

EMPLOYEES' WAGES

The wages of an employee shall consist of all pecuniary emoluments paid to or on behalf of the employee including:-

- Overtime payments;
- Cost of living payments;
- Commission on profits
- Payments for night or shift work;
- Holiday pay or other amounts set aside out of the employee's remuneration throughout the year to be paid to him or her periodically.

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YOUR SOCIAL SECURITY NUMBER

Your Social Security Number is the key to ensuring that your earnings are accurately recorded during your working years. Other people may have the same name you have, but your Social Security number is yours alone. It singles out your Social Security record from over 10,000 others.

USING YOUR SOCIAL SECURITY CARD

Treat Your Card as an important document and protect it against loss or theft. Take your card with you when you get a new job, and make sure that your employer copies your name and number correctly. You should never rely on your memory when you provide your Social Security number.

Record Your Number elsewhere for safekeeping. If you lose your card you can obtain a new one at the Social Security Office for a fee, or if you change your name - through marriage for example - you should come to the Office with your old Social Security Card in order to get your records changed and obtain a new card with your new surname.

If You Ever Find you have more than one Social Security number, get in touch with the Social Security Office promptly, someone there will help you correct your records so that you will get full credit for all earnings reported for you.

IN THE YEARS AHEAD

It Is A Good Idea to check your Social Security record regularly to make sure your earnings have been correctly credited. This is especially important if you change jobs often. By all means check to make sure that your employer reports correctly, or you will end up the loser. Never permit your employer to escape his/her responsibility to pay your contributions, remember that they are being paid for you.

EMPLOYMENT OF PERSONS

Employees are reminded that it is an offence to employ any person who does not possess a Social Security Card.

Contributions

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SOCIAL SECURITY CONTRIBUTIONS

These are payable at the rate of 10% of wages with the employers having the right to deduct 5% from their employees' earnings. There are weekly and monthly ceilings beyond which no further Social Security Contributions are payable. Please enquire for current ceilings. A contribution is not payable for any week Monday - Saturday, the whole of which the employee receives Sickness or Maternity Benefit.

WHEN SHOULD EMPLOYEES BEGIN PAYING CONTRIBUTIONS?

Contributions should be payable in the case of an Employee attaining the age of fifteen (15) years for the week in which that person reaches that age

WHEN SHOULD EMPLOYEES CEASE PAYING CONTRIBUTIONS?

Contributions shall cease in the case of an Employee attaining the age of sixty five (65) years for the week in which the employed person reaches that age provided that the birthday does not fall on the Monday of the week in question. However if the 65th birthday falls on the Monday of the week in question, contributions are payable.

CONTRIBUTIONS DEADLINE

Payment must be made by the last working day of the month following the month in which wages were paid.

CONTRIBUTIONS SURCHARGE

Employers who fail to pay contributions on time must pay a surcharge of 5% and additional surcharge of 2% per month on outstanding amounts.

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NOTIFICATION OF TERMINATION

When an employee leaves the employ of his/her employer, then notification in writing of this should be promptly sent to the Social Security Office.

CONTRIBUTIONS PENALTY

An Employer's failure to pay contributions or to comply with any obligation imposed on him/her by the Regulations constitutes an offence and shall be liable on summary conviction to a fine of $1,000, and a fine of $250 for each day on which the offence is continued.

SOCIAL SECURITY BOARD
ANGUILLA

CONTRIBUTION RETURN FOR ..... 20.....

Employer No. _____

Name of Business: _____

Mailing Address: _____

_____

I certify that on the back hereof (and on _____ attached sheets) is a complete and accurate list of all persons employed by me/this business in insurable employment during the above month, I further certify that I have shown below full and accurate details of all adjustments made to the wages of employees in respect of periods of employment prior to the state of the month.

Signature of Employer or Agent _____ Date: _____

SUMMARY OF CONTRIBUTIONS PAYABLE

BALANCE owing at Start of Month (as per Social Security Statement)	$
PLUS: Contributions for the above month	$
Additional contributions due (see Adjustments below)	$
SUB-TOTAL	$
BALANCE OWING	$

ADJUSTMENTS
TO BE COMPLETED ONLY IN RELATION TO WAGES PAID FOR EARLIER MONTHS

Social Security Number	Full name of Inusured Person	Month/Week Commenced	DETAILS REPORTED		ACTUAL DETAILS		Extra Contrib	Refund Due
			Wages	Contrib	Wages	Contrib		

Office Use Only

Contributions of $_____

I certify that the contributions herein have been correctly posted.

Receipt No: _____ Fines of $ _____ Run No.

Date: / /

_____ Cashier

_____ Certifying Officer

FORM CR. 1(4/89)

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The Self-Employed

Improving the Quality of Life for All

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WHO ARE SELF-EMPLOYED PERSONS?

These are persons who:

- Are sixteen (16) years of age or over and under sixty five (65) years of age;
- Are ordinarily resident in Anguilla;
- Operate a business of their own;

Are gainfully occupied in employment and do not work under the control of an employer.

CATEGORIES OF SELF-EMPLOYED PERSONS

Often times the following persons are self employed:

- Professionals such as accountants, lawyers, doctors, architects, dentists, consultants, chemists and engineers.
- Persons engaged in their own business in commerce and trade whether as directors, owners, proprietors including owners of shops, or persons who independently provide service of all kinds.
- Farmers – agricultural or horticultural.
- Fishermen.
- Taxi-drivers.
- Street vendors and traders.
- Technicians and skilled workers – plumbers, electricians, shoemakers, carpenters, beauticians and barbers.

Other persons who offer their skills and services for pay and are not subject to the general direction and control of the recipient of the service as to how such are to be applied.

INSURANCE OF SELF-EMPLOYED PERSONS

Effective January 1, 2003, the Anguilla Social Security Board extended coverage to all self-employed persons.

REGISTRATION OF SELF-EMPLOYED PERSONS

All self-employed persons are required to register with the Social Security

Board on the appropriate registration form – Form SE 1 available at the Board's Office.

All registered persons will be assigned a Social Security Number and issued a registration card bearing their full name and registration number. You are responsible for the safe keeping of your registration card. If the registration card is destroyed, lost or defaced, the matter should be reported to the Social Security Office for replacement.

Your registration number is important. You will not be able to pay contributions to the system without it and you will need to quote your number when communicating with the Board's Office.

If you have been previously registered as an employed person under the Registration Regulations, the same registration number would be maintained for the purposes of registration as a self-employed person.

CONTRIBUTIONS

A self-employed person is liable to pay a contribution for each contribution week or part of a week that he/she is employed as a self-employed person.

No contribution is payable when the self-employed person reaches the age of sixty five (65).

If you work both as a self-employed and employed person in the same contribution week, you will not have to contribute as a self-employed person and therefore will be liable for payment of contributions as an employed person only.

HOW MUCH CAN A SELF-EMPLOYED PERSON ELECT AS A WEEKLY INCOME?

At the time of registration, the self employed person must select a category of income on which contributions will be paid. The following table is an example of a list of Categories of Income.

Category	Weekly Income EC$	Weekly Contribution EC$	Tick Selection
A	1250.00	100.00	
B	1000.00	80.00	
C	800.00	64.00	
D	600.00	48.00	
E	400.00	32.00	
F	200.00	16.00	

The category that is selected by the self-employed will be valid for one year. At the end of the year the self-employed person will have the opportunity to select a category immediately above or below the initial one selected. In all cases the category will be valid for the period chosen. Please enquire about current categories of income.

If no selection is made by the required time each year, the self-employed person will be expected to pay contributions based on the category selected in the previous year.

There are certain stipulations that apply to self-employed persons over the age of fifty five (55);

1. A self-employed person who is over the age of fifty five (55) years on the appointed day shall not elect a weekly income which exceeds eight hundred dollars ($800.00).
2. When an insured person who has paid contributions as a self-employed person reaches the age of fifty four (54), he/she will be liable to pay contributions on the same weekly income that was elected in the year of his or her 54th birthday for any subsequent years up to retirement.
3. If an insured person aged 54 or older has never paid contribution as a self-employed person he/she may elect a weekly income not exceeding $800.00. Having made the election, contributions will be paid on the same weekly income for any subsequent years up to retirement.

RATE OF CONTRIBUTION

The amount of contribution payable by the self-employed person for each contributory week in respect of his employment shall be 8% of the weekly

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income elected by him/her in accordance with the categories of income set out in the table on page 19.

WHEN AND HOW SHOULD CONTRIBUTIONS BE PAID.

CONTRIBUTION CERTIFICATE

ANGUILLA SOCIAL SECURITY BOARD
R.S.A.c.S45 LAWS
SELF-EMPLOYED CONTRIBUTION CERTIFICATE

THIS FORM IS TO ACCOMPANY ANY SELF-EMPLOYED CONTRIBUTION PAYMENT

1. Self-Employed Social Security No.

SE

2. Name and Address

3. Tel No:

4. Period for which contributions are being paid

	FROM DD/MM/YY	TO DD/MM/YY	WEEKLY INCOME ECS	No. OF WEEKS	WEEKLY CONTRIBUTION ECS	TOTAL AMOUNT ECS
CURRENT						
ARREARS						

OFFICIAL USE ONLY

Receipt No:

Date:

Cashier

OFFICIAL STAMP

CAUTION: ***It is an offense to provide false information.***

I certify that the above information is true and correct.

Signature of Self-Employed

Date

I certify that the contributions herein have been correctly posted.

Certifying Officer

Date

Contributions are due to be paid not later than fourteen days after the end of the calendar month.

FORM SE 2 *2002*

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Unlike the majority of insured persons who work for someone else and will have their earnings reported by their employer, self-employed persons must report their own earnings and pay contributions themselves.

Every self-employed person shall, within fourteen (14) days after the end of each calendar month, pay all contributions payable by him/her for that month.

If, during the course of the calendar month the employment of a self-employed person ceases or is interrupted because of sickness, change of employment status, or other circumstances which might affect his/her liability to pay contributions for the whole month, he/she shall nevertheless, be liable to pay contributions in respect of that part of the month during which he/she was self-employed, that is, up to the day immediately proceeding the date of cessation: provided that a self-employed person shall not be liable to pay contributions as a self-employed person in respect of any period which he/she is either in receipt of benefit, (with the exception of survivors) or is liable to pay contribution as an employed person.

With each payment of contribution, the self-employed person must complete and submit a Contribution Certificate – Form SE -2. Correct names and social security numbers are the keys to successful processing of contributions.

CONTRIBUTION DURING MULTIPLE EMPLOYMENT

A person who, during one part of the calendar year, is mainly employed as an employed person and for another part of that year is mainly employed as a self-employed person shall be liable to pay contributions respectively as an employed person and as a self-employed person for the relevant period. However if you are working as a self-employed and employed person at the same time, you are only required to pay as an employed person.

CONTRIBUTIONS SURCHARGE

An additional charge of 3% will be added to the amount of late contributions

for the first month or part of a month. For every additional month or part of a month that the late contribution remains unpaid, it shall increase by 1%.

NOTIFICATION OF TERMINATION OF SELF-EMPLOYMENT

Every self-employed person who terminates his employment as a self-employed must communicate such termination to the Board's Office not later than the end of the calendar month following that, which includes the date of termination of employment. To terminate your employment, please complete and submit Form SE 3 – "Termination as a Self-Employed." This form is available at the Social Security Office.

RIGHT TO BENEFIT

For the purpose of determining the right to benefit of any self-employed person, contributions paid under the regulations by him/her shall be taken into account for Sickness Benefit, Maternity Benefit, Old Age Pension, Disability Pension, Funeral Grant and Survivors' Benefit.

TIME TO SUBMIT CLAIM

A self-employed person shall submit a claim for sickness benefit to the Social Security Office not later than 6 months from the day on which his/her incapacity for work commenced.

PENALTY

A self-employed person's failure to pay contributions or to comply with any obligation imposed on him/her by the Regulations constitutes an offense and shall be liable on summary conviction to a fine of eight hundred dollars ($800.00) or imprisonment for a term of six (6) months or to both such fine and imprisonment.

Benefits

Improving the Quality of Life for All

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The Social Security System pays the following Short-Term and Long-Term benefits to eligible insured persons under the System. No person should receive sickness or maternity benefit and be working at the same time.

Short-Term Benefits

SICKNESS BENEFIT

Sickness Benefit is designed to supplement wages lost by an insured person who is incapable of work due to bodily or mental illness, (except in the case of injury or disease received on the job). To become eligible for Sickness Benefit, such person's claim must be supported by the required medical certification or other evidence required by the Director, must be in insurable employment for a total of 26 weeks, and must have worked 8 out of the 13 weeks prior to the week he/she becomes ill. Sickness Benefit is usually payable from the 4th day of incapacity for work. However if sieckness is for 14 days or more in the first instance, benefit is paid from the 1st day of incapacity for work. Sickness Benefit is paid weekly at a rate of 60% of your average insurable earnings over the 13 week period prior to your date of claim. Sickness Benefit is payable for a maximum of 26 weeks in the first instance. If incapacity for work continues beyond 26 weeks, a continuation of payments for an additional, but not exceeding 26 weeks may be approved by the Board on the recommendation of a Board-approved physician.

MATERNITY BENEFIT.

Maternity Benefit is payable if you are a working woman who gives birth to a living child regardless of the term of pregnancy or to a stillborn child if the term of pregnancy is over 28 weeks. The benefit may consist of an allowance and/or grant. To become entitled to a Maternity

Allowance you must submit a claim supported by the requisite medical certificate and have been in insurable employment for 26 weeks and have been in insurable employment for a total of 20 weeks in the past 39 weeks immediately preceding the contribution week which is 6 weeks before the expected week of confinement or the week from which the allowance is claimed. A Maternity Grant of $1,200 is payable to a woman once she or her husband has been in insurable employment for a total of 26 weeks to the System regardless of whether or not she is presently employed.

FUNERAL GRANT

This grant is payable to the person who has met or to any person who gives the Director a written undertaking to meet the funeral expenses of an insured person, his/her spouse or child under age 15 whose parent(/s) was/ were insured. To qualify for the payment of a Funeral Grant the insured person must have paid into the system at least 26 weeks of contribution.

If the deceased person is 2 years old or younger, the eligible person receives $1,000 towards the burial. If between 2 and 15 years, $3,000 and older than 15 years the amount is $5,000.

LONG-TERM BENEFITS

DISABILITY BENEFIT/PENSION

Disability Benefit is payable to an insured person who is medically certified to be likely to remain permanently incapable of work. To qualify for a Disability Benefit, persons must not have attained age 65 and must have paid 150 weeks of contribution. (If a person is likely to remain permanently incapable of work, has not attained age 65 but has paid 50 weeks of contributions, he/she is entitled to a Disability Grant.) A minimum Disability Pension of $165 per week is payable for as long as the incapacity continues or until the pensionable age when it will be transferred to an Age Pension.

SURVIVORS' BENEFIT

Survivors' Benefit is payable to certain family members, (widow or widower of a deceased insured person, and unmarried children under age 15 or under the age of 21 and still in full-time education at the time of the insured person's death) and in some cases a dependant parent if the deceased person was in receipt of Disability or Age Benefit or had paid 150 contributions in respect of insurance employment. Survivors' Pension is either a pension or a grant depending on the entitlement of the insured person at the time of death. There are different age entitlements to this particular benefit for e.g, a widow or widower who is age 40 years of age or older shall receive a pension for life. A widow or widower below the age of 40 and had no children eligible for this pension or was not capable of work by way of disability shall receive a survivor's benefit for one year. In any case, if you remarry your pension ceases.

OLD AGE BENEFIT

Old Age Benefit is payable to an insured person who has attained the age of 65 years and is paid until death whether or not he/she continues to be employed. To qualify for an Old Age Pension you must have paid a certain number of weeks of contribution. The number of weeks are set at 300 weeks for 2010 and rise to 500 weeks by 2014 and beyond. A minimum Old Age Pension of $165.00 per week is payable. A grant is payable if you have contributed to at least 150 weeks of contribution but do not qualify for the pension.

NON-CONTRIBUTORY OLD AGE PENSION

A Non-Contributory Old Age Pension is paid to an Anguillian Belonger 68 years or older who has met certain qualifying conditions including a Means Test.

If someone has received an Old Age Contributory Grant or Disability Grant, he/she may still be eligible for a Non-Contributory Pension.

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WHEN AND HOW TO CLAIM

Claims for Sickness Benefit should be made on the approved form not later than six (6) months from the day on which the incapacity for work commenced.

Claims for Maternity Benefit should be made on the approved form and submitted to the Social Security Office not earlier than six (6) weeks before the expected week of confinement but not later than six (6) months after confinement. Be sure to send a birth certificate or certificate of confinement to the Office within one month of the baby's birth.

Claim for Funeral Grant must be completed on the Funeral Grant Claim form (available at the Social Security Office) and submitted along with a copy of the Death Certificate and the Undertaker's bill or receipts of funeral expenses not later than one (1) year after the death of an insured person, or his/her spouse or child.

Claim for Disability Benefit must be submitted within 1 year from the date that the doctor certifies that the insured person is permanently incapable of working. Claim forms are available at the Social Security Office.

Claim for Old Age Benefit should be completed on the appropriate form available at the Social Security Office and submitted along with your birth certificate or passport at least 3 months before attaining age 65.

Claim for Survivors' Benefit should be completed on the appropriate form available at the Social Security Office and submitted by Widow/ Widower and or Child/Children along with the following documents:

- Death Certificate
- Marriage Certificate
- Widow/Widower Birth Certificate
- EC Bank Account
- Child/Children Birth Certificate(s)
- Letter of Representation for Child/Children

Claim Form Sickness Benefit

Form SB1
Revised 2011

P.O. Box 243, JRW Bldg.
The Valley, Anguilla
Tel.# 264-497-2201/2
Fax# 264-497-5649
Email: info@ssbai.co
Website: www.ssbai.com

ANGUILLA SOCIAL SECURITY BOARD
SOCIAL SECURITY ACT
R.S.A. c. S45

APPLICATION FOR SICKNESS BENEFIT

TO PERSONS CLAIMING BENEFIT

This form is divided into four (4) Sections:- A to D
Sections A and B - To be completed by a Medical Practitioner
Section C - To be completed by the person claiming
Section D - To be completed by the Employer

THIS FORM MUST BE SUBMITTED NOT LATER THAN FOURTEEN (14) DAYS FROM THE DAY ON WHICH YOUR INCAPACITY FOR WORK COMMENCED.

ANY CHANGES OR ALTERATIONS MADE TO INFORMATION ON THIS FORM MUST BE INITIALLED BY THE PERSON AUTHORIZED TO SIGN THE SPECIFIED SECTION OF THE FORM. TO AVOID UNNECESSARY DELAY IN THE PAYMENT OF YOUR BENEFIT, PLEASE ENSURE THAT ALL SECTIONS ARE PROPERLY FILLED OUT.

ALL SECTIONS OF THIS FORM MUST BE COMPLETED.

TO EMPLOYER

You are kindly asked to fill out Section D of this form and deliver it to the bearer. Section B is to be detached and retained by you for your records. If you received the form after the employee has resumed work, kindly indicate when he/she resumed.

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Claim Form
Sickness Benefit

SECTION A

(To be completed by a Registered Medical Practitioner)

Patient's Name: ……..…… I hereby certify that

on ……..20……. I examined you and found that you are suffering from:

Illness Category Codes

I ☐ II ☐ III ☐ IV ☐ V ☐

VI ☐ VII ☐ VIII ☐ IX ☐ X ☐

OTHER: FOR OVERSEAS MEDICAL ATTENTION ONLY ☐ .....
Nature of Illness

(Please indicate illness by ticking the appropriate category of illness code box from the list above).

In my opinion, you will be fit to resume work on ……..…….……20……

Occupational Injury? Yes ☐ No ☐

Medical Practitioner's Name…….…….……
(Please print)

Address……..……

Signature……..…… Date……

(Please Affix Office Stamp)

The certificate shall cover a specified number of days or weeks from and including the date of the medical examination on which the certificate is based, which shall not exceed 14 days, but, when the incapacity has been caused by a serious accident or a surgical operation, the certificate may cover a period which shall not exceed 8 weeks.

SECTION B

(Medical Certificate for Employers)

I hereby certify that on ……..…….….. 20…... I examined ……..……..

…….and by reason of illness, he/she is incapacitated. In my

opinion, he/she will be fit to resume work on ……..…….. 20……..…...

Signature…….... Date…….……
(Please Affix Office Stamp)

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Claim Form
Sickness Benefit

SECTION C

(To be completed by Claimant)

To: The Director
Social Security Board

FOR OFFICIAL USE ONLY

Date Received……..…….. | Verification ……...
Claim No. ……..…… | ……...

Social Security No.

Date of Birth

Full Name……..……..…….

Address……..……

P. O. Box #..... Telephone #.....

I claim Sickness Benefit from……..……..…… 20…..……

I ceased working as a/an ……..…….... at the establishment of ……..……

……..……..…… on ……...……..…….. 20……...

My other employers during the last twenty-six (26) weeks were:

1. Name……..……..……. Address……...……

2. Name……..……..……. Address…….....

I hereby authorize the disclosure of the diagnosis for the purpose of the Anguilla Social Security Sickness Benefit.

Signature of Claimant ……..……..……..……

Date ……..…….. 20……..…...

If benefit is to be paid into your bank account, please provide the name of your bank and EC$ Account number: Bank……..……..……..……..... Account #.....

SECTION D

(To be completed by Employer)

This is to certify that ……..……..…….. has been employed in this establishment from ……..…… 20…….... His/her weekly/monthly rate of pay is stated overleaf. He/she last worked on …… ..……..…… 20…… and has been absent from ……..……..…… 20….. on account of incapacity which was/was not due to an injury sustained during the course of his/her employment here. **HE/SHE RETURNED TO WORK OR IS EXPECTED TO RETURN** ……..……..……..…… 20……

(cont'd overleaf)

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Claim Form
Sickness Benefit

List below the employee's earnings for the last thirteen weeks or three months prior to the week of illness. If he/she is paid monthly, indicate the number of weeks worked using the Mondays as your guideline.

Weekly Paid	Monthly Paid
Week beginning:	
1……..…….. 20…… $.....	$..... for the month of
2……..…….. 20…… $.....	…… 20…….
3……..…….. 20…… $.....	Number of weeks worked ……...……...
4……..…….. 20…… $.....	
5……..…….. 20…… $.....	
6……..…….. 20…… $.....	$..... for the month of
7……..…….. 20…… $.....	……..……..…… 20…….
8……..…….. 20…… $.....	Number of weeks worked……..……
9……..…….. 20…… $.....	
10……..…….. 20…… $.....	
11……..……..…… 20…… $.....	$..... for the month of
12……..…….. 20…… $.....	……... 20……...
13……..……... 20…… $.....	Number of weeks worked……...……
	Current month's salary $.....
	& current number of weeks ……..…….

I certify that the above information given by me is correct to the best of my knowledge and belief. I understand that I can be prosecuted if I knowingly give incorrect information.

Name of Employer……..……...……...

Registration No. of Employer ☐ Telephone # ☐

Name of person giving information……...…….

Signature……...…… Date……..……

(Please Affix Company Stamp)

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Claim Form Maternity Benefit

Form MB1
Revised 2010

P.O. Box 243, JRW Bldg.
The Valley, Anguilla
Tel.# 264-497-2201/2
Fax# 264-497-5649
Email: info@ssbai.com
Website: www.ssbai.com

ANGUILLA SOCIAL SECURITY BOARD
SOCIAL SECURITY ACT
R.S.A. c. S45

APPLICATION FOR MATERNITY BENEFIT

Section "A 1" & "A 2 " of this form must be completed and signed by a MEDICAL DOCTOR or a MIDWIFE registered in ANGUILLA.
Section "B" must be completed by the CLAIMANT.
Section "C" must be completed by the EMPLOYER on or after the last day of work preceding the maternity leave.

NOTE TO CLAIMANT

To avoid unnecessary delay in the processing of your benefit, please ensure that all aspects of this form are properly filled out, and that it is returned to the Social Security Office as soon as possible. After your confinement, please submit a Certificate of Confinement form filled out by the doctor or midwife who attended at your confinement or a copy of your child's birth certificate to the Social Security Office, within six (6) months of the date of confinement.

SECTION "A"
(TO BE COMPLETED BY A MEDICAL DOCTOR OR MIDWIFE REGISTERED IN ANGUILLA)

MEDICAL CERTIFICATE OF EXPECTED CONFINEMENT

To: Ms./Mrs. ..... I certify that I have examined you today and in my opinion you are pregnant. It is expected that your confinement will occur on ..... 20.....

NAME OF DOCTOR/MIDWIFE.....

SIGNATURE..... DATE.....

OR

MEDICAL CERTIFICATE OF CONFINEMENT

To: Ms/Mrs. ..... I certify that I attended to you at your confinement which took place on .....20..... after ..... weeks of pregnancy.

NAME OF DOCTOR/MIDWIFE.....

SIGNATURE..... DATE.....

(Please Affix Office Stamp)

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Claim Form
Maternity Benefit

SECTION "B"
(TO BE COMPLETED BY CLAIMANT)

Full name ……

Social Security Number | | | | | | Date of Birth:DD/MM/YY | | | |

Address ……

P.O. Box #…… Telephone #……

COMPLETE EITHER (1) OR (2) BELOW AS APPLICABLE:

1. GRANT ONLY—TO BE COMPLETED BY THE WIFE OF AN INSURED MAN

I hereby claim maternity grant in respect of my confinement. I am the wife of Mr. ……

an insured person whose employer is…… …… and whose Social

Security Number is | | | | | |

2. ALLOWANCE AND GRANT—TO BE COMPLETED BY AN INSURED WOMAN

I hereby claim maternity benefit from ……..20….. to …….. 20….. I ceased

work as a/an …… at the establishment of ……..

…… on …….. 20……

My other employers during the last 39 weeks were:

i.) Name…… Address……

ii.) Name…… Address……

…… ……
Signature Date

If benefit is to be paid into your bank account, please provide the name of your bank and EC$ Account number:

Bank:…… Account #……

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Claim Form
Maternity Benefit

SECTION "C"
(TO BE COMPLETED BY EMPLOYER)

This is to certify that Ms/Mrs. ……has been employed in this establishment from…… 20……., her present weekly/monthly earnings being $..... She last worked on …..…….. 20……. and should resume work on ……..…… 20……..

PLEASE INDICATE THE EMPLOYEE'S EARNINGS FOR THE LAST 39 WEEKS OR NINE (9) MONTHS OR PART(S) THEREOF, IMMEDIATELY PRECEDING COMMENCEMENT OF THE MATERNITY LEAVE. IF PAID MONTHLY, INDICATE THE NUMBER OF WEEKS WORKED USING THE MONDAYS AS YOUR GUIDELINE.

N.B.: IF YOUR CONTRIBUTIONS ARE UP TO DATE, PLEASE IGNORE. IF THEY ARE NOT, PLEASE LIST OUTSTANDING WEEK(S) OR MONTH(S) BELOW:

Weekly/Monthly Paid Employee			Weekly/Monthly Paid Employee		
1……	20……	$.....	21……	20……	$.....
2……	20……	$.....	22……	20……	$.....
3……	20……	$.....	23……	20……	$.....
4……	20……	$.....	24……	20……	$.....
5……	20……	$.....	25……	20……	$.....
6……	20……	$.....	26……	20……	$.....
7……	20……	$.....	27……	20……	$.....
8……	20……	$.....	28……	20……	$.....
9……	20……	$.....	29……	20……	$.....
10……	20……	$.....	30……	20……	$.....
11……	20……	$.....	31……	20……	$.....
12……	20……	$.....	32……	20……	$.....
13……	20……	$.....	33……	20……	$.....
14……	20……	$.....	34……	20……	$.....
15……	20……	$.....	35……	20……	$.....
16……	20……	$.....	36……	20……	$.....
17……	20……	$.....	37……	20……	$.....
18……	20……	$.....	38……	20……	$.....
19……	20……	$.....			
20……	20……	$.....	39……	20……	$.....

I certify that the above information given by me is correct to the best of my knowledge and belief. I understand that I can be prosecuted if I knowingly give incorrect information.

Name of Employer……

Registration No. of Employer ☐ Telephone # ☐

Name of person giving information……

Signature…… Date……

(Please Affix Company Stamp)

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Claim Form
Maternity Benefit

FOR OFFICIAL USE ONLY

Date Received……..	Verification ……..
Claim No. ……..	……..
Grant No. ……..	……..

Grant Condition Satisfied ☐ Yes ☐ No 26 weeks

Maternity Allowance Condition Satisfied ☐ Yes ☐ No 39 wks or 20 out of 39 wks immediately preceding the contribution week which is 6 wks before E.D.C. or week from which the allowance is claimed, whichever is later.

Date of Monday, 6 weeks prior to Expected Date of Confinement (E.D.C.) or week from which the allowance is claimed, whichever is later. ☐☐ DD ☐☐ MM ☐☐ YY

PERIOD FROM	PERIOD TO	NO. OF WKS	TOTAL EARNINGS	A.W.I.E.	W.B.R.	D.B.R.	TOTAL PAYMENT

Signature …….. Date ……..

(TO BE COMPLETED BY A MEDICAL DOCTOR OR MIDWIFE REGISTERED IN ANGUILLA)

MEDICAL CERTIFICATE OF EXPECTED CONFINEMENT FOR EMPLOYER

To: Ms./Mrs. …….. I certify that I have examined you today and in my opinion you are pregnant. It is expected that your confinement will occur on …..…….. 20……..

NAME OF DOCTOR/MIDWIFE……

SIGNATURE…… DATE……..

(Please Affix Office Stamp)

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P.O.Box 243, JRW Bldg
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