NATIONAL INSURANCE AND SOCIAL SECURITY ACT, 1969
MATERNITY BENEFIT – STATEMENT OF EARNINGS

(This form is to be completed by the Employer
and given to the Employee to take or send to
the nearest National Insurance Office)

WARNING: Any person who knowingly makes a false statement or false representation for the purpose of obtaining any payment for himself or for some other person under the National Insurance and Social Security Act, 1969 or produces or furnishes any document or information which he knows to be false in a material particular, renders himself liable to prosecution.

1. **PARTICULARS OF EMPLOYER**:

(a) NAME OF EMPLOYER/BUSINESS:

(b) NATURE OF BUSINESS:

(c) ADDRESS OF BUSINESS:

(d) EMPLOYER'S REGISTRATION NUMBER:

2. **PARTICULARS OF EMPLOYEE**:

(a) NAME OF EMPLOYEE:

(b) ADDRESS OF EMPLOYEE:

(c) NATIONAL INSURANCE NO:

(d) NATIONAL REGISTRATION NO:

3. **PARTICULARS OF EMPLOYMENT**:

(a) Has Employee been in your employment over the last 15 weeks? | Yes | No |
If the answer to (a) above is No,

(b) How long has employee been in your employment? …….....

(c) How many contributions have you paid for employee during period referred to at (a) or (b) above?

(d) Salary/wage paid to employee for last 6 months/26 weeks worked

MONTH	SALARY
1.	$
2.	$
3.	$
4.	$
5.	$
6.	$

WEEK ENDING	WAGE
1.	$
2.	$
3.	$
4.	$
5.	$
6.	$
7.	$
8.	$
9.	$
10.	$
11.	$
12.	$
13.	$

WEEK ENDING	WAGE
14.	$
15.	$
16.	$
17.	$
18.	$
19.	$
20.	$
21.	$
22.	$
23.	$
24.	$
25.	$
26.	$

(e) Last date employee worked:

(f) Rate of salary/wage to be paid to employee when absent from work:

$..... per month/week. From ..... to.....

((f) above to be completed only when employee will be paid during period of maternity benefit)
I certify that the above statements are true to the best of my belief and knowledge and I assume full responsibility as to their correctness.

Signature of Employer (or Rep): .....

Date: .....
Employer Stamp:

FOR OFFICIAL USE

1. DOCUMENTS SUBMITTED WITH CLAIM

1. .....

2. .....

3. .....

2. DECISION

ALLOWED	
DISALLOWED	

(Tick appropriate box)

IF ALLOWED

3. CALCULATION OF RATE

MONTH SALARY ($)

	Actual	Insurable
1.		
2.		
Total		
Avg. Monthly		

WEEK WAGES ($)

	Actual	Insurable
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
Total		
Avg. Weekly		

Rate = 0.7 x wkly/mthly ins. earnings

(To be completed if salary is paid by employer)

(a) Average monthly/weekly earnings $ _____

(b) 70% avg. mthly/wkly insurable earnings $ _____

(c) Salary/wage paid $_____

(d) Total item b) and c) $_____

(e) Item d) – item a)
(enter 0 if answer is negative) $_____

(f) Rate of Benefit (Item 6 - Item e)

$	Per month/week

Rate per month/week – 26/6

$	Per day

4. PARTICULARS OF PAYMENT

Date of Commencement | | | | Stop Date | | | | Review Date | | | |

Payment Made:

FROM	TO	AMT. $	PAID C	Prepared By	Date	Checked By	Date	Auth. By	Date	B.P.V No.	Date
1.											
2.											
3.											
4.											

5. IF DISALLOWED

1. Date claim Disallowed | | | | | | | |

2. Reason for Disallowance _____

3. Date claimant notified | | | | | | | |

6. IF DISQUALIFIED

Period of Disqualification

From | | | | To | | | |

Reason for Disqualification.....

.....

7. NOTIFICATION

Department/Section	
Form No.	
Date Sent	
Signature	
Remark	