



**Social Security Board
P.O. Box 698
Road Town, Tortola
British Virgin Islands**

CLAIM FOR MATERNITY BENEFIT
(EXPECTED CONFINEMENT)

Mrs./Miss.....Social Security #.....
Physical Address.....
Mailing Address.....
Telephone Number(s) Home Date of Birth/...../.....
Work..... dd mm yy

Current Employer.....
Occupation.....
Last Date Worked...../...../..... Period of leaveweeks
dd mm yy
Date of leave: From:.....20..... to20.....

- If you had more than one employer in the thirty nine (39) weeks before your incapacity began, please give details below.

Previous Employer.....
.....
(Signature) (Date)

If unable to write, mark X and have it witnessed	
Name (Witness to mark)	Sign:..... (Witness to Mark)
Occupation.....	Date:.....

Please tick the appropriate box:

- will pick up cheque Please mail

By Whom:
(ID Required)

- Note: 1. Maternity Benefit cannot be paid for any period earlier than six weeks before expected confinement as certified by a Medical Doctor
2. Maternity Benefit will not be paid for any period during which you are engaged in gainful employment.

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Medical Certificate of Expected Confinement

To be given by a Medical Practitioner or Midwife, not earlier than six weeks before the date of expected confinement.

I certify that I examinedresiding at on the under mentioned date, and in my opinion, she may be expected to be confined in the week which include the.....day of20.....

Any other remarks by medical Practitioner or Midwife

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.....

Doctor's Name:
(Please print)

Doctor's Signature.....

Address:

Telephone #.....

Date of Examination.....

Date of Signing:.....

*The week referred to is a contribution week, i.e. one which begins on a Monday