REPUBLIC OF NAMIBIA **Form 19**
SOCIAL SECURITY COMMISSION
SOCIAL SECURITY ACT, 1994

The Chief Executive Officer
Social Security Commission
Private Bag 13223
Windhoek
Namibia

IN ALL CORRESPONDENCE QUOTE

CLAIM FOR DEATH BENEFITS IN THE CASE OF RETIREMENT OR DISABILITY OF AN EMPLOYEE

(Section 31/Regulation 11)

This form must be completed for the purpose of claiming the death benefit payable in respect of an employee who retires or becomes permanently disabled

TO BE COMPLETED IN BLOCK LETTERS

TO BE COMPLETED BY THE CLAIMANT

1. Social Security Registration number:……
2. Surname:……
3. Previous surname (in case of change of surname under which registered):…….
4. First names:……
5. Date of birth:…… 6.Identity number: ……...….(if any)
7. Passport number:…….(if any)
8. Postal Address: ……..
9. Telephone number: ……10. Facsimile: ……...
11. Method of payment of benefits:

Cheque		Bank Transfer	

12. If benefits are to be transferred to Bank or Building Society account, indicate:…….
    (a) Name of financial institution:……
    (b) Name of branch:……
    (c) Branch number: …….
    (d) Account number:……
    (e) Type of account:……

    Holder of Account

Own		Husband		Wife	

13. If permanently disabled, give full particulars:…….
    (Documentary proof e.g. certificate by medical board, medical practitioner, etc must accompany this claim)

I certify that the above particulars are true and correct.

_____ _____

CLAIMANT **DATE**

PLEASE TURN OVER

DISABILITY INFORMATION

MEDICAL CERTIFICATE TO BE COMPLETED BY A MEDICAL PRACTITIONER:

I, ……..……..(Full names),

2. Surname: …….Practice number ……..……hereby certify that ……..…..(name of patient) has been under my treatment from ……..200…to ……200… and that he/she is suffering from:……

……..

(disease or injury to be stated as far as possible in non-technical terms with concise particulars as to history, symptoms and severity, and ascertainable cause).

Further certify that he/she is in consequence unable to perform his/her duties and I consider it essential for benefit of his/her health and recommend that he/she should retire from normal employment with effect from ……..…200……

…….. ……

MEDICAL PRACTITIONER **DATE**

TO BE COMPLETED BY THE EMPLOYER:

1. Name of employer: ……
2. Social Security Registration Number:……..……
3. Date employee retired or became permanently disabled: ……...……

I certify that the above particulars are true and correct.

** Attach proof of latest Social Security contribution /deductions from member's salary.*

…… ……. ……...

EMPLOYER **OFFICIAL STAMP** **DATE**

FOR OFFICIAL USE ONLY

Checked by: _____ Date: _____Time_____

Remarks: _____

_____