Form 19

REPUBLIC OF NAMIBIA
SOCIAL SECURITY COMMISSION
SOCIAL SECURITY ACT, 1994

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The Chief Executive Officer
Social Security Commission
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IN ALL CORRESPONDENCE QUOTE

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

(Section 31/Regualation 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 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. E-mail Address ………
10. Telephone number: ………………………………………………..11. Facsimile number: ………………………………………
12. Method of payment of benefits:

Cheque		Bank transfer	

13. 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: ………………………………………………………………………………………………..
14.. 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 in respect of disability of a member:

I, ……..…(full names),
Qualifications …………………………………………practice number ……………………………………..hereby certify
That …………………………………………………………………………………………………..(name of patient)
Has been under my treatment from ……………………………20………to…………………..20………………………..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 the benefit of his/her health and recommend that he/she should retire from normal employment with effect from ……………………..20…………..

______________________________ __________________

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 contributions/deductions from member's salary.*

_________________________ ___________________________________ _______________

EMPLOYER OFFICIAL STAMP DATE

FOR OFFICIAL USE ONLY

Checked by: ____________________________________Date: _______________

Remarks: ____
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