GOVERNMENT OF BERMUDA
Ministry of Finance

Department of Social Insurance

DISABILITY BENEFIT APPLICATION FORM

Please use BLOCK **CAPITALS** when filling out this form.
BE SURE TO ANSWER ALL QUESTIONS

When completed, this form should be taken or sent to:

DEPARTMENT OF SOCIAL INSURANCE
Ground Floor
Government Administration Building
30 Parliament Street, Hamilton HM 12
Bermuda

OFFICIAL USE
Social Insurance No.:
Claim No.:
Received By:
Date of Receipt/Stamp:
Approved/Disapproved By and Date:
Birth Cert/Passport No:
Verified By:

AN APPLICATION SHOULD BE MADE WITHIN 13 WEEKS FROM THE DATE A PERSON BECOMES ELIGIBLE FOR THE BENEFIT. DELAY IN CLAIMING MAY RESULT IN LOSS OF BENEFIT.

CONTRIBUTORY PENSIONS ACT, 1970

A person shall be entitled to a **Contributory Disability benefit** if he/she-

- Is over 18 years of age and under pension age 65
- Is incapacitated for gainful employment by reason of physical or mental disability or terminal illness
- Has paid not less than 150 contributions
- Has paid or been credited with a minimum of 50 yearly average contributions
- Produces a certificate from a registered physician certifying the incapacity

A person shall be entitled to a **Non-contributory Disability benefit** if he/she:

- Is over 18 years of age and under pension age 65
- Has been ordinarily resident in Bermuda for 10 years immediately preceding the application for benefit
- Is permanently incapacitated for gainful employment
- Produces a certificate from a registered physician certifying the incapacity

PARTICULARS OF CLAIMANT

1. SURNAME | FIRST NAME | MIDDLE NAMES | MR. MRS. MISS (CIRCLE ONE)

2. Maiden Name (or other surname at date of birth)

3. Permanent Address

Mailing Address (if different from above

Telephone Number(s)

Email Address

4. Date and place of birth. Please submit a **certified copy of your birth certificate and photo ID or valid passport** with this form.

Day | Month | Year | Place

4a. UK Insurance No:(If applicable)

5. Bank Name

Account Number

IBAN Number/Routing Number (If applicable)

Sort Code (If applicable)

6. Are you Bermudian? If so please state how acquired.

(i.e birth or otherwise) submitting documentary evidence. (passport stamp)	
6a. Are you ordinarily a resident in Bermuda?	
7. Have you resided in Bermuda continuously for 10 years immediately preceding this application? (Yes or No). If yes, please submit documentary evidence. (Residency Form)	
8. Occupation or Profession	Yes or No (Circle one)
9. Name of Last Employer	
10. Are you able to carry out gainful employment?	Yes or No (Circle one)
11. State your medical condition/ incapacitation/ Disability.	
12. Name of Physician	
Physician's address	
Physician's telephone number	
Date of last visit	
Was your last visit related to you current medical Condition? (If yes, explain)	
13. Date of commencement of incapacitation	Day Month Year Place
14. Date of last work day	Day Month Year Place
15. Are you in receipt of any other Social Insurance Benefit? (Yes or No, if yes, state what type of benefit).	

DECLARATION (WARNING: TO GIVE FALSE INFORMATION MAY RESULT IN PROSECUTION).

I DECLARE that to the best of my knowledge and belief the information given on this form is true.

Signature …… Date ……

If you are unable to sign the declaration yourself, it may be signed on your behalf by someone else who should state that he or she has done so.