GOVERNMENT OF BERMUDA
Ministry of Finance

Department of Social Insurance

APPLICATION FOR A NON-CONTRIBUTORY DISABILITY BENEFIT

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

FOR OFFICIAL USE
Insurance No.:
Claim No.:
Date of Receipt:
Approved/Disapproved By and Date:

CONTRIBUTORY PENSIONS ACT, 1970

A person shall be entitled to a non-contributory disability benefit if he/she –

(a) is over 18 years of age and under pension age 65
(b) has been ordinarily resident in Bermuda for 10 years immediately preceding the application for benefit
(c) is permanently incapacitated
(d) produces a certificate from a registered physician certifying the incapacity

1. SURNAME ..... MR. MRS. MISS (circle one)

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

3. Other Names .....
.....

4. Full Address and Postal Code .....
.....
Telephone Number/Email Address .....

5. Bank Name .....
Bank Address .....
Account Number .....

6. Date and place of birth. Please submit your birth certificate/passport or a certified copy of it with this form. It will be returned as soon as it has been examined by the Department. .....

DAY	MONTH	YEAR	PLACE
FOR OFFICIAL USE			
B. CERTIFICATE/PASSPORT No.		VERIFIED BY:	

7. Are you Bermudian? If so please state how required (i.e. birth or otherwise) submitting documentary evidence. .....

8. Name of Husband or Wife .....

9. Are you ordinarily resident in Bermuda? .....

10. Have you resided in Bermuda continuously for 10 years immediately preceding this application? (YES or NO). If yes, please submit documentary evidence. .....
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11. Are you able to carry out gainful employment? (YES or NO). .....

12. When did you become unfit for gainful employment? Please submit doctor's certificate of inability to work. .....

DAY	MONTH	YEAR
FOR OFFICIAL USE	VERIFIED BY:	

13. Have you been continuously incapable of work since that date? (YES or NO). .....

14. Are you in receipt of any other social insurance benefit? (YES or NO, if yes state type of beneft.) .....

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 ..... Telephone No. ..... 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.