

BOARD OF TRUSTEES



NATIONAL SOCIAL SECURITY FUND

P.O. BOX 30599, NAIROBI

APPLICATION FOR INVALIDITY BENEFIT

NOTE:

Before completing this application form, you must read the following notes carefully:

1. This application form is issued **FREE**. This claim is processed **FREE**.
2. You must give correct names and in the order they appear on your Fund membership card. Any change in names must be supported by a sworn affidavit and a Kenya gazette notice.
3. The **ORIGINAL** membership card must be attached to the application and if it is missing arrangements should be made to obtain a duplicate from the nearest **NSSF** office.
4. The address you give on this application form must be the one you are sure will get a letter delivered to you without difficulties.
5. After lodging a claim, you must notify the Fund immediately of any change of your address which would affect prompt dispatch of any letter or payment.
6. Your impression of the **Left Thumb Print** to be affixed on the application form must be done correctly at any **NSSF** office/police station/National registration bureau's office.
7. The employer(s) name(s), address (es) and your personal number(s), stations and period worked for in respect of each employer must be given clearly.
8. An original retirement letter (on medical grounds) or certificate of service plus a photocopy of the same must be produced on presentation of application.
9. This application form must be witnessed by a person well known to you.
10. Part II of this form must be completed by the applicant's doctor at the hospital attended and a full treatment/attendance record attached.
11. Part I (9) should be completed by your last employer.
12. You will be examined for confirmation of your invalidity by the Fund's appointed doctor after completion and submission of the form at any **NSSF** office.
SF/BN/IB/001
13. Part III (Director of the medical services) remarks will be completed after you have been examined by the Fund's appointed doctor.

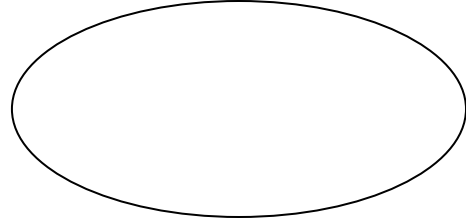
14. You must attach a clear and legible photocopy of your National Identity card centered on an A4 size paper, after the copy has been certified by an authorized officer at any NSSF office.

FOR OFFICIAL USE ONLY

Checked and received by:

OFFICIAL RUBBER STAMP

SIGNATURE.....



DATE.....

IMPORTANT:

- **YOUR MEDICAL/ TREATMENT RECORDS FROM THE HOSPITAL YOPU ATTENDED MUST BE ATTACHED TO THIS APPLICATION FORM.**

Please ensure that you have read the notes at the beginning of on page 1 & 2 before attempting to fill this application form.

PART 1

PARTICULARS OF MEMBERS

1. Your full name (IN BLOCK LETTERS).....
2. Your National ID card No.....
3. Your Fund membership number.....
4. Your home District.....
 - Division.....
 - Location.....
 - Sub-location.....
 - Village.....
5. Your N.S.S.F. local office for cheque collection.....
6. Your Permanent address for correspondence.....
.....

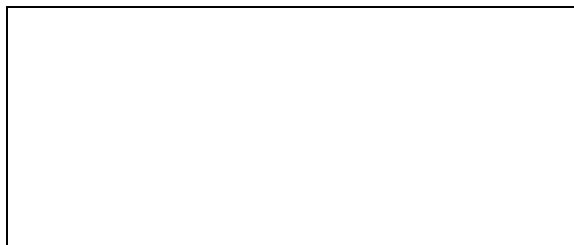
7. **DETAILS OF EMPLOYEMENT**

EMPLOYER'S NAME	ADDRESS	YOUR P/NO	DATE EMPLOYEMENT STARTED	DATE EMPLOYEMENT CLOSED
1 ST EMPLOYER				
2 ND EMPLOYER				
3 RD EMPLOYER				
4 TH EMPLOYER				
LAST EMPLOYER				

8. **PARTICULARS OF INVALIDITY**

- Date accident/illness occurred.....
- Date accident reported to Labour department by the employer.....
- Accident reported at.....
- Date of admission to hospital.....
- Name and address of hospital attended.....
.....

Official rubber stamp of hospital



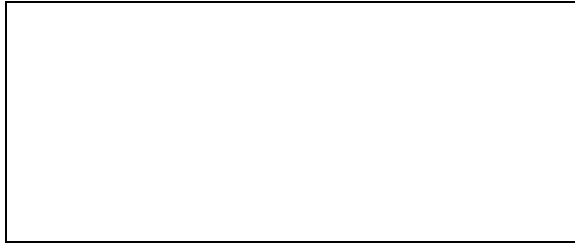
9. **LAST EMPLOYER'S CERTIFICATE**

I certify that.....

Was an employee of this establishment and his employment was terminated due to incapacity caused by accident/ chronic illness as recommended by medical practitioner in charge ofhospital.

Signature.....Designation.....

Official rubber stamp of employer



PART II: CERTIFICATE OF INVALIDITY

(Section 22 of the National Social Security Fund Act)

(To be completed by a hospital authority and signed by a qualified doctor)

MEDICAL REPORT FOR MR/MISS/MRS.....

In compliance with the regulations of Legal Notice No.134/1968 which requires a declaration by a qualified medical practitioner as the truth of statements of fact. I have examined the above named and accordingly certify that he/she is suffering:

- (a) Permanent total incapacity.
 - (b) Form partial incapacity of a permanent nature, and that he/she is unable by reason of such disability to earn a reasonable livelihood.
 1. The degree of permanent incapacity, if any is.....
 2. Doctor's detail medical report after examining the patient.....
.....
.....
.....
- Signature.....Date.....

Official rubber stamp



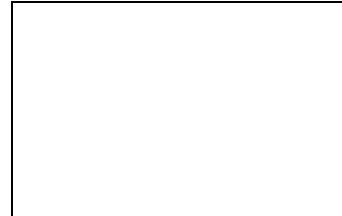
PART III

DECLARATION BY MEMBER

I am prevented by my disability as stated by doctor from earning a reasonable livelihood.

Date.....Signature.....

LEFT THUMB PRINT



Name of witness in full.....

Signature of witness.....Date.....

National Identity card No.....Occupation.....

Address.....

.....

PART III

REMARKS BY THE DIRECTOR OF MEDICAL SERVICES

.....

Signature.....Date.....

Official rubber stamp



WARNING

Any person who makes a false statement or representation or who produces or furnishes or causes to be furnished any information which he/she knows to be false in a particular material may render himself/herself liable to prosecution in accordance to NSSF Act, Chapter 258, and Laws of Kenya.

BOARD OF TRUSTEES

NAME: MR/MRS. OR MISS.....

RACE OR TRIBE.....NATIONALITY.....

PLACE OF RESIDENCE AND POSTAL ADDRESS.....

DISTRICT.....DIVISION.....

LOCATION.....SUB-LOCATION.....

N.S.S.F. No.....F.P.CLASS.....

DATE OF BIRTH.....

ROLLED ON IMPRESSIONS-RIGHT HAND

1. RIGHT THUMB	2. R. FORE FINGER	3. R. MIDDLE FINGER	4. R. RING FINGER	5. R. LITTLE FINGER
FOLD				

ROLLED ON IMPRESSIONS-LEFT HAND

6. LEFT THUMB	7. L. FORE FINGER	8. L. MIDDLE FINGER	9. L. RING FINGER	10. L. LITTLE FINGER
FOLD				

LEFT HAND

PLAIN IMPRESSION TAKEN SIMULTANEOUSLY

RIGHT HAND

NOTE-When a finger is amputated, deformed or so injured that the impression thereof cannot be obtained the fact should be noted in the space provided for that impression.

<p>Signature of: N.S.S.F. R.O.....OFFICE.....Date..... Classified by.....Date..... Tested by.....Date..... Filed by.....Date.....</p>	<p>Right Thumb Impression</p>
<p>SIGNATURE.....OR LEFT THUMB – IMPRESSION..... NATIONAL ID/CARD NO..... SF/OP/RG/003R (A)</p>	<p>Left Thumb Impression</p>

