NSSO | OVERSEAS SOCIAL SECURITY

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ADDRESS
Victor Hortaplein 11
1060 Brussels

CLAIM FOR PAYMENT OF SICKNESS AND DISABILITY INSURANCE BENEFITS

A. IDENTIFICATION:

1. Claimant [insured person]:

Surname: ..... Firstname: .....

Place and date of birth: ..... - __ __/__ __/__ __ __ __

Nationality: .....

National registration no.: __ __.__ __.__ __-__ __ __.__ __

Civil status: ..... Occupation: .....

Full address: .....

Telephone no.: .....

Fax no.: .....

E-mail: .....

The illness manifested itself on: __ __/__ __/__ __ __ __ The accident was sustained on: __ __/__ __/__ __ __ __

Date on which work was interrupted: __ __/__ __/__ __ __ __

The delivery is expected/took place on: __ __/__ __/__ __ __ __ This illness is a relapse: Yes No

2. Spouse or cohabitant:

Surname: ..... Firstname: .....

Date of birth: __ __/__ __/__ __ __ __ Nationality: .....

Date of marriage: __ __/__ __/__ __ __ __ Current employment: .....

3. Dependent children under 25 years:

	Surname	Firstname	Date of birth
1	.....	.....	__ __/__ __/__ __ __ __
2	.....	.....	__ __/__ __/__ __ __ __
3	.....	.....	__ __/__ __/__ __ __ __
4	.....	.....	__ __/__ __/__ __ __ __

Do these children benefit from child benefits or allowances? Yes No

B. DOCUMENTS TO BE ENCLOSED WITH THE CLAIM (only if the box is ticked):

Certificate of residence outside Belgium (documents issued by the Administration)

Certificate of school attendance for each child over the age of 18 if the child is following courses full time at an educational establishment.

Statement from the insurance fund where the insured person was enrolled if the period of insurance is less than six months.

In the case of delivery, an extract from the child's birth certificate.

Statement from the institution or the employer paying child benefit.

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C. BENEFITS WHICH THE CLAIMANT IS CURRENTLY RECEIVING:

Description of the benefits which the claimant is obliged to declare	Amount	Period	Being paid by (exact name and address)
1. Leave allowance:			
2. Severance allowance or payment in lieu of notice:			
3. Retirement pensions or allowances:			
4. Compensatory payment in respect of accidents at work or occupational diseases:			
5. Benefits, grants or allowances provided on the basis of any sickness, invalidity or unemployment legislation:			
6. Child benefit or allowances:			
7. (only for individually insured persons) Do you wish to continue paying contributions for the current health care contract? Yes No			

D. COMMITMENTS BY THE CLAIMANT:

The claimant undertakes to inform the General Directorate VII Overseas Social Security of any change occurring in:
(a) the composition of his/her family or the dependants resulting from it;
(b) the details of the benefits listed under C above;
(c) his/her resumption of work or registration as a job seeker (unemployment).

E. BANK OR POSTAL ACCOUNT NUMBER INTO WHICH THE BENEFITS MAY BE PAID:

Financial institution: .....

Account no.: __ __ __ /__ __ __ __ __ __ __ /__ __

The undersigned authorises the General Directorate VII Overseas Social Security to inform his/her employer - at the latter's request - of the amounts granted as sickness and disability insurance benefits: Yes No

I certify that this declaration is sincere and complete. I am aware that any false or incomplete declaration may lead to penalties being imposed (Royal Decree of 31 May 1933) and/or a recovery of the sums paid (Act of 17 July 1963).

Done at ..... on __ __ /__ __ /__ __ __ __

Signature*

The offices are open to the public from 9 am to 12 noon and in the afternoon only by appointment.

The data will be processed in compliance with the Act on the protection of privacy (Act of 8 December 1992). You may consult and rectify your data at any time. These data will only be used to process your claim.