NATIONAL INSURANCE SERVICES
P.O. BOX 305, ADMINISTRATIVE CENTRE

Tel. #: (784) 456 1514
Fax #: (784) 45 62604

NATIONAL INSURANCE ACT #33 OF 1986
CLAIM FOR SURVIVORS BENEFIT

Warning: Any person who knowingly makes a false statement or false representation for the purpose of obtaining benefit commits a criminal offence punishable by a fine or imprisonment or both.

To be completed by Applicant

PART A - PERSONAL INFORMATION

Name (in block capitals) ……………………………………………………………………………………………

Surname     Other Names

D  M  Y       NIS No.               

Date of birth: |___|___|___|    Kindly attach copy of birth certificate as proof of age

Postal Address: ……………………………………         Tel. #: …………………………...

…………………………………   Sex:  Male [     ]      Female [     ]

Marital Status: Married [     ]       Single [     ]     Widow/Widower [     ]      Divorced [     ]

Relationship to deceased ……………………………………………………………………………………

(if widow or widower attach copy of marriage certificate)

Common-law Relationship

Were you wholly or partially dependent on the deceased person?    Yes [     ]       No [     ]

Were you and the deceased person living together at the time of death?    Yes [     ]       No [     ]

If the answer is yes, please state how long you were living together.   Years [     ]   Months [     ]

If common-law wife/husband attach a sworn declaration from a Justice of the Peace, Lawyer or Notary Public).

Particulars of Deceased

Full name of deceased ……………………………………………………………………………………

Surname     Other Names

Form SUP 1 (Revised October 1998)
Address ……………………………………      NIS No. |___|___|___|___|___|___|

Date of birth: |___|___|___|     Date of death: |___|___|___|

Was death due to accident at work? Yes [ ] No [ ]
If yes, state date of accident ……………………………………………………………………….
If not, state cause of death ………………………………………………………………………..

Was deceased in receipt of benefit from NIS? Yes [ ] No [ ]
State which benefit ………………………………………………………………………………...

Name of last employer …………………………………………………………………………….
Address of last employer …………………………………………………………………………..

PARTICULARS OF CHILDREN OF DECEASED PERSON

<table>
<thead>
<tr>
<th>Full Name</th>
<th>Address</th>
<th>Sex</th>
<th>Date of Birth</th>
<th>Surviving parents Name</th>
<th>Address of Educational Institution</th>
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(Attach birth certificate of each child under 18 years)

One parent deceased [ ]     Orphan [ ]     Invalid [ ]

As far as you are aware are there any children of the deceased under the age of 16 years other than those mentioned above? Yes [ ]

If the answer to the above is yes, please state
Name …………………………………………. Address ………………………………………..
………………………………………….                         ………………………………………..

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

Signature of Claimant      Date

Please complete fully and send immediately to the National Insurance Office. Failure to apply within 3 months may mean loss of some benefit.

Form SUP 1 (Revised October 1998)