APPLICATION FOR INVALIDITY BENEFIT FORM

PENSION/PROVIDENT FUND

www.nssf.or.ke

Tick where Appropriately

Pension Fund ☐

Provident Fund (Old) ☐

Provident Fund (New) ☐

This application form is issued and processed FREE of charge.

PART A: Eligibility for invalidity pension

The member should have made at least thirty six monthly contributions to pension fund immediately preceding declaration of invalidity.

Should have been declared INVALID upon physical examination by a medical board

The Medical Board should have issued a dully signed certificate of invalidity

The Director of Medical Services (DMS) should have recommended payment

National Social Security Fund
Social Security House, Bishops Road, P.O. Box 30599-00100, Nairobi
Landlines: 2729911/ 2710552
Email: info@nssfkenya.co.ke

SF/BEN/IB/DF/002

PART B: Requirements

1. Member Statement
2. Original Membership card.
3. Original claimant's identity card.
4. Original and copy of Letter of retirement or termination on medical grounds from the last employer
5. Original and copy of GP-24(revised)/letter of Confirmation into P&P terms.(old fund)
6. Original and copy of ATM/Bank card
7. EFT Authority form
8. A full set of finger prints
9. Postal Address
10. Email address (where available)
11. Employer name(s) and working history
12. Left thumb print on the application form
13. Part D of this form must be completed by the doctor at the hospitals where the claimant received treatment
14. Certified Copies of hospital attendance records and treatment records
15. Part E should be completed by the last employer where member retired on medical grounds.

NOTE:

CERTIFIED MEDICAL/TREATMENT RECORDS FROM THE HOSPITAL THAT THE MEMBER ATTENDED MUST BE ATTACHED TO THIS APPLICATION FORM.

FOR OFFICIALUSE ONLY

Checked and received by

SIGNATURE………………………

DATE …………………………………...

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PART C: PARTICULARS OF MEMBER

To Be Completed By Member

Member Name *	
Member Number *	
Member ID Number *	

HOME PARTICULARS

Nationality *			
County *		Location *	
District *		Sub-Location *	
Village *			

Address *	**Code** *	**City/ Town** *
Email		

EMPLOYMENT HISTORY

EMPLOYER(S)NAME *	ADDRESS*	P/NO *	DATE EMPLOYMENT STARTED *	DATE EMPLOYMENT CEASED *
1st				
2nd				
3rd				
4th				
5th				

8. PART D: PARTICULARS OF INVALIDITY

To Be Completed By the Hospital

•Date accident/illness occurred……………………………………………………………….

•Accident reported at ……………………………........……………………………………

•Date accident reported to Ministry of Labour by the employer…...............…………

•Date(s) of admission in hospital (where applicable)

Admission date………………………………………………….

Discharge date…………………………...............................

Hospital name…………………………………………………

Postal address ……………………code…………………………....

Phone number……………………………………………………

Hospital official stamp

9. PART E: 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 of…………………………………………….. Hospital

Name of officer………………………………………….

Designation……………................……………l…….

Telephone No………………………………………….

Signature ……………………………………………

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PART F: CERTIFICATE OF INVALIDITY

To be completed by the Doctor/medical practitioner from the hospital that treated the patient

MEDICAL REPORT FOR MR/MISS/MRS…………………………………………………………………

In compliance with the Section 38 of the National Social Security Fund Act No.45 of 2013 which requires a declaration by a qualified medical practitioner as to the truth of statement of fact;

I have examined the above named and accordingly confirm that he/she is suffering from:-

a) Permanent total incapacity

b) Partial incapacity of a permanent nature, and that he/she is unable by reason of such disability to earn a reasonable livelihood.

The degree of permanent incapacity, if any is……………………percent.

Doctor's detailed medical report after examining the patient ....…………..................

……………………………………………………………………………………………………

……………………………………………………………………………………………………

Doctors Name……………………………………………

Telephone No……………………………………………

Signature …………………………………………………..

Date…………………………………………………………

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PART G: DECLARATIONBYMEMBER

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

Signature………………………………………

Date……………………………………………

Left thumb print

PART H

CONCURENCE BYTHE DIRECTOR OF MEDICAL SERVICES

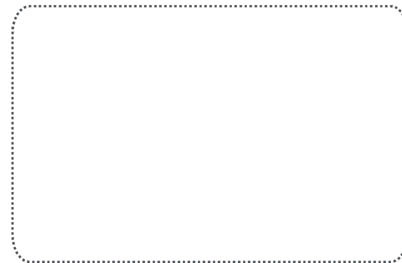
Based on the patient's certified copies of medical records attached herein, and based on the findings of the medical/invalidity assessment Board upon the physical examination of the patient and documented on the medical/invalidity assessment Board report here in,

I Concur ☐ NOT Concur ☐ with decision of the medical/invalidity assessment Board

Remarks…………………………………………………………………………………

…..…...................

Signature ……………………………………………… Date……...……………………



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WARNING

Any person who fails to disclose or misrepresents any material fact whether or not such non-disclosure or misrepresentation is fraudulent and receives any benefits he/she is not entitled to receive as a consequence of the non-disclosure or misrepresentation is liable to repay the benefits within **21 days.** A person who contravenes this is liable on conviction to a fine not exceeding **KSHS: 300,000/-** or imprisonment for a term not exceeding three months or both, in accordance to **NSSF ACT NO. 45 OF 2013.**