

ANTIGUA AND BARBUDA



THE MEDICAL BENEFITS REGULATIONS, 2011

STATUTORY INSTRUMENT

2011, No. 27

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THE MEDICAL BENEFITS REGULATIONS, 2011

2011, No. 27

THE MEDICAL BENEFITS REGULATIONS made in exercise of the powers contained in sections 38, 47, 52 and 59 of the Medical Benefits Act, 2010 No. 4 of 2010.

1. Short title

These Regulations may be cited as the Medical Benefits Regulations, 2011.

2. Interpretation

(1) In these Regulations—

“authorised person” means a person authorised in the manner set out under regulation 10(2) to collect prescriptions or make claims on behalf of a person who cannot do so;

“earnings” means wages, salaries and similar payments made to an employed person in respect of his employment but shall not include payments for sick or maternity leave, severance pay, allowances for travelling or meals or similar allowance;

“Act” means the Medical Benefits Act 2010, No. 4 of 2010; and

“medical practitioner” means a medical practitioner registered in accordance with the Medical Practitioners Act 2009, No. 3 of 2009.

(2) For the purpose of these regulations, a self-employed person is a person who works for himself in a trade, business, profession or activity that he operates to provide services or products to customers and includes directors of corporations.

3. Beneficiaries

For the avoidance of doubt, a person who may receive benefits under the Scheme is a person who—

- (a) satisfies the requirements under section 41 of the Act;
- (b) has paid medical benefits contributions in respect of at least twenty six weeks in any calendar year, or any consecutive period of twelve months;
- (c) who was born in Antigua and Barbuda or is lawfully ordinarily resident in Antigua and Barbuda and
 - (i) is certified by a medical practitioner to be suffering from the following diseases—

- (a) hypertension;
 - (b) diabetes;
 - (c) cardiovascular diseases;
 - (d) sickle-cell anaemia;
 - (e) cancer;
 - (f) leprosy;
 - (g) certified lunacy;
 - (h) glaucoma;
 - (i) asthma;
 - (j) Parkinson's disease; and
 - (k) epilepsy;
- (ii) is rendered permanently incapable of work by virtue of age or otherwise;
 - (iii) is less than sixteen years of age; or
 - (iv) is less than 21 years of age and still a student.

4. Registration

(1) Subject to subsection 33(2) an application for registration under section 32 of the Act shall be made to the Board, in the case of—

- (a) an employer, in the Form set out in Schedule V; and
- (b) a self employed person, in the Form set out in Schedule III.
- (c) an employed person, in the Form set out in Schedule VIII.

(2) An application for registration under section 46 of the Act shall be made to the Board in the Form set out in Schedule IV.

(3) Where the Board determines it is necessary, an application for registration shall be accompanied by an authorisation for disclosure in the Form set out in Schedule XII and a certificate from a registered Medical Practitioner in the Form set out in Schedule XIII.

(4) A person who satisfies the requirements for registration under the Act shall be issued with a certificate of registration in the Form set out in Schedule IX.

5. Monthly remittance forms and due date for payment of Contributions

(1) The Board shall determine the months and dates for which contributions are due to be paid in respect of a person who is required to make contributions to the Scheme under the Act.

(2) The Minister may by Notice in the *Gazette* publish the months and dates determined by the Board under sub-regulation (1).

(3) An employer who is required to pay contributions to the Scheme under the Act shall pay his contribution on or before the 14th day of each month for which his contribution is due to be paid unless he is authorised in writing by the Chief Executive Officer to pay his contributions on a different date.

(4) An employer under sub-regulation (3) shall also submit to the Board a monthly remittance Form in the manner set out in Schedule XIV.

(5) A person who has been issued with certificate of voluntary registration shall pay his contribution to the Scheme on or before the 14th day of each month for which contribution is due to be paid unless he is authorised in writing by the Chief Executive Officer to pay his contributions on a different date.

(6) A self-employed person shall pay contributions to the Scheme in accordance with sub-regulation (1).

6. Voluntary Contributions

A person who has been issued with certificate of voluntary registration under section 46 of the Act, may be required to pay a contribution of 3.5% of a notional salary of \$571.43 per month or the amount of \$20.

7. Penalty for late payment of contributions

(1) A person who contravenes regulation 5 shall pay an amount representing 10% of the payment due to be paid to the Scheme in addition to the amount he is required to pay to the Scheme under the Act.

(2) Where there are extenuating circumstances, a person may apply in the Form set out in Schedule VII to the Chief Executive Officer for exemption from payment of the penalty for late payment of contributions.

(3) Further to sub-regulation (1) where a person has payments due to be paid to the Scheme outstanding at the end of a financial year, he shall pay an amount representing 5% of the payment due to be paid to the Scheme for that year in addition to the amount he is required to pay under sub-regulation (1).

8. Exemptions from payment

(1) A person who is on sick leave or maternity leave from work and this leave is authorised by a medical practitioner is exempted from payment of contributions to the Scheme for the period of time for which the leave is granted.

(2) No deductions shall be made from the salary of an employed person under sub-regulation (1) by an employer for the period of leave authorised by the medical practitioner.

9. Effect of sick or maternity leave on entitlement to benefit

Where a person is exempted from payment of contributions to the Scheme due to sick or maternity leave, he shall not lose his entitlement to benefit and the exemption from contribution to the Scheme shall not prevent him from future entitlement to benefit under the Scheme.

10. Claims

(1) A person claiming a benefit under the Act shall present a valid registration card to the Scheme.

(2) If a person who is required to collect medication from a pharmacy under the Scheme is unable to do so, that person may authorise another person to collect the medication on his behalf but may only do so when he has completed and submitted to the Board authorisation in the form prescribed under Schedules I or II, whichever is applicable.

(3) A claim shall be made within 3 months of the date on which the benefit accrued.

(4) A claim shall be made in the Form set out in Schedule X and shall be accompanied by a medical certificate issued by the medical practitioner who is treating the person making the claim.

(5) A person shall receive, upon the submission of a claim to the Board, a receipt in the Form set out in Schedule XI.

(6) If a claim is made for medication or supplies that are not available under the Scheme at the time the claim is made, a pharmacist employed by the Board, on processing the claim may, permit the person making the claim for the medication or supplies to obtain the necessary medication or supplies from a pharmacy designated by the Board for that purpose.

(7) A list of the pharmacies designated by the Board under sub-regulation (6) shall be prominently displayed in all pharmacies regulated by the Scheme.

11. Returning Resident

A resident of Antigua and Barbuda, who lives overseas for more than 3 years continuously, except for those in full-time study at an institution recognised by the Board shall upon their return to Antigua and Barbuda reside in Antigua and Barbuda for 3 consecutive months before they qualify to resume receiving benefits under the Act.

12. Migrants

(1) An unemployed person who migrates to Antigua and Barbuda shall not be registered under the Act unless he has lawfully resided in Antigua and Barbuda for at least twelve consecutive months.

(2) A person who migrates to Antigua and Barbuda and becomes employed in Antigua and Barbuda shall not benefit under the Act unless he has satisfied the requirements of regulation 3(b).

13. Second Opinion

The Board may, before a benefit is awarded to a person, obtain a second medical opinion in respect of any benefit claimed under the Act.

14. Medical Benefit Services

(1) The Minister may by Notice, publish in the *Gazette* a list of medical institutions in Antigua and Barbuda for which payment for hospitalization in accordance with sub-regulation 2 may be refunded under the Scheme.

(2) Benefits under the Act may include—

- (a) a refund for payment or payment for hospitalization in any medical institution listed pursuant to sub-regulation (1) but shall not include the cost of room and amenities;
- (b) medications and other supplies provided for in the Medical Benefits Formulary for the treatment of the diseases set out under regulation 3;
- (c) a refund for payment or payment for medical and surgical care and services including laboratory and other investigations prescribed by a registered medical practitioner;
- (d) a refund for fees paid to a medical practitioner or consultant on behalf of a person who is entitled to receive benefits under the Scheme who is treated for any of the diseases set out under regulation 3; and
- (e) a refund for payment or payment for treatment outside of Antigua and Barbuda for any illness where that treatment is not available in Antigua and Barbuda at the time it is required and referral by a registered medical practitioner is obtained for that treatment.

(3) A person who is referred by a registered medical practitioner for treatment outside of Antigua and Barbuda is entitled, after the initial consultation, to one additional overseas consultation at the discretion of the Board but must be referred for that consultation by a registered medical practitioner.

(4) Where a person is temporarily outside of Antigua and Barbuda for the purpose of vacation, business or some similar purpose and is required to obtain medical treatment in an emergency situation, the expenses paid for that medical treatment may be refunded on the approval of the Board—

- (a) subject to regulation 15(d); and
- (b) following the submission of any supporting documentation that the Board may consider necessary.

15. Rates of benefits

- (1) The Minister may by Notice publish in the *Gazette*—
 - (a) a Fee Schedule in accordance with which claims for refunds under the Scheme will be awarded;
 - (b) the list of the diseases for which expenses for treatment and services may be provided for under the Scheme;
 - (c) the sum that shall be refunded to persons with any of the prescribed diseases for medical appointments; and
 - (d) the maximum amount that will be refunded to a person who has obtained medical treatment overseas.

(2) A person who receives medical care or service in a medical institution in Antigua and Barbuda as prescribed for any condition provided for under the Scheme shall be refunded in accordance with the Fee Schedule published under sub-regulation (1).

(3) Refunds for out-patient services and overseas medical treatment shall be made in accordance with the Fee Schedule under sub-regulation (1).

16. Classification of Self-Employed Persons

(1) A self-employed person shall when registering in the Form set out in Schedule III disclose his earnings for the year prior to that for which he will be required to make contributions.

(2) After a self-employed person is registered he shall at the end of each subsequent year make a declaration of his earnings in the Form set out in Schedule XV for that year.

(3) A self-employed person shall submit to the Chief Executive Officer all relevant information relating to his income as may be required for the purpose of determining his rate of contribution.

17. Rates of Contributions

(1) An employer shall pay contributions to the Scheme at the rate of 3½% of the salary or wages of all of his employees who are under the age of 60 years.

(2) The contribution to be paid on behalf of an employed person who has attained the age of 16 years or over but who has not attained 60 years of age shall be 3½% of that person's salary or wages.

(3) The contribution to be paid on behalf of an employed person who has attained the age of 60 years or over but who has not attained 70 years of age shall be 2½% of that person's salary or wages.

(4) A self-employed person aged 16 years or over but who has not attained 60 years of age shall pay contributions to the Scheme at the rate of 5% of the category into which his salary falls as determined by the Board.

(5) A self-employed person aged 60 years or over but who has not attained 70 years of age shall pay contributions to the Scheme at the rate of 2 ½ % of the category into which his salary falls as determined by the Board.

(6) The Minister may by Notice publish in the *Gazette* the categories into which the salaries of self-employed persons fall for the purpose of computing contributions.

18. Cessation of Self-Employment

(1) Where a person ceases to be self-employed he shall within 10 working days of the date upon which he becomes un-employed—

(a) notify the Chief Executive Officer in the Form set out in Regulation VI that his business has been closed; and

(b) pay all outstanding contributions to the Scheme.

(2) A person who ceases to be self-employed but who fails to comply with sub-regulation (1) shall pay all contributions due to be paid under the Scheme until he complies with sub-regulation (1).

19. Offences

(1) A person who sells to another person medicine or supplies obtained under the Medical Benefits Scheme commits an offence and is liable on summary conviction to a fine of \$5000.00 or to pay compensation for the medicine or supplies obtained under the Medical Benefits Scheme or to both.

(2) A person who makes a false declaration for the purposes of registration as an employer, employee or self-employed person commits an offence and is liable on summary conviction to a fine of \$5000.00.

SCHEDULE 1

Regulation 10



MEDICAL BENEFITS SCHEME

LETTER OF AUTHORIZATION (A1)

I _____ (Name of Beneficiary) _____ (MBS Number)

Authorize the following three (3) persons to collect my medication. **

(Authorized person(s) must be over sixteen (16) years old.)**

Signature of Beneficiary: _____ Date: _____

Address: _____

Telephone Number: _____ Cell: _____

Witnessed by:
.....
(Print full Name) - Authorized persons and the beneficiary cannot witness this form.

Signature: Date:

Address:

Telephone Number: Cell:

Please note that there is a verification process to ensure that the information given is correct.

OFFICIAL USE

Processed by: Date:

VERIFIED BY: **DATE:**

Nevis Street, P.O. Box 424 St. John's, Antigua Telephone: (268)481-6200/6367/8 Fax: (268) 481-6370 /6330

SCHEDULE II

Regulation 10



MEDICAL BENEFITS SCHEME

LETTER OF AUTHORIZATION (A2)

Important Read Carefully

LETTER OF AUTHORIZATION (A2) is a certification form to facilitate beneficiaries who are not competent to complete the form. This form should be completed and signed by a

person of the following designation and station, whether currently employed or retired: a Magistrate, Notary Public, Minister of Religion qualified under the law to perform marriages, Professional Engineer, Professional Accountant, Police Officer (*Gazetted Rank*), Bank Manager, Registered Medical Practitioner, Dentist, Permanent Secretary, Principal Assistant Secretary, Principal of a Primary or Secondary School, Head of Government Department, Barrister-at-Law, Solicitor or Attorney who has been personally acquainted with the applicant for no less than two (2) years and resident in Antigua and Barbuda.

Please note that there is a verification process to ensure that the information given is correct.

I _____ (*declarant*), under penalty of perjury pursuant to the laws of Antigua and Barbuda, certify that _____
(*Name of beneficiary*)

MB Number _____ is a beneficiary of the Medical Benefits Scheme.

He/she authorizes the following three (3) persons to collect his/her medication**

*(**Authorized persons must be over sixteen (16) years old)*

Signature of Beneficiary: Date:

Address Tel. Number: Cell:

Signed by: Occupation:
(*Signature*)

Full Name: Date:
(*in block letters*)

Telephone Number: Cell:

Affix stamp (if applicable)

OFFICIAL USE

Processed by: Date:

Verified by: Date:

SCHEDULE III

Regulations 4 and 16



MEDICAL BENEFITS SCHEME

REGISTRATION FORM FOR SELF-EMPLOYED PERSONS

Please tell us about yourself

1. First Name
2. Middle Name(s) (Alias)
3. Surname
4. MBS Number (Soc. Sec. #)
5. Date of Birth
6. Home Address
.....

- 7. How long have you lived at this address
- 8. Home Telephone Number(s) (Cellular)
- 9. Email Address
- 10. Are you a Citizen of Antigua and Barbuda? YES NO
- 11. Please provide the following documents:
 - a. A Valid Passport
 - b. A Valid Work Permit (where required)
 - c. Documentary Proof of Legal Residency (where required)
- 12. Have you ever registered with MBS as a self-employed person?
YES NO (Give Details)

Please tell us about your Business

- 13. When did you start your business?
- 14. Does your business have a name? YES NO
Give Business Name
- 15. Business Address
- 16. Business Telephone (Cell)
- 17. What kind of business are you engaged in?
.....
- 18. What is your position in the Business?
- 19. Are there other Partners in the Business? YES NO
Please give their names and addresses
.....

20. Based on the chart below, please indicate your monthly income category.

A B C (\$..... . 00)

CLASS	MONTHLY EARNINGS	RATE
"A"	Over \$4,500.00	5%
"B"	\$3,000.01 to \$4,500.00	5%
"C"	\$3,000.00 and under	5%

21. Signature of Applicant Date

22. Registered By

23. Verified By

SCHEDULE IV

Regulation 4



MEDICAL BENEFITS SCHEME

**APPLICATION FOR A CERTIFICATE OF VOLUNTARY
REGISTRATION**

1. First Name

2. Middle Name(s) (Alias)

- 3. Surname
- 4. MBS Number (Soc. Sec. #)
- 5. Date of Birth
- 6. Home Address
.....
How long have you lived at this address?
- 7. Home Telephone Number(s) (Cellular)
- 8. Email Address
- 9. Name(s) of Previous Employer(s) if applicable
 - (1) (Period of Employment)
 - (2) (Period of Employment)
- 10. Are you currently receiving medication from us? YES NO
Please give details:
.....
- 11. Please provide the following documents:
 - a. A Valid Passport
 - b. A Valid Work Permit (where required)
 - c. Documentary Proof of Legal Residency(where required)

I certify that the information provided is true and correct

12. Signature of Applicant Date

Note: *A Certificate of Voluntary Registration is only valid until you find new employment. As soon as you secure this employment, the certificate must be returned to the Medical Benefits Scheme forthwith. Using a Certificate of Voluntary Registration for purposes of*

benefits while in employment/self-employment is an offence under section 46 of the Medical Benefits Act 2010, No. 4 of 2010.

SCHEDULE V

Regulation 4



MEDICAL BENEFITS SCHEME

P.O. Box 424, Nevis Street, St. John's, Antigua. Telephone: (268) 481-6200/6216-19481-6367/8 Fax: 481-6370

Employer Registration Number

REGISTRATION FORM FOR EMPLOYER

1. Business Name

.....

2. Trade Name (if applicable).....

3. Business License Number

4. Number of persons employed: Male..... Female.....

5. Location where main activities will be or are carried on: (be specific).....

.....
.....

6. Mailing address.....P.O. Box No.....

7. Email address

8. Business Phone Mobile Phone Fax No.....

9. Business commence date.....

10. Date wages were first paid.....

11. SECTOR: Private Government
Quasi Government

12. TYPE OF OWNERSHIP: Sole Partnership Corporation/ Limited
Liability Company

13. OWNERS & DIRECTORS :

Name(s)	Address	Title	Phone No. /Cell

14. Was the business acquired from someone or previously registered with the Scheme?

Yes No If yes, complete lines 15 -17

15. Previous Business Name
.....

16. Previous Business Owner Name and Address
.....

17. Date of acquisition or Business Name

Change.....

18. List all business locations:

Business/Trade Name Location Type of activity or product

(be specific)

19. Is your payroll computerized? Yes No

Name of Payroll software used:
.....
.....

Name (print).....

Signature.....

Title of Officer.....

Date.....

OFFICIAL USE

Registration Number:

.....

Zone:

.....

Dispatched documents: employer letter R3A D3 Deduction table

Comments:

.....

.....

.....

Processed by: **Date:**

.....

VERIFICATION

Comments:

.....

.....

.....

I certify that the information contained in the application is complete and accurate, and all required documents have been submitted.

.....

Customer Service Supervisor

Date:

SCHEDULE VI



MEDICAL BENEFITS SCHEME

NOTICE OF DISCONTINUATION OF BUSINESS

Important Read Carefully

You need to notify the Medical Benefits Scheme when you close your business. This allows the Scheme to close your account. Failure to properly notify the Scheme may cause unwanted correspondence and/or additional contacts for estimated arrears as your business may be viewed as owing outstanding contributions.

You need to be specific and accurate in providing the relevant information, as it is a criminal offence, subject to penalties under the MBS Act, for failure to pay your contributions.

1. Registration Number: _____ 2. Business Name: _____

3. Business Address: _____ 4. Business Telephone Number: _____

5. Owner's/Officer's Name: _____

6. Current Address: _____

7. Telephone Number: _____ 8. Cell Number: _____

9. On _____, 20____, this business will discontinue operations:

Permanently

Temporarily: Period Start Date: _____ Period End Date: _____

dd/mm/yyyy

dd/mm/yyyy

10. The undersigned requests:

The registration is cancelled and the account closed.

The account is temporarily closed.

If closure (permanent end of business) complete # 11 & 12 or skip to # 13:

11. Does the business currently have employees?

Yes

No

If yes, the effective date the employees will be severed: _____

dd/mm/yyyy

12. Has there been a transfer or a change of ownership? Yes No

If yes, state below:

Trade name of new business:

New owner's name:

Starting date of new business: _____

dd/mm/yyyy

13. If this is a consolidated registration, are all locations being closed? Yes No

If no, list specific locations to be closed:

Signature of Employer: _____ Title: _____ Date: _____

Prepared by: _____ Date: _____

For Official Use

Was the date that the business was discontinued estimated?	Yes	No
Accounts receivable and records remain to be collected?	Yes	No
A warrant is recommended?	Yes	No

Comments:

Prepared By (Invigilator): _____ Date: _____

Account Status Changed By (Customer Service Clerk): _____ Date: _____

Nevis Street, P.O. Box 424, St. John's, Antigua Telephone: (268)481-6200/6367/8 Fax: (268) 481-6370 /6330

SCHEDULE VII

Regulation 7



MEDICAL BENEFITS SCHEME

**APPLICATION FOR WAIVER OF PENALTY FOR LATE
PAYMENT OF CONTRIBUTIONS**

To: Chief Executive Officer
Medical Benefits Scheme

Name of Business Registration Number

Address of Business

Month and Year for which waiver is Requested

Amount of Contribution due \$

Late Payment Amount (10%) \$

Reasons for Application of Waiver:

.....
.....
.....
.....

.....
.....

I declare that the information provided is true and correct. I understand that any false information provided is an offence under the Medical Benefits Act and subject to

.....

Name of Person making Request for Waiver

Position Business Stamp

Signature Date

SCHEDULE VIII

Regulation 4



MEDICAL BENEFITS SCHEME

REGISTRATION FORM FOR EMPLOYED PERSONS

MEDICAL BENEFITS Number:

SURNAME / LAST NAME:

CHRISTIAN / FIRST NAMES:

ALIASES:

MAIDEN NAME / OTHER NAMES KNOWN BY:

ADDRESS:

DATE OF BIRTH:

SEX:

PLACE OF BIRTH:

NATIONALITY:

TELEPHONE NUMBER:

MOBILE NO:

E-MAIL ADDRESS:

SOCIAL SECURITY NO:

VERIFICATION DOCUMENT:

DATE OF REGISTRATION:

MARITAL STATUS:

DATE OF MARRIAGE:

SPOUSE:

MOTHER'S NAME:

EMPLOYER NUMBER AND NAME:

DATE OF EMPLOYMENT:

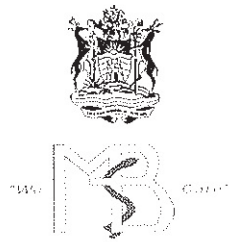
REGISTERED BY:

VERIFIED BY:

SIGNATURE OF APPLICANT:

SCHEDULE IX

Regulation 4



MEDICAL BENEFITS SCHEME

CERTIFICATE OF REGISTRATION

Name:

Address:

Registration Date:

Medical Benefits No:

Medical Benefits Card Due Date:

YOU ARE INELIGIBLE TO CLAIM BENEFITS UNTIL YOU RECEIVE YOUR BENEFICIARY CARD WHICH WILL NOT BE ISSUED UNTIL CONTRIBUTIONS HAVE BEEN PAID TO THE SCHEME ON YOUR BEHALF FOR A PERIOD OF SIX MONTHS.

SCHEDULE X

Regulation 10



MEDICAL BENEFITS SCHEME

CLAIM FORM

Date received:

Claim Number:

Medical Benefits Number:

Name:

State preference if you desire your cheque to be mailed YES..... NO.....

Mailing address:

Telephone No:

Mobile Number:

E-mail address:

Payee Name:

Member's Signature: Date:.....

Authorised Signature:..... Date:.....
(On behalf of Member)

Official use only

Amount claimed:.....

Amount refunded:.....

Comments:.....

Processed by:.....
(Benefits Department Clerk)

Approved by:.....
(Supervisor for Benefits Department)

SCHEDULE XI

Regulation 10



MEDICAL BENEFITS SCHEME

CLAIM RECEIPT

Name:

Medical Benefits Registration Number:

Date received:.....

The Medical Benefits Board of Antigua and Barbuda hereby acknowledges the receipt of your claim, reference number.....

SCHEDULE XII

Regulation 4



MEDICAL BENEFITS SCHEME

AUTHORISATION FOR DISCLOSURE

To the Chief Executive Officer
Medical Benefits Scheme

Full Name:

Address:

Date of Birth:

Place of Birth:

Residing in Antigua and Barbuda From:

Signature:

Date:

I hereby authorise the disclosure of the diagnosis overleaf for the purpose of my registration under the Antigua and Barbuda Medical Benefits Scheme.

Name:.....

Address:.....

.....

Date:.....

SCHEDULE XIII

Regulation 4



MEDICAL BENEFITS SCHEME

MEDICAL CERTIFICATE

To (name of patient):

Medical Benefits Number:

I hereby certify that on the _____ day of _____, 20____ I examined you and found you to be suffering from the following:

.....
.....
.....

(Please print)

Name of practitioner:
(Please print)

Registration Number:

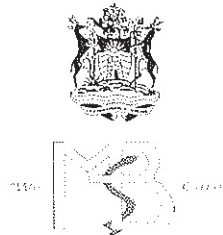
Signature:

Address:

Date:

SCHEDULE XIV

Regulation 5



MEDICAL BENEFITS SCHEME

MONTHLY REMITTANCE

Registration Number:

Earnings

KEY 3 ½ Contribution
 %
 3 ½ Contribution
 %

Employer:.....

P.O.Box. No.:..... Address:.....

For the month of20.....

PLEASE NOTE THAT EARNINGS EXCLUDE SICK OR MATERNITY LEAVE PAY,
 TRAVELLING & MEAL OR SIMILAR ALLOWANCES

Registrat ion Number	NAMES OF EMPLOY EES	S E X	EARNINGS AND CONTRIBUTION					Employee s Earnings for the month	Employee s Insurable Earnings	No. of week s work ed	* M W	Comme nts
			W E/ /	W E/ /	W E/ /	W E/ /	WE/ / or month ly salary					
			\$	\$	\$	\$	\$		\$			
			3 ½ %	3 %	3 %	3 %	3 ½ % \$	3 ½ %	\$			
			3 ½ %	3 %	3 %	3 %	3 ½ % \$	3 ½ %	\$			
	DO NOT WRITE ON THIS LINE											
			\$	\$	\$	\$	\$		\$			
			3 ½ %	3 %	3 %	3 %	3 ½ % \$	3 ½ %	\$			
			3 ½ %	3 %	3 %	3 %	3 ½ % \$	3 ½ %	\$			

			3 1/2 % \$	3 1/2 % \$	3 1/2 % \$	3 1/2 % \$	3 1/2 % \$	1/2 %					
	DO NOT WRITE ON THIS LINE												
			\$	\$	\$	\$	\$	3 1/2 % \$		\$			
			3 1/2 % \$	3 1/2 % \$	3 1/2 % \$	3 1/2 % \$	3 1/2 % \$	3 1/2 % \$		\$			
	DO NOT WRITE ON THIS LINE												
			\$	\$	\$	\$	\$	3 1/2 % \$		\$			
			3 1/2 % \$	3 1/2 % \$	3 1/2 % \$	3 1/2 % \$	3 1/2 % \$	3 1/2 % \$		\$			
	DO NOT WRITE ON THIS LINE												
			\$	\$	\$	\$	\$	3 1/2 % \$		\$			
			3 1/2 % \$	3 1/2 % \$	3 1/2 % \$	3 1/2 % \$	3 1/2 % \$	3 1/2 % \$		\$			
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SCHEDULE XV

Regulation 16



MEDICAL BENEFITS SCHEME

DECLARATION

Name:

Registration Number:

Type of Business (if changed):

Address:

Telephone Number:

Statement for the year 20.....

Attachments (please list here if applicable):

I declare the above information to be true and
(please print)

correct.

.....

Signature

.....

Date

Made the 29th day of April, 2011.



The Honourable Wilmoth Daniel,
Minister responsible for Health.