Injury Benefit

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SOCIAL SECURITY

** Indicates mandatory information*

Scope for this application: *Tick (✓) as applicable*

Tick as applicable (you can select more than one option as necessary)

- ☐ Claim for Injury Benefit to the Department of Social Security
- ☐ Report to the Occupational Health and Safety Authority
- ☐ Report to the Occupational Health and Safety Authority by the employer

Section 1: Personal Details

ID Card Number: * _____

Title: * _____

Name: * _____

Surname: * _____

Date of Birth *(DD/MM/YYYY)*: * _ _ / _ _ / _ _ _ _

Section 2: Permanent Address

Address

House Number / Name: * _____

Locality: * _____

Street: * _____

Post Code: * _____

Section 3: Applicant Details

Status:

- ☐ Single
- ☐ Married / Civil Union / Cohabitation
- ☐ Single Parent
- ☐ Separated maintaining spouse
- ☐ Separated not maintaining spouse

Gender: _____

Nationality: _____

☐ Select this box if you wish to receive an SMS notification about benefit payments.

Telephone Number: _____

Mobile Number: _____

Fax Number: _____

E-mail: _____

Work: ☐ Employed ☐ Self Employed

☐ Part-Time ☐ Full-Time

Type of Work _____

I work with a roster / shift or six days per week ☐ Yes ☐ No

I don't work on _____ and _____ ☐ Yes ☐ No

Spouse Details *(if applicable):*

ID Number	Name	Surname

Spouse works Full-Time? ☐ Yes ☐ No

Payment Details

The payment should be deposited in a bank Savings or Current account but not in a Loan account.

Only in the case of a Bank Garnishee Order you can receive payment by cheque. ☐ Yes ☐ No

Bank: * _____

IBAN: * | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

The IBAN number that you provide will be used for **all** benefit payments, both current and future

Comments

Section 4: Case Details

Information about the Case

Injury Case: Date of Injury _ _ / _ _ / _ _ _ _ Time of Injury _____

Disease / Medical Case: The condition is the result of an Injury at Work ☐ Yes ☐ No

Information about the work place / environment that caused the case (Example: factory, warehouse, dockyard, construction site, hotel, restaurant, hospital, etc.)

_____

_____

_____

What caused the case (Example: slip, fall from a height, dropping of heavy objects or liquids, burns, breakage of material, loss of control or break-down of machinery or tools, gas leakage, impact by an object, exposure to chemicals, etc.)

Provide more details about machinery, tools, substances, vehicles, scaffolding or other items you were working with before the accident.

With what was the impact causing the accident? (Example: hit the floor, hit by a falling object, electrical shock, exposure to toxic substance, machinery, etc.)

Details of two witnesses of the accident: (to be filled only in case of Injury and NOT in case of Disease / Medical Condition)

Witness 1		
ID Number	Name	Surname

Witness 2		
ID Number	Name	Surname

Applicant's Declaration

I, the undersigned, confirm:

a) That I was injured at work / am suffering from a work-related disease or medical condition,
b) That information provided in the above sections are correct, and
c) In the case of an injury, I have not yet returned to work after my injury.

I know that, in the case of a claim for Injury Benefit, if this claim is not received by the Director (Benefits) within 10 days from the date of injury, I may not be entitled for Benefit. I authorise the Department of Social Security to pass on the information about my case to the Occupational Health and Safety Authority as required for the compilation of statistics.

Signature

Date

Employer's Declaration

1. Applicant's Details

ID Card Number: * _____ Title: * _____

Name: * _____ Surname: * _____

Address

House Number / Name: * _____ *Locality:* * _____

Street: * _____ *Post Code:* * _____

2. To be filled by Employer in the case of an Employed Person or by a Police Officer in the case of a Self-Occupied Person

Declaration in case of an Employed Person *(to be filled by Employer)*
I confirm that the mentioned accident / medical condition happened during or in connection with the mentioned person's work.
If the accident / medical condition did not happen during or in connection with employment, give further details.

_____

_____

_____

_____

_____

Company's Details

Name: _____

Address: _____

_____

Telephone Number: _____

E-mail: _____

Official Rubber Stamp

P.E. Number: _____ VAT Number: _____

Indicate size of enterprise by ticking (✓)

Size of Enterprise	Tick (✓)
0 employed (includes self-employed who do not employ any of them)	☐
1 – 9 employed	☐
10 – 49 employed	☐
50 – 249 employed	☐
250 – 499 employed	☐
500 employed or more	☐
Size of enterprise not known	☐

Did the employed return to work? ☐ Yes ☐ No

If Yes, fill in also the following declaration:

I declare that the above-mentioned person has returned to work on _ _ / _ _ / _ _ _ _

After being absent from work between _ _ / _ _ / _ _ _ _ to _ _ / _ _ / _ _ _ _

_____ _____

Employer's Signature Date

Declaration in case of a Self-Occupied Person *(to be filled by a Police Officer)*

I declare that an Injury Report at the place of work has been logged in by the mentioned person.

_____ _____

Police Officer Signature Police Officer Number

_____

Date

3. To be filled in case of a Public Service Employee

For use by the Head of Department *(where applicable)*

I hereby declare this application's submission without prejudice.

_____ _____

Employer's Signature Date

Annex A

Report of Injury

Medical Doctor Declaration

1. Applicant's Details

ID Card Number: * _____ Title: * _____

Name: * _____ Surname: * _____

2. To be filled by the Medical Doctor Examining the Injured Person

I have examined the injured person and certify that he / she is not able to report back for work today due to an injury specified in **Table A** and **Table B** below.

In my opinion the person will not be able to return to work for at least _____ more (days / weeks / months).

Table A – Classification of Type of Injury at Work

Medical Doctor is requested to tick (✓) type of injury on the table below:

Type of Injury	Tick (✓)
Injury not known or not specific	☐
Superficial Wound or Injury	
Superficial Injury	☐
Open wound	☐
Other type of superficial wound or injury	☐
Fracture of Bones	
Closed fractures	☐
Open fractures	☐
Other type of bone fractures	☐
Dislocations, Disjoints and overwork	
Dislocations	☐
Disjoints and overwork	☐
Other types of dislocations, disjoints and overwork	☐
Amputation of body parts	☐
Concussion and Internal Injury	
Concussion and head injury	☐
Internal Injury	☐
Other types of concussion and head injury	☐

Type of Injury	Tick (✓)
Burns, Scalds and Skin Inflammation due to cold	
Burns and scalds	☐
Burns due to chemical	☐
Inflammations of skin due to cold	☐
Other types of burns, scalds and skin inflammation due to cold	☐
Poisoning and Infections	
Severe poisoning	☐
Severe infection	☐
Other types of poisoning and infections	☐
Drowning and Shortness of Breath	
Shortness of breath	☐
Drowning	☐
Other types of drowning and shortness of breath	☐
Noise Effects	
Severe hearing loss	☐
Other noise effects	☐
External temperature, Light and Radiation Effects	
Heat and Sunstroke	☐
Radiation Effects	☐
Low temperature effects	☐
Other effects due to External Temperature, Light and Radiation	☐
Shock	
Shock from aggression or threatening	☐
Traumatic Shock	☐
Other types of shock	☐
Multiple Injury	☐
Other specific injuries not listed in this table	☐

Table B – Part of Body Effected due to Incident

Medical Doctor is requested to tick (✓) the part of body effected due to the incident on the table below:

Part of Body Effected due to Incident	Tick (✓)
A nonspecific part of the body	☐
Head	
Head, Brain, Nerves of the Skull	☐
Face	☐
Eyes	☐
Ears	☐
Teeth	☐
Various parts of the head	☐
Another part of the head not mentioned above	☐
Neck and backbone	
Neck and backbone	☐
Other parts of the neck not mentioned above	☐
Back and backbone	
The back and the backbone	☐
Other parts of the back not mentioned above	☐
Torso	
Ribs, joints, shoulders	☐
Chest	☐
Pelvis, Stomach	☐
Various parts of the torso	☐
Other parts of the torso not mentioned above	☐
Upper part of the body	
Shoulders and shoulders' joints	☐
Arm and elbow	☐
Hands	☐
Fingers	☐
Wrist	☐
Various parts of the upper part of the body	☐
Parts of the upper part of the body not mentioned above	☐
Lower part of the body	
Hips and hips' joints	☐
Legs and knee	☐
Ankle	☐

Part of Body Effected due to Incident	Tick (✓)
Foot	☐
Toes	☐
Various parts of the lower part of the body	☐
Parts of the lower part of the body not mentioned above	☐
Whole body or various nonspecific parts	
Whole body	☐
Various body parts	☐
Other parts of the body not mentioned above	☐

_____ _____

Name and Surname (*Doctor*) Medical Council Number

_____ _____

Signature (*Doctor*) Date

Data Protection Declaration:

The Department of Social Security collects all relevant personal information to provide its services to individuals who qualify for assistance, allowance or non-contributory pensions in accordance with the Social Security Act (Cap. 318.). The Department may verify the information submitted by you in line with Article 133 (b) of the Social Security Act to ensure its accuracy in relation to the claim. Personal data may be disclosed to departments / third parties, who may also have access to your data as authorised by law. Personal information may also be exchanged with benefits institutions of other countries to combat and deter fraud, as provided for in international treaties or bilateral agreements to which Malta is a party. You will be informed in due course of the result of your claim after it has been assessed.

The Department of Social Security treats your personal information in accordance with the Data Protection Act, (Cap. 440.) to protect your privacy. You may request in writing to access information held about you, and eventually to rectify, and where applicable to erase incorrect information, having regard to the claim for which you applied. Such request is to be addressed to "The Data Controller" at the Department and appropriate action would be taken at the earliest possible time. When making such requests, kindly quote your identity card number, national insurance number, your name and address and include any other relevant documentation to identify your case.