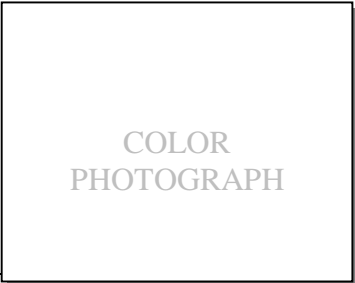




NATIONAL SOCIAL SECURITY AND WELFARE CORPORATION (NASSCORP)
15TH Street & Payne Avenue, Sinkor, Monrovia, Liberia

SOCIAL SECURITY BENEFITS CLAIM FORM C1
Claims Must Be Submitted Through Formal Transmittal Letters



SECTION 1: PARTICULARS OF EMPLOYER AND EMPLOYEE (To be filled in for all claims)

Employer's /Entity's Full Name	SS Code	Contact information	
Insured person's Full Name (Last Name, First Name Middle Name)	SS Number	Date of Birth	Occupation/Type of Job
		m m d d y y	

SECTION 2: DEPENDENTS (widow, widower, children, parents, grandparents) Fill in for DEATH AND SURVIVOR benefits	SECTION 3: EMPLOYMENT HISTORY SINCE SEPTEMBER 1, 1988 (Fill in only if the insured person is not or was not already receiving Social Security pension)
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Names of Dependents	Age or Date of birth	Sex	Relationship	Previous Employer's Name	From Year	To Year	Currency of Earnings	
							LD	USD

SECTION 4: REQUIREMENTS PER TYPE OF CLAIM (To be attached)

Temporary Disablement Benefit (Accident, Industrial or Occupational) 1. Formal Transmittal Letter from Employer 2. NASSCORP Accident Report from Employer (Form B 26) 3. Two passport size color photos 4. Police Report in case of motor accident or Industrial Accident Report (B 26) 5. Two Eyewitnesses' Statements in case of industrial accident 6. Medical Report/Bill 7. Original Medical Expense Receipt(s) for Re-imbursement	Death Benefit or Survivor's Pension Benefit/Grant 1. Formal Transmittal Letter From Employer/Claimant 2. Certification of Marriage 3. Certification of Death of the Deceased Insured Person 4. One Group Color Photo of Dependents ** 5. Police Report in case of motor accidents 6. Two Eyewitnesses' Statements in case of an industrial accident	Retirement Pension/Grant & Invalidity Pension/Grant 1. Formal Transmittal Letter From Employer/Claimant 2. Two Passport Size Color Photos
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** Dependents include widow, widower, parents, grandparents, children under age 18 years and up to age 21 years for children in school full time



SECTION 5: EARNING HISTORY OF CLAIMANT [Monthly earnings over last ten (10) years or for the tenure of employment if length of employment with current Employer is less than ten (10) years]. Monthly earnings for the last twelve (12) months in case of Employment Injury. [Filled in by Employer]

PERIOD	YEAR												
MONTH	YEAR	YEAR	YEAR	YEAR	YEAR	YEAR	YEAR	YEAR	YEAR	YEAR	YEAR	YEAR	YEAR
January													
February													
March													
April													
May													
June													
July													
August													
September													
October													
November													
December													
Total													

I declare that I, or the aforementioned insured person, was (retired, injured, invalidated, deceased) on the date mm dd yy.

Name of Claimant _____ Signature _____ Contact # _____

ENDORSEMENT BY EMPLOYER'S AUTHORIZED REPRESENTATIVE

Name _____ Title _____ Signature _____ Date _____

COMPANY
STAMP