



CRIMINAL INJURIES COMPENSATION BOARD

Fourth Floor, ABMA Building, #55-57 St. Vincent Street, Port of Spain
Telephone: 627- 2374(6); 624-4696; 627-2321; 625-2855;
Fax: (868) 627-1761

CHECK LIST: Submission of Claims to the CICB

For all Applicants

- Completed application form with current - Phone Contact *and* Postal Address
- Police Report of the incident.
- Two forms of valid Identification birth certificate, drivers permit, ID card
- Three 3 copies of all documents (legal size paper 11x14)
- CICB National Insurance form, completed at the NIB office.
- CICB Public Assistance form completed at the Social Welfare office.
- Proof of Earnings -Job letter/pay slip.
- Proof of payment/award from other institutions, in relation to injury.
- Insurance benefits

For Injury Victims

- Medical report from health institution where injury was treated.
- CICB Medical Form completed by doctor
- Receipts for Medical Expenses
- Photo Pictures of injury
- Results from medical test. e.g X-rays/ other relevant documents.

For Dependents of Victims

- Marriage certificate (if applicable)
- Birth certificate for all dependent listed.
- Victim's Identification e.g birth certificate, drivers permit, ID card
- Proof of Paternity- If victim's name is not list on birth certificate.
- Contact number for the parent/guardian of other dependents.

For Burial Expenses

- Death Certificate
- Receipts from funeral agency (must have been paid by applicant).
- Invoice from the funeral agency.
- Declaration of the source of funds used to pay for burial.
- Burial grant receipts from National Insurance Board (if applicable).
- Funeral grant receipt from Social Welfare (if applicable).

CRIMES COVERED

- Murder, Manslaughter,
- Wounding with intent,
- Inflicting injury with or without a weapon,
- Using a drug with intent to commit an offence,
- Administering poison or other destructive or noxious substances so as to endanger life or inflict grievous bodily harm,
- Administering poison with intent to injure or annoy,
- Offences under the Sexual Offences Act. {Act No. 27 of 1986}
- Offences under the Trafficking in Persons Act. {14 of 2011}.

IMPRISONMENT

A person receiving payments from other sources after being paid by the Board may be asked to repay amounts equal to payment made by the Board. Persons who provides false information to the Board, fails to disclose the amount received from any other source, in respect of the injury, or fails to refund the amount received, commits an offence and is liable on summary conviction to a fine equal to that of the compensation received or the amount received from other sources whichever is less and to imprisonment for six months.

PLEASE NOTE

ALL APPLICATIONS MUST BE SUBMITTED WITHIN

ONE (1) YEAR

OF

INJURY OR DEATH.

SECOND SCHEDULE



[Section 24(2)]

APPLICATION FOR COMPENSATION UNDER THE CRIMINAL INJURIES COMPENSATION ACT, 1999

To: The Chairman
Criminal Injuries Compensation Board

I..... of
(Address)

being a victim of a crime or a dependent person entitled to compensation, hereby apply for compensation under the above Act and furnish the following particulars—

Name of Victim
(Print in block letters)

Name of Applicant (if different from above)

Capacity in which application madeAs Victim

..... As Dependant

Age..... Date of Birth Sex

Occupation.....

Place of Employment

Earnings (Monthly)..... Other..... NIS#.....

Identification: Passport ID Card

Driver's Permit

Crime committed Date.....

Nature of injuries or loss sustained

Circumstances of injuries or loss sustained.....

No. of dependants and dates of birth

Name	Date of Birth	Relationship
1.
2.
3.
4.

Police Station where complaint was made

Date on which complaint was made

Status of Police Investigation.....

(State whether police investigations have begun, are in progress or are completed)

.....

.....

.....

Court Proceedings

(State whether these are civil or criminal)

Status of Court Proceedings

.....

(State whether these have begun and if they have been completed state the result)

Medical Treatment Received

(Please attach medical certificate)

.....

Whether Insured Yes No

Name of Company

Type of Insurance

Do you waive your right to pursue the cause of action which arises as a result of the crime?

..... Yes No

Declaration

(State whether you have received or expect to receive amounts from another source or sources)

.....

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Undertaking *(to repay any amounts received from other sources)*

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List all documents accompanying application

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.....

.....

Signature

.....

Date

REQUEST FOR INFORMATION FROM THE DIVISION OF SOCIAL WELFARE

Address
.....
.....
.....

TO: THE DIRECTOR
Division of Social Welfare
Ministry of Social Development and Family Services

SECRETARY
CRIMINAL IN JURIES COMPENSATION BOARD

Dear Sir/Madam,

I hereby request information regarding any
Applicant's Name
Social Benefits and/or Grants be issued to me.

Yours Faithfully,

.....
Signature of Applicant

Date:

Dear Sir/Madam,

In accordance with the above request, I wish to advise as follows;

1. The Claimant:- A) Is **Not** a beneficiary of any Social Welfare benefits.
B) Is a beneficiary of Social Welfare benefits.
2. Claimant received a **Burial Grant** of (\$).....
Amount in words
..... for the burial of
3. Claimant is in receipt of **Public Assistance Grant** (\$).....
Amount in words
..... Per..... As with effect from.....
4. Claimant is in receipt of **Disability Assistance Grant** (\$).....
Amount in words
..... Per..... As with effect from.....
5. Claimant is in receipt of (\$).....
state benefit Amount in words
..... Per..... with effect from.....
6. Other Remarks:.....

Name of Claimant
ID

Yours Faithfully,
.....
Manager, Local Office
/f/Executive Director
Date:.....

REQUEST FOR INFORMATION FROM THE NATIONAL INSURANCE BOARD NIB

Address
.....
.....
.....

TO: THE EXECUTIVE DIRECTOR
The National Insurance Board
Trinidad and Tobago.

SECRETARY
CRIMINAL INJURIES COMPENSATION BOARD

Dear Sir/Madam,

I hereby request information regarding my
Applicant's Name
records at the National Insurance Board. The following information may be of relevance to you:-

Date of Birth _____ NIS number _____

Yours Faithfully,

..... Date:
Signature of Applicant

Dear Sir/Madam,

In accordance with the above request, I wish to advise as follows;

- 7. The Claimant:- A) Is **Not** a beneficiary of NIB benefits.
B) Is a beneficiary of NIB benefits.

8. Claimant received a **Burial Grant** of (\$)
Amount in words
..... for the burial of

9. Claimant is in receipt of **Survivors Benefit** (\$)
Amount in words
..... Per..... As with effect from.....

10. Claimant is in receipt of **Invalidity Benefits** (\$)
Amount in words
..... Per..... As with effect from.....

11. Claimant is in receipt of (\$)
state benefit Amount in words
..... Per..... with effect from.....

12. Other Remarks:.....

Name of Claimant

ID

Yours Faithfully,
.....
Manager, Local Office
/f/Executive Director

Date:.....