TURKS AND CAICOS ISLANDS NATIONAL INSURANCE BOARD

FOR OFFICIAL USE ONLY
DATE RECEIVED:
CLAIM NUMBER:

UNEMPLOYMENT BENEFIT TERMINATION OF SERVICE FORM

(If more than one employee, attach listing outlining details)

TO BE COMPLETED BY THE EMPLOYER AND EMAILED TO: nibclaims@tcinib.tc

I certify that: ☐ Mr. ☐ Mrs. ☐ Ms.

Full Name: ____
First Name MI Surname

NIS # Claimant ☐☐☐☐☐☐

Has been employed with ____

NIS # Employer ☐☐☐☐☐☐ From: ______________ To: ______________
DD/MM/YYYY DD/MM/YYYY

Employer Address: ____

______________________________ Phone Number: ______________________

Last day for which he/she was paid: ______________
DD/MM/YYYY

If pay in lieu of notice was made, how many weeks? ______________

If vacation payment was made, how many weeks were paid? ______________

Reason for termination / layoff: ____

If known, what us the expected date of re-employment? ______________________

Last wage / salary ______________ ______________
Amount $ Date Paid: DD/MM/YYYY

I certify that the information contained on this form is true to the best of my knowledge and belief.

Employer / Representative: ______________________ ______________________
Name (Please print) Signature

Position: ______________________________

Telephone contact: ______________________

E-mail address: _________________________

Affix Business/Company Stamp/Seal Here

Important Note:

Any person, who for the purpose of obtaining any benefit or other payment under this Ordinance, whether for himself or for some other person knowingly makes any false representation or knowingly allows to be produced any document or information which he/she knows to be false, shall be liable to a fine commits an offence and is liable on summary conviction to a fine of $1000 or to imprisonment for a term of six months, or to both.

Date: _______________________

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