SOCIAL SECURITY (MEDICAL CERTIFICATION) (JERSEY) ORDER 1974

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Jersey

SOCIAL SECURITY (MEDICAL CERTIFICATION) (JERSEY) ORDER 1974

Arrangement

Article

Supporting Documents

Jersey

SOCIAL SECURITY (MEDICAL CERTIFICATION) (JERSEY) ORDER 1974[1]

THE EMPLOYMENT AND SOCIAL SECURITY COMMITTEE, in pursuance of Article 29 of the Social Security (Jersey) Law 1974,[2] orders as follows –

Commencement [see endnotes]

1 Interpretation

(1) In this Order, unless the context otherwise requires –

"determining authority" means, as the case may require, the determining officer or the Social Security Tribunal;

"incapacity" means incapacity by reason of which a person is rendered incapable of work;

"Law" means the Social Security (Jersey) Law 1974;[3]

"signature" means, in relation to any certificate, the name by which the person giving the certificate is usually known (any name other than the surname being either in full or otherwise indicated) written by that person in the person's own handwriting; and the expression "signed" shall be construed accordingly.

(2) For the purpose of any provision of this Order providing that any certificate shall be in a form set out in Schedule 1 or 2, any reference to such form shall include a reference to any such other form substantially to the like effect as the Minister may from time to time approve.

2 Evidence of incapacity and confinement[4]

(1) Every person claiming short term incapacity allowance shall furnish evidence of incapacity, in respect of the day or days for which the claim is made –

(a) in the form set out in Part B of Schedule 1; or

(b) by such other means as the determining authority may accept as sufficient in the circumstances of any particular case or class of cases.

(2) Where the evidence is in the form set out in Part B of Schedule 1, the certificate in that form (as defined in paragraph 1 of Part A of that Schedule) shall be completed in accordance with Part A of that Schedule.

(3) Every woman by whom or on whose behalf a claim for maternity benefit is made shall furnish evidence –

(a) where the claim is made in respect of expectation of confinement, that she is pregnant and as to the stage which she has reached in her pregnancy; or

(b) where the claim is made by virtue of the fact of confinement, that she has been confined.

(4) The evidence to which paragraph (3) refers shall be furnished –

(a) in the form set out in Part B of Schedule 2; or

(b) by such other means as the determining authority may accept as sufficient in the circumstances of any particular case or class of cases.

(5) Where the evidence is in the form set out in Part B of Schedule 2, the certificate in that form shall be completed in accordance with Part A of that Schedule.

3 Citation

This Order may be cited as the Social Security (Medical Certification) (Jersey) Order 1974.

SCHEDULE 1

(Article 2(1))

INCAPACITY

PART A

RULES FOR MEDICAL CERTIFICATION

1. In these rules, unless the context otherwise requires –

   "certificate" means that part of the form in Part B of this Schedule that is headed "Doctor's section";[5]

   "claimant" means the person in respect of whom a certificate is given;

   "practitioner" means a medical practitioner not being the claimant.[6]

2. Every certificate shall be in writing in ink or other indelible substance, and shall contain the following particulars –

   (a) the claimant's name;

   (b) [7]

   (c) a concise statement of the disease, disablement or injury by which the claimant is, in the practitioner's opinion, at the time rendered incapable of work;

   (d) the date on which the certificate is given,

   and shall bear, under the words "Doctor's signature", the signature of the certifying practitioner written after there have been entered on the certificate the claimant's name and a statement of the disease, disablement or injury.[8]

3. The statement of the incapacitating disease, disablement or injury in the certificate shall specify the cause of incapacity as precisely as the practitioner's knowledge of the claimant's condition at the time of the examination permits:

   Provided that, if in the practitioner's opinion a disclosure to the claimant of the precise cause would be prejudicial to the claimant's well-being, the certificate may contain a less precise statement.

4. Every certificate must have been given on a date not more than one day later than the date of the examination on which it is based, and no further certificate based on the same examination shall be furnished other than a certificate to replace an original certificate which has been lost or mislaid, but in that case the form shall be clearly marked "duplicate".

5. [9]

6. Every certificate must cover a specified number of days or weeks from and including the date of the examination on which the certificate is based, which period shall not exceed 28 days or, where at that date the certificate of incapacity has continued for not less than 28 days, 13 weeks. [10]

7. [11]

8. In computing any period of time in relation to any certificate given under rule 6 of these rules, Sunday shall not be disregarded.[12]

PART B[13]

EVIDENCE OF INCAPACITY

Office use only Certificate number

S101 Medical Certificate - Short Term Incapacity Allowance (STIA) benefit

1 Doctor's section - always complete this section

I certify that I have examined (first and last name)

Examination date (DD MM YYYY) / /

Reason for illness and incapacity for work

Ailment code

Return to work date (certificate valid until)

/ /

Is this ailment a flare up of an existing Long Term Incapacity Allowance (LTIA) condition?

Yes ☐ No ☐

Backdate certificate to (DD MM YYYY)

/ /

You **must** provide further details if

- this certificate is backdated by more than 3 days.
- this is a duplicate certificate.
- there is information available which you feel we need to know to support this claim.

Doctor's ID

Doctor's signature

Doctor's name

How we will use your data

We, the Social Security department, will use the information provided and other relevant information we hold to assess your entitlement to STIA. Where we have consent, or laws allow, we may:

- use the information to assess other benefits or services provided by Social Security.
- forward the information to other organisations e.g. for investigating fraud or pursuing debt.
- report accidents at work or work-related illnesses to the Health and Safety Inspectorate.

Claiming STIA benefit

Complete and sign the next page of this form and send the original to the Social Security Department, PO Box 55, La Motte Street, St. Helier, Jersey, JE4 8PE. Your claim may be delayed if you do not return the form to us as soon as possible.

You are not allowed to work and claim STIA. You must tell us if you return to work before your **return to work date** (as given by your Doctor in section 1), or if your circumstances change in any way that may affect your claim.

Further information on STIA can be found at www.gov.je/STIA

States of Jersey

- Write in **BLOCK CAPITALS** and use only **blue** or **black** ink
- Keep within boxes provided and place a ☒ in questions requiring a Yes or No

2 Personal details - always complete this section

First names

Social Security number

Last name

Date of birth (DD MM YYYY) / /

Address

Postcode

Is this where you currently live? Yes ☐ No ☐

Contact phone number

3 Your claim

3.1 Is this **your first** certificate for this period of illness?
Yes ☐ **If yes**, complete all of section 3 No ☐ **If no**, move on to section 4

3.2 What date did you become unfit for work? (DD MM YYYY) / /

3.3 What date did you last work? (DD MM YYYY) / / **or** I have been unemployed for more than 6 months ☐

3.4 Do you claim benefits from another country, or does someone else claim on your behalf?
Yes ☐ No ☐ If yes, tell us which benefit
Country Amount per week £ .

3.5 Have you paid social security contributions in the last 3 years in another country?
Yes ☐ No ☐ If yes, tell us which country

3.6 What is the reason for this illness or injury? (please see "How we will use your data" overleaf)
An accident at work ☐ A work related illness ☐ Neither ☐

4 Who do you want us to pay? Select either option 4.1 or 4.2

4.1 Your employer. They should enter their STIA authority code

OR

4.2 You directly. Tell us your bank details (the details you give will not change any other benefit payments)
Name of account holder
Sort code - - Your account number
Is this a repeat certificate for this period of illness? Cross here if you want us to use the same bank details. ☐

- **I understand that the law does not allow me to work, including voluntary or unpaid work, and claim this benefit.**
- **I will tell Social Security if I return to work early or if my circumstances change in any way that may affect my claim, including absences from Jersey.**
- **I understand that Social Security may speak to my Doctor about the information provided on this form in order to process this claim.**

Signature

SCHEDULE 2

(Article 2(2))

CONFINEMENT

PART A

RULES FOR CERTIFICATION

1. In these rules "midwife" means a person authorized to exercise the profession of midwife in Jersey under the Loi (1922) sur la Santé Publique (Sages-femmes).[14]

2. Certificates of confinement or expected confinement shall be in writing in ink or other indelible substance signed by the medical practitioner or midwife attending the woman.

3. Every certificate of confinement or expected confinement shall contain the following particulars –

   (a) the woman's name;

   (b) as appropriate, the actual date of confinement or the week in which it is to be expected that the woman will be confined, and in either case the date of the examination on which the certificate is based; and

   (c) the date on which the certificate is given,

   and the certificate shall be adjusted and completed accordingly.[15]

4. After a certificate based on an examination has been given, no further certificate based on the same examination shall be furnished other than a certificate to replace an original certificate which has been lost or mislaid, but in that case the form shall be clearly marked "duplicate".

PART B[16]

EVIDENCE OF CONFINEMENT

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States of Jersey
Social Security Department

MATERNITY BENEFIT - ALLOWANCE AND GRANT CLAIM FORM

Claim Number
(For official use only)

1. CERTIFICATE OF PREGNANCY

For Doctor's or Midwife's use only: This section should be completed by a Registered Medical Practitioner or Certified Midwife no earlier than 13 weeks before the date the baby is due.

Title Surname Forename(s)

I certify that I have examined

and that in my opinion the due date is / /

Date of Examination / /

Actual date of birth / /

Signature of Doctor or Midwife

Number of babies expected

Name of Doctor or Midwife

Today's date / /

2. NOTES TO THE CLAIMANT:-

WHEN TO COMPLETE THIS FORM.

Maternity Allowance
This allowance is paid to make it easier for you to give up work to have your baby. The amount you receive will depend on the Social Security Contributions you have paid.

The allowance may be paid for a total of 18 weeks but you cannot receive the allowance whilst you are working. You may attend work for 'keeping in touch' days. Please see the "Maternity Benefits" leaflet (SSD8) for details.

Maternity Grant is a lump sum which is paid to help you with the general expense of having your baby and is paid on either your own, your husband's or your civil partner's contribution record.

If you are claiming on your husband's/civil partner's contribution record, please remember to send your marriage certificate/Civil Partnership Registration with this claim form.

You should submit your claim form to us no earlier than 13 weeks before the baby is due (claims can be considered up to 6 months after the birth).

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MATERNITY BENEFIT - ALLOWANCE AND GRANT CLAIM FORM

3. YOUR PERSONAL DETAILS

If you wish to claim benefit, please complete this form and send it to the Social Security Department, PO Box 55, La Motte Street, St Helier, Jersey JE4 8PE. It is important that you write in BLOCK CAPITALS keeping within the boxes provided, using black or blue ink. Please read the leaflet entitled "Maternity Benefits" (SSD8) before you complete this form. It explains the benefits available and the conditions you have to satisfy, and is available from the Department of Social Security.

Surname

Title

Social Security Number

Forename(s)

Date of Birth / /

Previous Surname *(if applicable)*

Address

Postcode

Daytime phone number

What is your current marital or civil partnership status

- single ☐
- married or civil partner ☐
- separated ☐
- widowed or surviving civil partner ☐
- divorced or civil partnership dissolved ☐

The date of your marriage or registration of civil partnership(If applicable) / /

Husband's/Civil Partner's/Partner's Surname

Title

Their Social Security Number

Their Forename(s)

Their Date of Birth / /

If your partner is claiming Home Responsibility Protection do you wish to claim an increase of benefit in respect of them? Yes ☐ No ☐

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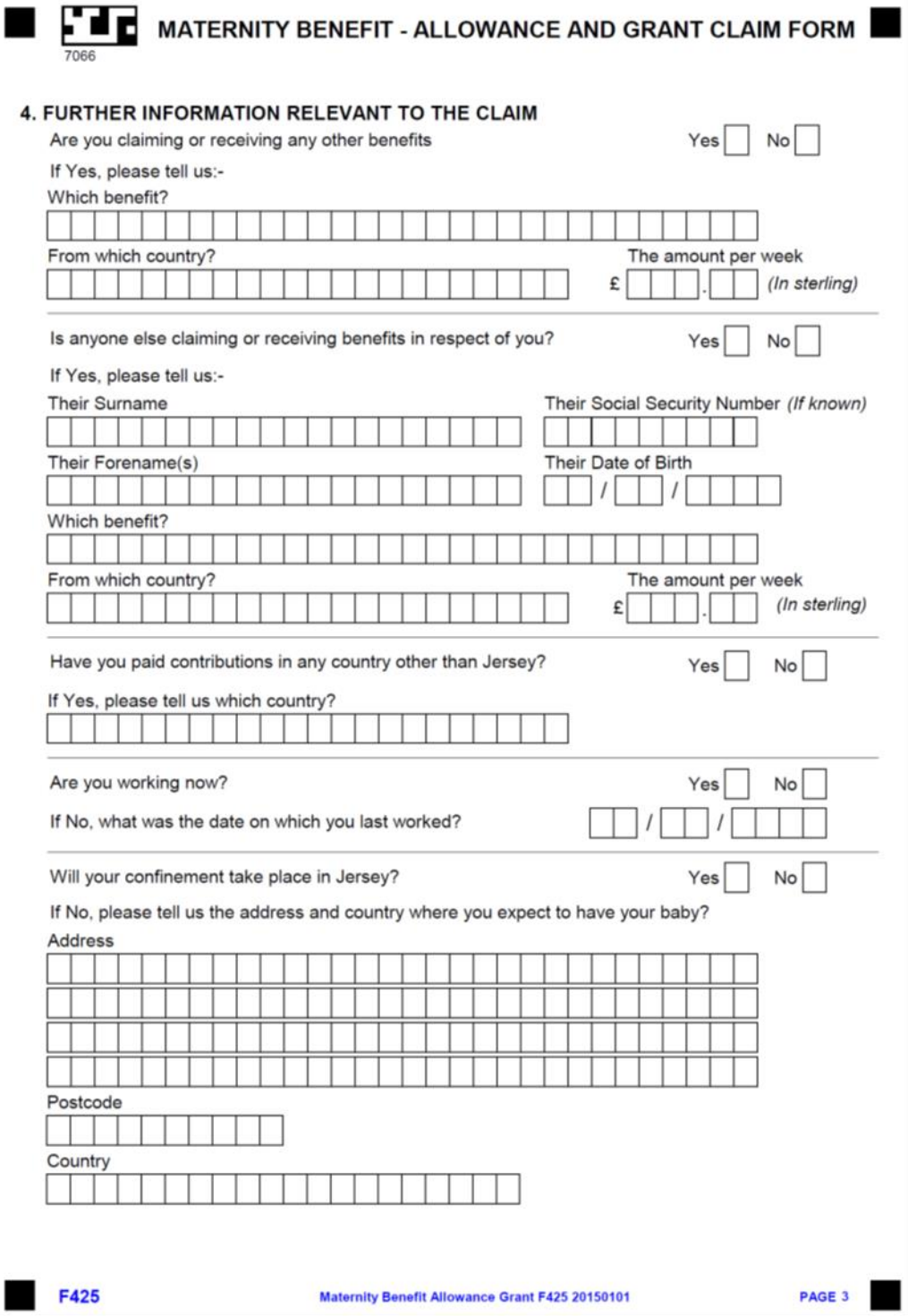

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MATERNITY BENEFIT - ALLOWANCE AND GRANT CLAIM FORM

4. FURTHER INFORMATION RELEVANT TO THE CLAIM

Are you claiming or receiving any other benefits Yes ☐ No ☐

If Yes, please tell us:-

Which benefit?

From which country? The amount per week

£ . *(In sterling)*

Is anyone else claiming or receiving benefits in respect of you? Yes ☐ No ☐

If Yes, please tell us:-

Their Surname Their Social Security Number *(If known)*

Their Forename(s) Their Date of Birth / /

Which benefit?

From which country? The amount per week

£ . *(In sterling)*

Have you paid contributions in any country other than Jersey? Yes ☐ No ☐

If Yes, please tell us which country?

Are you working now? Yes ☐ No ☐

If No, what was the date on which you last worked? / /

Will your confinement take place in Jersey? Yes ☐ No ☐

If No, please tell us the address and country where you expect to have your baby?

Address

Postcode

Country

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MATERNITY BENEFIT - ALLOWANCE AND GRANT CLAIM FORM

5. TO BE COMPLETED ONLY IF YOU ARE CLAIMING BEFORE YOUR BABY IS BORN

Article 22(2) of the Social Security (Jersey) Law, 1974 provides that the Maternity Allowance period may not start earlier than 11 weeks and not later than the date your baby is due. In order that we may know at which point you wish your own Allowance to begin, please complete the statement below. Before deciding please remember that the Allowance cannot be paid for any period while you are working, although you may attend work for 'keeping in touch' days. Please see "Maternity Benefits" leaflet (SSD8) for details.

I wish my Maternity Allowance period to begin on ☐☐ / ☐☐ / ☐☐☐☐

6. PAYMENT DETAILS

We would like to pay your Maternity Benefit direct to your bank account. Please tell us the:-

Name of your Bank

Bank Address

Branch Sort Code ☐☐ - ☐☐ - ☐☐

Bank Account Number ☐☐☐☐☐☐☐☐

Name(s) under which the account is held

C ☐

(For official use only)

7. DECLARATION AND SIGNATURE.

If you are submitting an application for payment to an Agent or Authority please tick this box ☐

I declare to the best of my knowledge and belief all the statements on this form are true and complete and I claim Maternity Benefit.

Your Signature

Today's Date ☐☐ / ☐☐ / ☐☐☐☐

WARNING: This information may be cross checked and any person who knowingly makes any false statement or false representation for the purpose of obtaining benefit for themselves or for someone else commits a criminal offence for which they may be prosecuted. They may also be required to repay the amount fraudulently obtained. The Department must be notified of any change in circumstances, including temporary absences from the Island.

Privacy Statement

The Social Security Department collects information for the purpose of dealing with all matters relating to the benefits and services it administers. We may check information about you with other information we have. We will not give information about you to anyone outside the Department unless the law allows us to or we have your consent.
The Social Security Department is the Data Controller for the purposes of the Data Protection (Jersey) Law 2005.

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ENDNOTES

Table of Legislation History

Legislation	Year and No	Commencement
Social Security (Medical Certification) (Jersey) Order 1974	R&O.6084	1 January 1975
Social Security (Medical Certification) (Amendment) (Jersey) Order 2004	R&O.82/2004	1 October 2004
Social Security (Medical Certification) (Amendment No. 2) (Jersey) Order 2004	R&O.109/2004	1 October 2004 – except Article 4(1), 1 July 2005
States of Jersey (Amendments and Construction Provisions No. 8) (Jersey) Regulations 2005	R&O.48/2005	9 December 2005
Social Security (Miscellaneous Provisions No. 4) (Jersey) Order 2014	R&O.213/2014	1 January 2015
Social Security (Medical Certification) (Amendment No. 3) (Jersey) Order 2018	R&O.56/2018	30 April 2018

Table of Renumbered Provisions

Original	Current
1(2)	spent, omitted from this revised edition
(3)	1(2)

Table of Endnote References

[1] *This Order has been amended by the States of Jersey (Amendments and Construction Provisions No. 8) (Jersey) Regulations 2005. The amendments replace all references to a Committee of the States of Jersey with a reference to a Minister of the States of Jersey, and remove and add defined terms appropriately, consequentially upon the move from a committee system of government to a ministerial system of government*

[2] *chapter 26.900*

[3] *chapter 26.900*

[4] *Article 2* *substituted by R&O.109/2004; former Article 2(1) amended by R&O.82/2004*

[5] *Schedule 1* *Part A, paragraph 1: definition "certificate" substituted by R&O.109/2004*

[6] *Schedule 1* *Part A, paragraph 1 amended by R&O.56/2018*

[7] *Schedule 1* *Part A, paragraph 2(b) deleted by R&O.109/2004*

[8] *Schedule 1* *Part A, paragraph 2 amended by R&O.109/2004*

[9] *Schedule 1* *Part A, paragraph 5 deleted by R&O.56/2018*

[10] *Schedule 1* *Part A, paragraph 6 amended by R&O.56/2018*

[11] *Schedule 1* *Part A, paragraph 7 deleted by R&O.56/2018*
[12] *Schedule 1* *Part A, paragraph 8 amended by R&O.56/2018*
[13] *Schedule 1* *Part B substituted by R&O.56/2018*
[14] *chapter 20.850*
[15] *Schedule 2* *Part A, paragraph 3 substituted by R&O.109/2004*
[16] *Schedule 2* *substituted by R&O.213/2014*