The National Insurance Board
Of the Commonwealth of The Bahamas
The National Insurance Act, 1972

For NIB Use Only

Registration Form (DP-1) received? ☐Yes ☐No

Receiving Officer _____

NATIONAL PRESCRIPTION DRUG PLAN
INDIGENT CERTIFICATION FORM

Section A: Client Details *(To be completed by client)*

☐ Mr.
☐ Mrs.
1. ☐ Ms. _____
Last Name *First Name* *Middle Name(s)*

2. N.I.#: _____ 3. Date of Birth: _____
dd/mm/yyyy

4. Address: _____

5. City/Settlement: _____ 6. Island: _____

7. Telephone #1: _____ 8. Telephone #2: _____

9. P.O. Box: _____ 10. Email Address: _____

Section B: Social Services Details *(To be completed by Department of Social Services)*

11. Is client receiving assistance from Social Services at this time? ☐ Yes ☐ No

12. If yes, please indicate expiration date of assistance. _____
dd/mm/yyyy

*Comments, if necessary:*_____

13. The client has been assessed and deemed: ☐ Indigent ☐ Not Indigent

14. Authorized Signature: _____ _____
Name (please print) *Signature*

15. Date form completed by Social Services: _____
dd/mm/yyyy

Please affix Department of Social Services stamp in the box at left.

Section C: Client's Declaration

I certify that the information contained in this form is true and correct to the best of my knowledge and belief. I undertake that if this benefit is awarded I shall inform the National Prescription Drug Plan Office of any change in my condition, which may affect my entitlement to this Benefit.

16. Client's Signature: _____ 17. Date: _____
dd/mm/yyyy

IMPORTANT NOTES

A. In order to apply for the National Prescription Drug Plan as an Indigent, one must have an income of $210 or less per week ($10, 920 or less per annum).

B. This form MUST be accompanied by a **completed** National Prescription Drug Plan Registration Form (Form DP-1).