

Form No. 2
The Criminal Injuries (Compensation) Act, 1973

**Application on Behalf of Dependents of a Deceased
Person with Respect to the Compensation Payable to such Dependents**

***ALL APPLICATIONS MUST BE COMPLETED IN FULL; FAILURE TO DO SO WILL DELAY
CONSIDERATION BY THE CRIMINAL INJURIES COMPENSATION BOARD***

**APPLICATIONS MUST BE MADE WITHIN ONE YEAR OF THE DATE OF INJURY/DEATH FOR
WHICH THIS APPLICATION IS BEING MADE.¹**

1. On the _____ day of _____, 20_____
Personal injury was caused to _____
late of _____
and on the _____ day of _____, 20_____
the death of the said _____ resulted from injury.
2. A copy of the Probate (or Letters or Administration)(if any) is enclosed herewith.
3. An application under the Act is hereby made by _____
the representative of the said _____, deceased acting on
behalf of the dependents of the said deceased for the payment of compensation in respect of
the following matters:
- | | |
|--|-----------------|
| a) Expenses actually and reasonably incurred as a result of the injury | \$ _____ |
| b) Pecuniary loss as a result of incapacity for work | \$ _____ |
| c) Other pecuniary loss resulting directly from the injury | \$ _____ |
| d) Other expenses resulting directly from the injury | \$ _____ |
| e) Pain and suffering and loss of amenities | \$ _____ |
| f) Costs of proceedings under this Act | \$ _____ |
| TOTAL AMOUNT CLAIMED AS COMPENSATION: | \$ _____ |

¹ NOTE: In accordance with the Criminal Injuries (Compensation) Act 1973

4 (1) An application for compensation shall be made within one year of the date of the injury or death in respect of which the application is made; but the Board may, if it thinks fit, extend the period of one year for a further period not exceeding twelve months.

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PARTICULARS

1. **Name and Address of the deceased:** _____

Age: _____ **Birth Date:** _____ **Status:** _____
Occupation at the time of incident: _____
Employer at the time of incident: _____
Insurance at the time of incident _____

2. **Name of the Applicant:** _____
Address of Applicant: _____

Email address: _____
Tel. no: Home: _____ **Work:** _____ **Cellular:** _____

3. **Name and address of offender(s)** _____

4. **Time & Place of Incident** _____

Circumstances which caused the injury _____

5. **Nature of injury to the deceased** _____

DEATH CERTIFICATE REQUIRED

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6. Details of hospital or dental treatment, if any, and particulars of any incapacity or disability, whether temporary or permanent; if permanent whether total or partial, and if temporary, estimated duration of incapacity or disability:

7. Period during which the deceased had to be absent from work and average weekly or monthly earnings of the deceased at the time of the injury: _____

8. Average weekly amount which the deceased was earning or was able to earn in some possible employment after the injury _____

9. Sick pay or other payment, allowance or benefit received consequent of the injury

10. Pension, gratuity, social security benefit, insurance compensation payable or damages recovered as a consequence of the injury _____

11. If the offender has been prosecuted, particulars of prosecution of offender and conviction (if any) _____

12. If no prosecution, date of report of offence to Police _____

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13. Details of any previous application to the Board by the deceased for compensation (if applicable)

Dated this _____ day of _____ 20_____

Signature: _____
Applicant or his guardian, if applicant is under age 18 (or his legal representative)

PLEASE NOTE THAT THE HEARING WILL BE IN PRIVATE

I hereby verify that the above statements are correct, and true. I agree to give all reasonable assistance that may be required, and authorize the following to supply information to the Board.

- i) I authorize the doctors, dentist and the hospital(s) to release reports as to my information relevant to this application;
- ii) I authorize the Bermuda Police Service to supply a copy of any statements
- iii) I authorize the Department of Financial Assistance to give details of payments and any other information relevant to the deceased;
- iv) I authorize the employers of the deceased to give details of earnings, pension rights and any other matters relevant to the application.

I understand that the Board may notify any of the above that a claim has been submitted, and may inform them of the decision.

Date: _____ Signature: _____

ENSURE THAT YOU HAVE REVIEWED AND COMPLETED THE APPLICATION CHECKLIST. THIS WILL ASSIST IN CONFIRMING THAT THE APPLICATION IS READY FOR SUBMISSION.

(for office use only)

CICB Application No. _____

Date Received: _____

ANY COMMENTS: _____
