NATIONAL HEALTH INSURANCE
TERMINATION CERTIFICATE

Form M

INSTRUCTIONS

1. Please complete in duplicate.
2. Issue original to the employee and submit a copy to the NHI Office within seven (7) days of termination of employment. Failure to do so can result in a fine upon summary conviction.

EMPLOYER INFORMATION

NAME: _____

ADDRESS: _____

NHI REGISTRATION NUMBER: _____

I certify that Mr./Miss/Mrs./Ms. _____
☐ ☐ ☐ ☐

whose National Health Insurance Membership Number is _____

was employed at the above-mentioned company from D___ M___ Y ____ To D___ M___ Y ____

Total earnings paid during this period was $_____

Total value of contributions deducted from this earnings was $ _____

Total value of contributions paid to the NHI Office for this period was $ _____

I declare that the information provided is true and correct.

Employer's Name …… **Date: D____ M____ Y ____**

Employer's Signature ……..……

Designation……

COMPANY STAMP

OFFICIAL USE ONLY

Officer's Name:_____ Signature:_____

Date: D____ M____ Y ____