

Employee's Declaration

I declare that to my knowledge all information given is true, complete and correct. I understand that if the information given is false, I will be penalized as stipulated in the Criminal Code and can also lose the right for benefit, or part of it as stipulated in the Social Security Act (Cap. 318.). I bind myself to inform immediately any change in circumstance to the Director General (Social Security). Failure to do so may result in the forfeiture of entitlement for the benefit or part of it.

Name and Surname

Identity Card Number

Signature

Date

