

**THIS LIST IS A SUMMARY OF GENERAL REQUIREMENTS FOR ALL APPLICANTS. WORC RESERVES THE RIGHT TO REQUEST ADDITIONAL INFORMATION OR DOCUMENTATION AS DEEMED NECESSARY.**

**PLEASE NOTE THAT WHEN SUBMITTING THE REQUEST FOR A TEMPORARY WORK PERMIT EXTENSION, IT MUST BE SUBMITTED ON OR BEFORE THE CURRENT TEMPORARY WORK PERMIT EXPIRES. THE SUBMISSION OF A LATE TEMPORARY WORK PERMIT EXTENSION WILL RESULT IN THE APPLICANT WORKER HAVING TO CEASE WORK IMMEDIATELY AND AWAIT THE OUTCOME OF THE APPLICATION.**

- Cover letter signed by Employer with detailed summary of why the extension is required. Include employee duties & responsibilities.
- CI\$250 Non-refundable application fee, and a work permit fee which amounts to 50% of the normal annual work permit fee.
- A fully completed Medical Declaration Cover Letter, must be less than one year old at date of submission.
- Accommodation Form signed by Employer, Landlord, and Employee (form AC001)
- Health Insurance & Pension Supplement Form signed by the Employer and Employee (HP001)

### FOR ACCOMPANYING DEPENDANTS

Important Note: Certified copies of birth and/or marriage/civil partnership certificates are only required if this is the first time adding the respective dependant.

- Child(ren):** 17 years and under:
  - 1) Certified Birth Certificate
  - 2) Letter from a local school confirming acceptance/attendance.
- Child(ren):** 18 years and over:
  - 1) Medical Declaration Cover Letter (less than 1 year old)
  - 2) Certified Birth Certificate
  - 3) Signed and sealed Police Clearance certificate (less than six months old, from last place of residence)
  - 4) Letter from school confirming acceptance/attendance (required annually).
- Spouse/Civil Partner:**
  - 1) Medical Declaration Cover Letter (less than 1 year old)
  - 2) Certified copy of Marriage/Civil Partnership certificate
  - 3) Signed and sealed Police Clearance certificate (less than six months old, from last place of residence)
  - 4) Affidavit (AF66-10) to be completed if applying under Section 66(10)

**DO NOT USE LIQUID PAPER OR CORRECTION TAPE, IF AN ERROR IS MADE CROSS OUT AND INITIAL THE CHANGE(S) OR USE A FRESH PAGE**

**IMPORTANT NOTE:** It is a Government requirement that suitable accommodation must be available for the employee and for any dependants. Accordingly, this form must be completed in full by the Employer, attested to by the Employee and Landlord/Rental Agent, and submitted along with the Work Permit Application Form.

1. Is the prospective Employee on Island?  Yes  No If No, move to question 9.
2. Employee's Physical Address \_\_\_\_\_  
 District \_\_\_\_\_ PO Box and KY \_\_\_\_\_ Telephone No \_\_\_\_\_  
 Block and Parcel No \_\_\_\_\_
3. Type of Building  Dwelling House  Apartment  Hotel
4. How many rooms are available for the employee and his/her family?  
 Bedrooms \_\_\_\_\_ Bathrooms \_\_\_\_\_ Living Rooms \_\_\_\_\_ Kitchens \_\_\_\_\_
5. Will any of these rooms be shared with other occupants of the dwelling?  Yes  No  
 If Yes, give details - including number of other occupants and which rooms.  
 \_\_\_\_\_
6. This accommodation is  Owned by the Employer  Owned by the Employee  Rented by the Employer  Rented by the Employee
7. If Rented, what is the period of lease? \_\_\_\_\_
8. If Rented, the name and address of the Landlord/Rental Agency is \_\_\_\_\_  
 (i) House No \_\_\_\_\_ (ii) Street Name \_\_\_\_\_  
 (iii) District \_\_\_\_\_ (iv) PO Box and KY \_\_\_\_\_ v) Telephone \_\_\_\_\_
9. When the Employee arrives on Island to work, please advise on their proposed physical address:  
 \_\_\_\_\_

I understand and agree that a representative of the Department of WORC may be required to view the premises described above at any reasonable hour of the day. I declare that the information provided above by me is true and correct and I understand and accept that if it is proven that I have made a false statement, I am liable on conviction to a fine of CI \$5,000 and imprisonment for one year.

Landlord Name	Landlord Signature	Date (DD/MM/YYYY)
Employee Name	Employee Signature	Date (DD/MM/YYYY)
Primary Employer Name	Primary Employer Signature	Date (DD/MM/YYYY)

**PLEASE DO NOT LEAVE ANY QUESTION BLANK. IF A QUESTION DOES NOT APPLY TO YOU, INSERT "NOT APPLICABLE" OR "N/A" IN THE SPACE PROVIDED.**  
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## SUPPLEMENT - TO BE COMPLETED BY EMPLOYER AND ATTESTED TO BY THE EMPLOYEE

**PENSION PLAN** In accordance with the National Pensions Act after an employee has completed 9 months of employment in the Cayman Islands, the enrollment & payment of pension contributions are mandatory.

1. Do you have a valid Pension Plan for this employee in accordance with the National Pensions Act and its current revisions?  
 Yes  No If No, why not? \_\_\_\_\_
2. What is the name of the Company and Administrator of your registered Pension Plan?  
 Company \_\_\_\_\_  
 Telephone No. \_\_\_\_\_ E-Mail Address \_\_\_\_\_  
 Registration No. \_\_\_\_\_ Employee Pension No. \_\_\_\_\_
3. Are your Company's Pension Plan contributions for this employee paid up to date?  Yes  No  
 If No, why not? \_\_\_\_\_

**HEALTH INSURANCE** In accordance with the Health Insurance Act every person, and their dependants, resident on Island must have health insurance coverage effected by their employer.

1. Do you have a valid Health Insurance Plan for this employee in accordance with the Health Insurance Act and its revisions and regulations thereunder? If No, why not?  Yes  No  
 \_\_\_\_\_
2. What is the name of the Company and Administrator of your registered Health Insurance Plan?  
 Company \_\_\_\_\_  
 Telephone No. \_\_\_\_\_ E-Mail Address \_\_\_\_\_  
 Employee Membership No. \_\_\_\_\_ Policy No. \_\_\_\_\_
3. Are your health insurance premiums for this employee paid up to date?  Yes  No  
 If No, why not? \_\_\_\_\_

### EMPLOYER'S DECLARATION:

I declare that the information given above is correct and confirm that the employee for whom the work permit is being sought is or will become a member of the above Health Insurance Plan in accordance with the Health Insurance Act and is a member or will join the above Pensions Plan in accordance with the National Pensions Act.

I understand that I will be responsible for any medical expenses incurred by the employee and their dependants in the absence of a standard health insurance contract.

I understand making a false statement or representation knowing the same to be false in accordance with the Section 66 (10) of the Caymanian Protection Act (2022 Revision), I am liable on conviction to a fine of up to CI \$5,000.00 and imprisonment of one year.

Name of Employer \_\_\_\_\_

Authorized signatory for  
 and on behalf of Employer \_\_\_\_\_  
Cannot be Agency signature

Print Name \_\_\_\_\_

Date (DD/MM/YYYY) \_\_\_\_\_

### EMPLOYEE'S DECLARATION:

I declare that the information given above is correct and confirm that the employer from which I seek employment has or will enrol me in the Health Insurance Plan and has or will enrol me in the above Pension Plan (unless exempted by Pensions Act).

I understand making a false statement or representation knowing the same to be false in accordance with the Caymanian Protection Act (2022 Revision), I am liable on conviction to a fine of up to CI \$5,000.00 and imprisonment of one year.

Name of Employee \_\_\_\_\_

Signature \_\_\_\_\_  
Cannot be Agency signature

Date (DD/MM/YYYY) \_\_\_\_\_