MIBFA

METAL AND ENGINEERING INDUSTRIES BARGAINING COUNCIL SICK PAY FUND

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SICK PAY CLAIM FORM

FOR ABSENCE FROM WORK DUE TO SICKNESS OR INJURY
(NOT INJURY ON DUTY) IN EXCESS OF PAID SICK LEAVE
ENTITLEMENT UNDER AN INDUSTRIAL AGREEMENT

TO BE COMPLETED BY THE EMPLOYEE

Surname | Date of Birth

First Names | Tel No

I.D. Number | Marital Status

Income Tax Reference No | Revenue Office

Residential Address

Postal Code

Trade Union of which a Member | Membership No

Period for which Sick Pay is claimed: From | To | inclusive

IN CASES OF INJURY, STATE

Date of injury | Cause | Where occurred

NOTE POLICE REPORT TO BE ATTACHED IN CASE OF GUNSHOT WOUND

I certify that – my absence was not due to injury while on duty as defined in the COIDA Act, and that the above information is correct.

I approve the completion of the Medical Certificate.

I authorise the Fund to

(a) pay any benefit due into a Bank as follows

NAME OF BANK | Branch | Branch Code

Account Number | Name of Account Holder (NB. Holder must be the Claimant)

Type of account (Mark the appropriate block with an X) Current | Savings | Transmission

(b) forward any benefit payable through the post to the following address and acknowledge that such posting shall constitute full and final settlement of all amounts due in terms of this application

Postal Address

Postal Code

Delete whichever is not applicable:

Date …… Signature of claimant ……

NOTE: Bank account details must be confirmed by either one of the following:

1. **Bank Mandate Form to be completed or**
2. **Cancelled signed cheque or**
3. **Statement of bank account with bank stamp or**
4. **Employer to confirm banking details on company letterhead with company stamp.**

TO BE COMPLETED BY EMPLOYER

Name of Employer

Address

Postal Code

Tel No:

Co Ref No:

DETAILS OF EMPLOYEE

Surname

Works Number

First Names

Date of Engagement

Occupation

Normal Working Week | 5 days | 6 days | Hours…….

Rate of Pay | R…….. | per hour | per week

Period of absence to be claimed

Mark with an X

From To inclusive State if still absent YES NO

No. of days Sick Leave Due days

Excluding Weekend and all Public Holidays
Dates of Paid Sick Leave From the Company

From To inclusive Days

From To inclusive Days

From To inclusive Days

From To inclusive Days

I/We certify that the above information is correct and that.

- the above absence is not due to disablement falling within the provisions of the Workmen's Compensation Act, 1941.
- annual paid leave dates applicable.

From To

Date Signature Name

Designation

EMPLOYER'S RUBBER STAMP

TO BE COMPLETED BY MEDICAL PRACTIONER
(Only if no Medical Certificate has been already issued)

When did you attend to the patient? On …….……..…….. day of ……..…… 20…….

I hereby certify that I have examined the above Mr/Mrs/Ms ……..……..

is/was suffering from……. and to the best of my knowledge patient is adhering to the treatment prescribed by me and the ailment cannot be attributed to alcoholism, use of narcotics or pregnancy.
(Please Print)

According to my knowledge he/she was unfit

for work from …….. up to and including ……..

Will be fit to return to duty on: ……..

Name of Medical Practitioner (please print)……

Signature and Professional Qualifications …….

Practice No. ……..……..

Address……

Telephone Number……

NOTE: Any charge for this certificate is borne by the patient.

THIS BANK MANDATE FORM MUST BE COMPLETED BY THE EMPLOYER OR BANK OFFICIAL

ALL ALTERATIONS MUST BE SIGNED BY APPLICANT, EMPLOYER AND BANK OFFICIAL

CHEQUE ACCOUNT HOLDERS MAY ATTACH A SIGNED CANCELLED CHEQUE OR CASHED CHEQUE AS BANK CONFIRMATION

A. APPLICANTS BANK DETAILS:

(1) Surname of Applicant (Payee)

(2) Maiden Name

(3) Name of Applicant (Payee)

(4) Identity Number

Identity Document to be produced

B. DETAILS OF ACCOUNT – N.B.

To be verified by bank official or employer as correct and active/current and belonging to the applicant as listed on page 1.

(1) Name of bank

(2) Address of Bank

Postal Code

(3) Name of Branch

(4) *Branch Code

*Code at place where account is kept will be supplied by Bank or Employer.

(5) Account Number

(6) Type of Account

(7) Date account opened DD MM YY

.....

SIGNATURE
(ACCOUNT HOLDER)
(Must be the same signature as the applicant's on page 1)

.....

DATE

.....

FULL NAMES
OF EMPLOYER OR BANK OFFICIAL

SIGNATURE OF BANK OFFICIAL OR EMPLOYER AND STAMP OF BANK OFFICIAL OR EMPLOYER