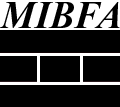
**METAL AND ENGINEERING INDUSTRIES BARGAINING COUNCIL SICK PAY FUNDS**



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| 42 Anderson Street |  | P.O. Box 6539 |
| 3rd Floor  Johannesburg | **APPLICATION FOR FUNERAL BENEFITS** | Johannesburg, 2000  Telephone (011) 870-2000 |
| 2001 |  | Fax: (011) 870-2414 |
|  |  | Website: [http://www.mibfa.co.za](http://www.mibfa.co.za/) |

1. **Name of deceased** (in full) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. **Identity number of deceased**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- |
| MARRIED | SINGLE | WIDOWED | DIVORCED |

1. **Marital status of deceased** (place cross in block which applies)

|  |  |  |
| --- | --- | --- |
| Day | Month | Year |

1. **Date of death** (death certificate must be produced)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **a. Name of employer at time of death\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(certificate of service must be produced)

**b.** Co Ref No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Works Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Full Name of applicant**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Relationship of deceased \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **If the applicant is not the surviving spouse –**
   1. The funeral account must be produced together with evidence of payment if account has been paid.
   2. Any other relevant information in support of this claim \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Full names of applicant)

Of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Full Address)

Applicants Telephone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

do hereby make oath and say

1. That all information given in this form is true and correct
2. \*That I authorise the Fund to pay any benefits due into a Bank account as follows:

Name of Bank: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Branch: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Postal Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Account Number: Branch Code:

Type of Account: \*Current / Savings / Transmission

1. \*That I authorise the Fund to forward any benefits payable through the post to the following address and the such posting shall constitute full and final settlement of all amounts due in terms of this application:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Postal Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* (Delete whichever is not applicable)

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Identity Number of Applicant Signature / Mark of Applicant

SIGNED AND SWORN / AFFIRMED BEFORE ME AT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

this \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_20\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The deponent has acknowledged that he / she knows and understands the contents of this document.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Commissioner of Oaths

**NOTE :** (i) Commissioner of Oaths are available at any police station or Post Office or the office of any attorney

(ii) Copies of original documents may be submitted provided they are certified as the true copies by a Commissioner of Oaths

**CERTIFICATE OF SERVICES**

|  |  |
| --- | --- |
| TO: METAL AND ENGINEERING INDUSTRIES  BARGAINING COUNCIL SICK PAY FUND  PO BOX 6539  JOHANNESBURG  2000  TELEPHONE: (011) 870 2000  FAX NUMBER: (011) 870 2414 | FROM: (State name and address of employer.  To be imprinted with firm’s rubber stamp. ) |

This is to certify that the particulars as mentioned hereunder are a true records of the employment of

……………………………………………………………………………………………….…………………………………with this company.

Employee name (in full) ……………………………………………………………………………………………………………………………

Identity No …………………………………………………………………………………Works No ……………………………………………

Occupation …………………………………………………………………………..........Co Ref No …………………………………………...

Period of Employment: From…………………………………………………..to……………………………………………………………….

Reason for termination of employment …………………………………………………………………………………………………………..

|  |  |  |
| --- | --- | --- |
| \*Remuneration  At date of termination of Employment –  Complete (a), (b), (c), (d),  (e) or (f) as applicable. | Weekly Paid Employee Per Week  R C | Monthly Paid Employee Per Month  R C |
| 1. Death 2. Retirement 3. Incapacitation 4. Retrenchment 5. Redundancy 6. Resignation | ……………………….....  …………………………..  …………………………..  …………………………...  …………………………...  …………………………... | ……………………….....  …………………………..  ……………………….....  …………………………..  ……………………….....  ………………………….. |

The appropriate return form for benefits has been handed to the employee.

………………………………………………….. ……………………………………………………………

DATE FOR AND BEHALF OF EMPLOYER

“Remuneration” means the actual wages payable to the employer each week in respect of the ordinary hours worked by such employee in the shifts of the establishment concerned during such week including moneys payable in terms of any agreement or under any law, but excluding amounts paid in respect of overtime, shifts or other allowances and holiday leave bonuses.

**NOTE:** In the event of contributions not having been paid to the fund in respect of the above member up to date of termination of employment, kindly arrange to forward a guarantee stating the period involved to insure that this claim is being processes with minimum delay.