# METAL AND ENGINEERING INDUSTRIES BARGAINING COUNCIL SICK PAY FUND INJURY ON DUTY

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**Claim for payment of special benefits in respect of absence from work due to disablement falling within the provision of the workmen’s Compensation Act, 1941 up to a maximum of three working days for each period of such absence.**

**TO BE COMPLETED BY THE EMPLOYEE**

Surname Date of Birth

First Names Tel No

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I.D. Number Marital Status

Income Tax Reference No. Revenue Office

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|  |  |  |  |  |  |  |  |  |  |

Residential Address

Postal Code

|  |  |  |  |
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Trade Union of which a Member Membership No

Period for which Special Benefit is claimed: From To inclusive

State cause of injury:

……………………………………………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………………………………………

Date Time Place

I approve the completion of the Medical Certificate and the disclosure of the nature of the disablement.

**I authorise the Fund to**

1. pay any benefit due into a Bank account 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

1. 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

|  |  |  |  |
| --- | --- | --- | --- |
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Date Signature of claimant

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

1. **Bank Mandate Form to be completed.**
2. **Cancelled signed cheque.**
3. **Statement of bank account with bank stamp.**
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 Rate of Pay

|  |  |  |
| --- | --- | --- |
| 5 days | 6 days | Hours……………. |

R…….. per hour per week

Period of absence due to disablement which has been reported to the Workmen’s Compensation Commissioner.

From …………………… a.m. /pm…………. on ………………….. ………….. N.B.: State if still absent …..…. YES ……… NO

To ………………………. a.m./pm………….. on ………………….. ………….. inclusive, no of days ……………………….…….

Details in regard to period of absence during first three working days:

 Date Ordinary hours of shift Hours worked

1st working day of absence ……………………………………………………………………………………..…

2nd working day of absence ……………………………………………………………………………..…………

 3rd working day of absence ………………………………………………………………………………..………

 I/We certify that the above information is correct.

Date Signature Name

Designation

**EMPLOYER’S RUBBER STAMP**

**TO BE COMPLETED BY MEDICAL PRACTIONER**

When and where did you first attend the above-mentioned in consequence of disablement?

On …………………….. day of ……………………… …………… at…………………………………………………………………..

Date of commencement of disablement ………………………….… Date of fitness for duty ………………..……………………………..….

(In cases of doubt state ±)

Present Condition………………………………………………………………………………………………………………………………..

I hereby certify that I have by personal examination satisfied myself that Mr / Mrs / Miss…………………………………………

Is / was suffering from……………………………………………………………….. and to the best of my knowledge patient is adhering to the treatment prescribed by me. **(Please print)**

Signature and Professional Qualifications …………………………………………………………………………………………………………. Name of Medical Practitioner (please print)…………………………………………………………………………………………………………

Practice No: ……………………………………………………………………………………………………………………………………….

Address ……………………………………………………………………………………………………………………………………………

Telephone Number…………………………………………………….………………………… Date. ……………………………………….……

NOTE: Any Charge for this certificate is borne by the patient

MANDATE FOR PAYMENT OF BENEFIT TO BANK

ALL ALTERATIONS MUST BE SIGNED BY APPLICANT AND BANK OFFICAL

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

1. **APPLICANTS BANK DETAILS:**
2. Surname of Applicant (Payee)

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1. Maiden Name

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1. Name of Applicant (Payee)

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1. Identity Number

|  |  |  |  |  |  |  |  |  |  |  |  |  |
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**Identity Document to be produced**

1. **DETAILS OF ACCOUNT – N.B.** **To be verified by bank official as correct and active/**

**current and belonging to the applicant as listed on page 1.**

1. Name of bank

|  |  |  |  |  |  |  |  |  |  |  |  |  |
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1. Address of Bank

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**Postal Code**

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| --- | --- | --- | --- |
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## Name of Branch

|  |  |  |  |  |  |  |  |  |  |  |  |  |
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1. \*Branch Code

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
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1. Account Number

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

1. Type of Account

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1. Date account opened

|  |  |  |
| --- | --- | --- |
| **DD** | **MM** | **YY** |

**FULL NAMES**

**OF BANK OFFICAL**

 …………………………………………………………

………………………………………………………………

 **SIGNATURE**

**(ACCOUNT HOLDER)**

**(Must be the same signature**

**As the applicant’s on page1)**

………………………………………………………………

**DATE SIGNATURE OF OFFICAL**

 **AND STAMP OF BANK**