



METAL AND ENGINEERING INDUSTRIES BARGAINING COUNCIL SICK PAY FUND

42 Anderson Street
Johannesburg
2001

P.O. Box 6539
Johannesburg 2000
Phone/Foon 0860102544
Fax: (011) 870-2414
Website: <http://www.mibfa.co.za>

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	<input type="text"/>	Date of Birth	<input type="text"/>
First Names	<input type="text"/>	Tel No	<input type="text"/>
I.D. Number	<input type="text"/>	Marital Status	<input type="text"/>
Income Tax Reference No	<input type="text"/>	Revenue Office	<input type="text"/>
Residential Address	<input type="text"/>		
	<input type="text"/>	Postal Code	<input type="text"/>
Trade Union of which a Member	<input type="text"/>	Membership No	<input type="text"/>
Period for which Sick Pay is claimed:	From <input type="text"/>	To <input type="text"/>	inclusive
IN CASES OF INJURY, STATE	<input type="text"/>	<input type="text"/>	<input type="text"/>
	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 and that the above information is correct.

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

I authorise the Fund to

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

NAME OF BANK	<input type="text"/>	Branch	<input type="text"/>	Branch Code	<input type="text"/>	<input type="text"/>	<input type="text"/>
Account Number	<input type="text"/>	Name of Account Holder (NB. Holder must be the Claimant)	<input type="text"/>				
Type of account (Mark the appropriate block with an X)	Current	<input type="checkbox"/>	Savings	<input type="checkbox"/>	Transmission	<input type="checkbox"/>	

(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	<input type="text"/>						
	<input type="text"/>	Postal Code	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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 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

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 PRACTITIONER

Where and when did you first attend to the patient? At.....

On day of

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 and the ailment cannot be attributed to alcoholism, use of narcotics, venereal disease or pregnancy. (Please Print)

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
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.....
**FULL NAMES
OF EMPLOYER OR BANK OFFICIAL**

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

.....
DATE

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