

## NATIONAL BARGAINING COUNCIL FOR THE ELECTRICAL INDUSTRY OF SOUTH AFRICA

TO BE COMPLETED  
IN INK

ONLY A PERIOD OF MORE THAN  
2 WORKING DAYS ARE PAID OUT

### *SICK BENEFIT FUND – CLAIM APPLICATION*

TO BE COMPLETED BY EMPLOYER

NAME OF COMPANY : \_\_\_\_\_  
REG NO. : \_\_\_\_\_  
POSTAL ADDRESS : \_\_\_\_\_  
TELEPHONE NUMBER : \_\_\_\_\_  
NAME OF EMPLOYEE : \_\_\_\_\_  
CATEGORY : \_\_\_\_\_  
IF EMPLOYED LESS THAN SIX MONTHS  
PREVIOUS EMPLOYER NAME : \_\_\_\_\_  
FIRST WORKING DAY OF SICK LEAVE : \_\_\_\_\_  
(MUST CORRESPOND WITH DOCTORS NOTE)  
DATE RETURN TO WORK : \_\_\_\_\_

\_\_\_\_\_  
EMPLOYERS SIGNATURE

\_\_\_\_\_  
DATE

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TO BE COMPLETED BY EMPLOYEE

I, the undersigned declare that :

1. The information given above is correct
2. My illness or injury is not covered by the Occupational Health and Safety Act. I further agree that :
3. The acceptance of this form shall in no way constitute any admission of liability by the Council.
4. The Medical Practitioner may disclose information regarding my illness or injury.

\_\_\_\_\_  
EMPLOYERS SIGNATURE

\_\_\_\_\_  
DATE

TO BE COMPLETED BY DOCTOR

I, the undersigned declare that :

- (1) I am a registered Medical Practitioner , and
- (2) I have examined the employee referred to above, and
- (3) The illness or injury of the said employee is if such nature that he can not carry out his normal duties, and
- (4) I realize that the Fund is a sick pay scheme only and that the said employee (if he qualifies) must submit the medical account to his/her relevant Medical Aid Scheme (fund)
- (5) The illness or accident apparently did not result from insanity, self injury, attempted suicide, alcoholism, use of narcotics, venereal disease, mental disorder or neurosis, professional sport, or from performing any unlawful act or from riot, civil commotion, war, hostilities or engaging in fighting, and is not covered by the Workmen's Compensation Act.

.....  
DATE

.....  
DOCTORS SIGNATURE

PLEASE ATTACH MEDICAL CERTIFICATE

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CONDITIONS :

- (1) Application must be filled in correctly and reflect the company stamp.
- (2) A doctor's note must accompany application.
- (3) If employee does not have a bank account, a signed letter of authorization is required to deposit into a designated account.
- (4) If the employer pays the employee while on leave and requires a refund : proof of pay slips and a signed letter of receipt from the employee must be attached.
- (5) Applications that are not filled in correctly and, if not accompanied by the necessary documentation will not be processed.
- (6) A certified copy of the death certificate must be attached to qualify for the benefit.
- (7) Please attach a copy of Identity Document.

BANKING DETAILS OF EMPLOYEE

NAME OF ACCOUNT HOLDER : \_\_\_\_\_

ACCOUNT NUMBER : \_\_\_\_\_

BANK : \_\_\_\_\_

BRANCH CODE : \_\_\_\_\_

BRANCH : \_\_\_\_\_