

N.B.C.E.I.
National Bargaining Council For The
Electrical Industry Of South Africa

Suite 1302
13th Floor
Mercury House
320 Smith Street
Durban
4000

P O Box 722
Durban
4000

Tel : 031 306 8100/ 1/ 2/ 3/ 4
Fax : 031 306 8105
Email : noasheen@ebckzn.co.za

SICK PAY CLAIM FORM

PLEASE COMPLETE FULLY, ATTACH A RECENT COPY OF THE EMPLOYEES PAYS LIP PRIOR TO PROCEEDING ON SICK LEAVE AND ENSURE THAT ALL SIGNATURES ARE AFFIXED

Please write claimant's name as it appears in his Identity Book, and/or attach a copy thereof on first application

Claimant's Surname _____ Date of Birth _____

Claimant's Christian Names _____ I D No _____

Residential Address _____

Banking Details of Claimant:

Banking Institution _____ A/C No _____ Branch _____

Branch Code _____ Account Type: * Transmission/Savings/Cheque/Current

Are you a member of a Trade Union, if so which _____

Period for which Sick Pay is applied for: From _____ to _____ (Inclusive)

Have you claimed any benefits from Sick Pay during the past 52 weeks? Y N

Have you been employed in the industry during the past 13 weeks? Y N

If an Apprentice state:

Year of Apprenticeship _____ Whether Apprentice is a contributor to Fund _____

If injured, state cause of injury eg. Sport, Motor Cycling (for pleasure or to and from work etc.)

I/we certify that the above information is correct and that I was not paid leave pay from work. Nor was my absence due to injury sustained at work.

I approve the completion of this medical certificate and the disclosure of the nature of illness.

Date _____

Signature of Claimant _____



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COMPANY NAME: _____

Address: _____

I/We certify that Mr/Ms/Mrs _____ was employed by me/us as an
(designation) _____ at an *hourly rate of pay of _____ and
was absent from work from _____ am/pm on _____ inclusive, to _____
viz _____ working days. *His/her net pay per week is R* _____

And that the above named was not paid holiday leave during the said period nor was absence due to an injury whilst on duty.

I/We attach a copy of a recent payslip for the abovenamed, and the Original Doctor's Certificate

The above named has been employed by me/us and has contributed to the Fund since
_____ 200 ____ and works a *five/six day week. The present rate of contribution to the Fund is
_____ - per week.

* Delete where applicable

Date _____ Firm's Stamp and Signature of Employer

TO BE COMPLETED BY MEDICAL PRACTITIONER (IF NO CERTIFICATE ISSUED)

When first attended the above named on _____ day of _____ 200_____

Consequence of Illness

Date of Commencement of Illness _____ Date of first Consultation _____

Date of fitness for duty _____ Present _____

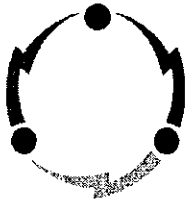
Remarks _____

I hereby certify that I have by personal examination satisfied myself that _____
_____ was suffering from _____ and to the best of my knowledge is
adhering to the treatment prescribed by me and cannot be attributed to Insanity, Mental disorder, Alcoholism,
use of Narcotics, Venereal Disease or Pregnancy.

Signature and Professional title (of Doctor)

Address _____

Tel: _____ Date: _____



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APPLICATION FOR REIMBURSEMENT OF SICK PAY BENEFITS ADVANCED TO EMPLOYEES BY EMPLOYERS

I/We, the undersigned certify that Sick Pay Benefits have been paid by me/us on behalf of the National Bargaining Council for the Electrical Industry of South Africa KZN Region – in respect of the following employee, and hereby make application for the reimbursement thereof. *Please ensure the employee's signature is affixed hereto as proof of payment hereof.*

Full Name of Employer _____

Period of Illness: From _____ to _____

Amount of Benefit paid: R _____

Firm Name and address: _____

Firm Banking Details

Banking Institution _____ A/C No _____ Branch _____

Branch Code _____ Account Type: * Transmission/Savings/Cheque/Current

Date _____

Firm's Stamp and Signature of Employer
Or his Accredited Representative

Capacity: _____

I, by my signature hereunder, acknowledge that I have received the sum of R _____
I also renounce any further rights against the Sick Pay Fund in respect of this claim sick Pay Fund in respect of this claim. Over payments or erroneous payments in respect of this claim are recoverable.

Witness

Date

Signature or Mark of
Claimant

NB. Sick Pay Claim Form duly completed by Claimant must be attached to this application form together with the Original Doctor's certificate (Page 1 & 2)