NATIONAL BARGAINING COUNCIL
for the Hairdressing • Cosmetology • Beauty & Skincare Industry
Postnet suite #83, Private bag x1, Florida Hills, 1716 TEL: 0861427227 FAX: 0865850314
E-MAIL accounts@hcsbc.co.za

NATIONAL SICK PAY FUND APPLICATION FORM

COMPLETE ALL FIELDS ON THE FORM ACCURATELY
INCLUDE A COPY OF YOUR IDENTITY DOCUMENT

Salon Code:	*(refer to statement)*	Union No.:
Region:		
Full Names and Surname:		
ID Number:		**attach a copy**
Date of Birth: DD/MM/YYYY		
Employee's Address:		
Cell Phone Number:		E-mail:
Name of Salon:		
Salon Address:		
Salon Tel Number:		Salon E-mail:
Contact Person:		
Registered Basic Salary:		
Employee Job Title:		
Commision Earner	**YES** ☐	**NO** ☐
Basic Salary Only	**YES** ☐	**NO** ☐
Basic & Commision	**YES** ☐	**NO** ☐
Start Date:		
Marital Starus:		
Self Employed:	**YES** ☐	**NO** ☐

I, the employee, hereby confirm that all infromation stated on this form, is true and correct.

DATE: **EMPLOYEE SIGNATURE:**

TO BE COMPLETED BY YOUR EMPLOYER

I, the employer or duly authorised person/s, hereby confirm that all information stated on this form, is true and correct.

DATE: **EMPLOYER'S SIGNATURE:**

Important:

(1) Please attach a clear copy of your ID