NATIONAL BARGAINING COUNCIL

for the Hairdressing • Cosmetology • Beauty & Skincare Industry

POSTNET SUITE 83, PRIVATE BAG X1, FLORIDA HILLS, 1716 * Tel: 0861 427 227 * FAX: 0865850314 * E-MAIL sickpayfund@hcsbc.co.za

SICK PAY FUND CLAIM FORM

COMPLETE ALL FIELDS ON THE FORM ACCURATELY

IN ORDER FOR YOUR CLAIM TO BE PROCESSED WE NEED ALL RELEVENT FORMS

Important: Illegible, late, incomplete claims will not be paid. No half days or family responsibility will be paid. Claims must be submitted in full as stipulated by Fund Rules within 90 days of first incidence.
The SPF will execute its best endeavors to make payment within 30 days of receipt of a complete claim. Government Hospital/Clinic – medical certificates must be stamped and signed by the Hospital/Clinic and must be certified.

Certified Medical Certificate ☐ **Payslip indicating deduction** ☐
Latest stamped bank statement ☐ **Certified copy of ID** ☐

Member Number: EM (***obtainable from statement)***

Name and Surname:

ID Number: **Attach a certified true copy**

Employee's Address:

Cell Phone Number: E-mail:

Name of Salon:

Salon Address:

Salon Tel Number: Salon E-mail:

Contact Person:

Registered Basic Salary:

Job Title:

Commission Earner **YES** ☐ **NO** ☐

Basic Salary Only **YES** ☐ **NO** ☐

Basic & Commission **YES** ☐ **NO** ☐

Scheduled salon off day/s: (days of the week that you do not work) ***If it varies, attach your roster.***

Mon ☐ **Tue** ☐ **Wed** ☐ **Thur** ☐ **Fri** ☐ **Sat** ☐ **Sun** ☐

Do you work a 5 or 6 day week: **5** ☐ **6** ☐

Is the Salon open on a Sunday **YES** ☐ **NO** ☐

Period of Service in current salon:

BANKING DETAILS OF APPLICANT (NO 3RD PARTY ACCOUNTS ACCEPTED)

Name of Account Holder: Name of Bank:

Account Number: Account Type: Branch Code:

CLAIM DETAILS

Sick days for this claim: **Excluding scheduled off days. Separate claim form for every break in claim**

CERTIFICATION OF APPROVAL BY EMPLOYER FOR FIRST DAY OF ABSENCE WITHOUT A MEDICAL CERTIFICATE:

I_________________, the claimant's employer/ duly authorised by the employer, hereby certify that I have approved the claimant's first (one) day's absence due to illness on _______________(date)

Signature of Employer:___________________ **(See clause 5.6.2 of the Rules)**

Full Name:___________________ Position: ___________________

DATE: **CLAIMANT'S SIGNATURE:**______________________________

TO BE COMPLETED BY YOUR EMPLOYER

I, the claimant's employer or duly authorised person/s, hereby confirm that all information stated on this form, is true and correct. I hereby also confirm that the claimant was off sick and not at work during the dates stipulated in the Employer's certification of approval and/or attached medical certificate and they have not been paid by the salon.

From: **To:** **Return to work:**

DATE: **Employer's Signature:** __________________________