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 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:
Ilegible, Late, Incomplete claims will not be paid. No halfdays or family responsibility, will be paid.
Claims must be submitted in full as stipulated by Fund Rules within 90 days of first incidence.
Please take note, SPF will execute its best endeavours to make payment within 30 days of receipt of a complete claim. Government Hospital/Clinic – medical certificate 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:

Commision Earner	**YES**	☐	**NO**	☐
Basic Salary Only	**YES**	☐	**NO**	☐
Basic & Commision	**YES**	☐	**NO**	☐

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

Mon ☐ **Tue** ☐ **Wed** ☐ **Thu** ☐ **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. Seperate claim form for every break in claim

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 on the medical certificate and they have not been paid by the salon.

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

DATE: **EMPLOYER'S SIGNATURE:**