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

NATIONAL SICK BENEFIT FUND CLAIM FORM

CHECKLIST

- [ ] This Sick Benefit Fund claim form is to be completed including Occupation, Wage Category; rate per hour, hours per week.
- [ ] Doctor's certificate/s declaring the employee unfit for duty from **day one (1) of absence**.
- [ ] Proof of payment - please take note that the Employer is liable to pay the employee for the first 10 days per annual leave cycle that he has been booked off and then to submit a claim to the Council for a refund in terms of the SBF Rules. Please also include the amount the Employer has paid in (Section 1).
- [ ] **In the case of a first time claim OR NEW banking details - Proof of banking details must be submitted. It is the firm's responsibility to advice Council of any changes is banking details.**
- [ ] In the case of an injury, a detailed background to the incident must be supplied (Section 3). SBF rules will be applied.

SECTION 1 - TO BE COMPLETED BY MEMBER

Full Names and Surname: ____

ID No:______________________________ Occupation: ____________________________ Designation or Wage Category_________________________

BENEFITS: The first 10 days per annum (each employee's annual leave cycle) are paid at 100% of actual wages, thereafter from day 11 to 30 days per annum paid at 60% of actual wages, and from day 31 to day 130 paid at 33% of actual wage. For non-scheduled employees, the maximum benefit reimbursement is limited to earnings of R30, 000.00 p.m.

I certify that I have received Sick Fund payment from my employer for the period ___________________**to** _____________________ **of R___________________ (To be completed if the claim is part of the first 10 days per annum BUT MUST also be completed if the FIRM is claiming a reimbursement in terms of Section 2 (6) below)**

I apply for Sick Pay as detailed below. If I was injured, I have given the details overleaf. I have not worked during the period of my illness or injury. I further realize that it is an offence to make a false statement on this application.

SIGNATURE:____ DATE:________________________________

SECTION 2 - TO BE COMPLETED BY EMPLOYER

EMPLOYER'S RUBBER STAMP / EMPLOYER'S SIGNATURE:

(I) I/ We hereby confirm that this employee: (Name)____

(2) Joined the company on ___________________________ and works a 5-day week / 6-day week.

(3) Was off sick from ___________________________ to _________________________ inclusive, i.e. ____________________days.

(4)Earns R ___________________ per week/per month, works a ____________________hour week. **PLEASE COMPLETE CORRECTLY.**

Please complete the number of normal working hours the Employee was expected to complete during this period of absence.

DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7	DAY 8	DAY 9	DAY 10	TOTAL

(5) A valid medical certificate is attached.

(6) TO BE COMPLETED ONLY IF THE FIRM IS CLAIMING A REIMBURSEMENT IN RESPECT OF 11 TO 130 DAYS IN ANNAUL LEAVE CYCLE

- [ ] **Please indicate in this block (if applicable).** I/We hereby confirm that the firm has paid the employee the applicable % wage for days 11 to 30 AND/OR days 31 to 130. **We attach proof of this payment and require that the firm is reimbursed.**

SIGNATURE:____ DATE:_______________________________

SECTION 3 - INJURY REPORT TO BE COMPLETED BY MEMBER IF INJURED

The injury was sustained as follows:

____

____

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☐ I declare that I have not / will not be submitting a claim to any third party for loss of earnings e.g. COIDA (Workman's Compensation, The Road Accident Fund etc.

SIGNATURE:____ DATE:_________________________

SECTION 4 - NOTES

1. All alterations on this form must be initialed by the person completing that portion of the form.
2. Overpayments or erroneous payments in respect of this claim are recoverable.
3. No Sick Benefit Fund monies will be paid in advance.
4. No Sick Fund Benefits are payable in respect of Public Holidays specified in the Agreement for the Industry.
5. No Sick Fund Benefits are payable in respect of Short time or Lay off specified in the Agreement for the industry.
6. Claims must be submitted within 90 days of first absence to the above address.
7. The full weekly SBF contribution is payable to the Council irrespective of the amount of days worked.
8. **ALL NEW MEMBERS AND ALL NEW FIRMS BANKING DETAILS MUST BE SUBMITTED ON THE FIRM'S LETTERHEAD AND SIGNED BY AN AUTHORISED REPRESENTATIVE OF THE FIRM. THIS MUST BE SUBMITTED TOGETHER WITH THE CLAIM.**

FOR OFFICE USE ONLY

100% Sick Pay: ________________days i.e._______________hours at R___________ x 100% R______________
(From day 1 of absence)

60% Sick Pay: __________________days i.e._______________ hours at R___________ x 60% R______________
(From day 11 of absence)

Pen/Prov waiver: _______________days i.e._______________ hours at R___________ x 14% or 15% R____________
(From day 11 of absence)

33% Sick Pay: __________________days i.e._______________ hours at R___________ x 33% R______________
(From day 31 of absence)

Pen/Prov waiver: _______________days i.e._______________ hours at R___________ x 14% or 15% R____________
(From day 31 of absence)

Date: ___________________________ Payment No: ________________________ Amount R______________

COMMENTS: ____

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