Hci SICK PAY FUND CLAIM FORM

P O BOX 1964, ROODEPOORT, 1725   TEL (011) 760-1685   FAX (011) 760-1274

Answer ALL questions ACCURATELY

Surname of Claimant ______________________________

First Names ______________________________

I.D. No. ______________________________

(Note : Please ATTACH a copy of your I.D.)

Yr Postal Address ______________________________

______________________ Code ____________________

Telephone No. (Home) ______________________ Work ____________________

Name of Employer ______________________________

Employer's Address ______________________________

____

Job Title/Position ______________________________

Period of Service __________ yrs __________mths

Claimant's Bank Details

Name of Bank ______________________ Branch Code ____________________

Yr Account No ______________________ Account Type ____________________

Name of Doctor you
Consulted for this illness claim ______________________________

Date of first visit for this claim ______________________________

Date of last visit for this claim ______________________________

Total number of visits for this claim ______________

I hereby certify that I was off work due to illness from ____________________(insert date) and that I returned to work on ____________________(insert date).

Specify the nature of the illness ______________________________

The certificate of Dr. ______________________________ (fill in Doctor's name) is attached.

Date ____________________ **Claimant's Signature** ____________________

Employer's Authentication of Claim

I, the Claimant's Employer, hereby certify that the information stated above is correct, and that the Claimant was off work from ____________________(insert date) and that the Claimant returned to work on ____________________ (insert date).

Date ____________________ **Employer's Signature** ____________________

N.B.

(1) llegible or incomplete claims will be RETURNED.
(2) If the claimant is an employer the Authentication need not be completed.
(3) If the absence was for Plastic Surgery or Gynaecological reasons a FULL Doctor's Report MUST be submitted with your claim. (This is ESSENTIAL).