



MOTOR INDUSTRY SICK AND ACCIDENT PAY FUND

CLAIM FORM FOR SICK/ACCIDENT PAY

Mibco SSC, P O Box 2578, Randburg, 2125 Phone 011/369 7500 Fax 086 676 7410

Member's Surname		Employee / Council Number	
Member's Full Names		Member's Union Number	
Member's Identity Number		Member's contact telephone number	
Details of Employer			
Name		From	To
Present			
Previous			

Period of absence due to sickness/accident	From	To

The member is employed and remunerated as follows: (Mark the appropriate block with an X)	Member works		Income
	5 Day week		R
	6 Day week		R
	7 Day week		R
	Monthly		R

Has the member been paid by the Employer for the period of absence? (Mark the appropriate block with an X)	Yes	
	No	

PAYMENT METHOD

CHEQUE

TO BE POSTED _____

POSTAL CODE _____

ELECTRONIC PAYMENT

NAME OF ACCOUNT HOLDER _____

NAME OF BANK _____ BRANCH CODE _____

ACCOUNT NUMBER _____

NOTE: **A CANCELLED CHEQUE, BANK STATEMENT OR PRINTOUT FROM THE BANK MUST BE ATTACHED.**

We, the Employer and Employee, certify that the information as given above is correct:

Company Stamp

Signature of Employer or accredited representative.

Member's signature

MEDICAL OFFICER'S CERTIFICATE

The Medical Certificate must clearly state **the name of the patient, the date unfit for work and the nature of illness**, and must be attached to the back of this application form.

If the illness is an injury due to an accident, please state below the cause and place of the accident.
