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AGRICULTURAL WAGES BOARD SICK PAY SCHEME
CLAIM FORM

Name:

Address:

Postcode:

Home Telephone Number:

Policy No:

Employee Details

Employee Name:

Employee Address:

Employee NI No:

Date of Birth:

Date employment commenced:

AWB Work Grade:

Is Employment Full Time Fixed Hours? Yes / No

Days on which employee normally works:

Part Time Fixed Hours? Yes / No

Part Time Flexible Hours? Yes / No

Number of hours worked per week?

If either Flexible or Part Time please advise hours worked:

Continued

When was last day employee worked?

When did employee return to work?

Is employees absence due to accident? Yes / No

If Yes, where did this occur?

Please detail accident circumstances:

Was this during working hours? Yes / No

Was employee travelling to or from work? Yes / No

Is employees absence due to sickness? Yes / No

If Yes, what was cause of illness?

Employees Dr/Consultant Name:

Dr Practice/Hospital Name:

Dr Practice/Hospital Address:

Telephone No:

Fax No:

Prior to absence was employee under notice of redundancy/dismissal? Yes / No

If Yes, when was notice due to take effect:

Please advise statutory min. wage paid during absence: £

Please advise amount of overtime paid during absence and rate: £

Please advise amount of SSP recovered: £

Declaration:

I/WE DECLARE THE FOREGOING DETAILS TO BE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF:

Signed:

Date: