NEW ZEALAND FREEZING WORKERS BENEFITS & WELFARE FUND

ACCIDENT AND ILLNESS CLAIM FORM

No claims admitted unless notified within THREE MONTHS of absence

MEMBER'S DETAILS

Name: *First*	*Middle*	*Family*
Address:		
Suburb:	City:	Post Code:
Mobile Phone:	Home Phone:	
Email:		
Bank Account Details: [_ _] [_ _ _ _] [_ _ _ _ _ _ _] [_ _ _]		
Employer's Name:	Membership Number:	
Nature of Injury or Illness:		
As a direct result of your injury or illness, what period were you unable to work?		
From:	To:	
Signature of Member:	Date:	
Signature of Union Representative:	Date:	

Doctor's Certificate (*At Claimants Expense*)

It is essential that full particulars are given so that the Medical Officers of the Fund may understand the exact nature and extent of the injury/ illness.

Please state fully the exact nature of injury or illness	
What was the cause of accident or illness as known to you?	
Please give full details of any complaint from which the member is suffering and is likely to retard or otherwise affect his/ her recovery.	
State the dates within your knowledge that the injured member as a direct and sole consequence of the accident or illness has been unable to work	From:_____ To:_____ Number of Days:_____
Are you aware of anything in claimant's previous medical history which might have contributed the accident or illness? (Continue on back if necessary)	

I certify that my forgoing statements are true and correct

Signature: Date:	Qualifications: Address:

FOR PERIODS OF ABSENCE – 3 DAYS OR LESS:
PLANT SECRETARY/ PRESIDENT'S **SIGNATURE**_____**Date:**

For Office Use:

Cheque/Direct Credit/ Banked Date Paid: Weeks: Days: Amount Paid:$

N.Z. Freezing Workers Benefits & Welfare Fund, P.O. Box: 17 056, Greenlane, Auckland 1546 , New Zealand

Phone: 0800 877 277 | +64 9 520 0035 | Fax: +64 9 523 1286 | Email: admin@meatunion.org.nz

Form Filling Instructions

N.Z FREEZING WORKERS BENEFITS AND WELFARE FUND

ACCIDENT AND ILLNESS CLAIM FORM (007)

PLEASE PRINT CLEARLY

Print Clearly & Send Promptly.

Action:
Complete the form entirely
Provide medical certificate /Doctor / Shed Official
Check and Verify
Post, fax or email
Send to NZFWB & WF, Auckland Office

Form Check List. *Please follow the serial numbers with each blank on the form*

1. Your name: First name , Middle name, Last name (Family Name)
2. Your full address; House number, street, suburb, city and post code
3. Your mobile and home phone numbers
4. Your email address
5. Your bank account number
6. Name of Employer and Membership number
7. Nature of Injury or Illness
8. For what period as a direct result of your injury or illness, were you unable to work? e.g. If the Dr. said you can be off work until 7th, then you are paid up to the 6th.
9. Signature of member
10. Date of signature
11. Signature of Shed Official
12. Date of signature
13. Provide a medical certificate at your expense or
14. The Doctor must fill out his section on the form up till his signatures.
15. If absent for 3 days or less the Plant Shed Official must sign and date this form to verify claim.