REPUBLIC OF NAMIBIA

Form 16

SOCIAL SECURITY COMMISSION

SOCIAL SECURITY ACT, 1994

Cnr. A Klopper & J. Haupt Streets – Khomasdal

The Chief Executive Officer
Social Security Commission
Private Bag 13223
Windhoek
Namibia

Telephone: 280 7999
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IN ALL CORRESPONDENCE QUOTE

CLAIM FOR SICK LEAVE BENEFITS

(Section 30/Regualation 10)

TO BE COMPLETED IN BLOCK LETTERS BY THE CLAIMANT:

1. Social Security registration number: …….
2. Surname: ……
3. Previous surname (in case of change of surname under which registered): ……..
4. First names: ……...
5. Date of birth: ……. 6. Identity number:……...(if any)
7. Passport number: ……..(if any)
8. Postal Address: …….
9. E-mail Address …….
10. Telephone number: …… 11.Facsimile number: ……

12. Method of payments:

Cheque		Bank transfer	

13. If benefits are not be transferred to Bank or Building Society account indicate:…….
    (a) Name of financial institution ……
    (b) Name of branch……
    (c) Branch number: ……
    (d) Account number……..……..
    (e) Type of account……
    (f) Holder of account:

Own		Husband		Wife	

14. Are you entitled to any remuneration or compensation in respect of any period for which you qualify for sick leave benefits in terms of Social Security Act, 1994:

Yes		No	

If "Yes", state particulars of nature thereof and amount: ……...
…….

I certify that the above particulars are true and correct.

_____ _____

CLAIMANT DATE

Please turn over

MEDICAL CERTIFICATE TO BE COMPLETED BY A MEDICAL PRACTITIONER:

I, ……(full names),

2. Surname: ……Practice number ……hereby certify that ……(name of patient) has been under my treatment from ……..20……..to……20……and that he/she is suffering from: …… ……. disease or injury to be stated as far as possible in non-technical terms with concise particulars as to history, symptoms and severity, and ascertainable cause).

Further certify that he/she is in consequence unable to perform his/her duties and I consider it essential for recovery of his/her health and he/she should have leave from ……..20……. To……20……for the purpose of:……...

_____ _____
Medical Practitioner Date

TO BE COMPLETED BY THE EMPLOYER:

1. Name of Employer:…….

2. Social Security registration number: ……..
3. Monthly income of employee: N$ …….
4. Date of commencement of sick leave: ……
5. Date on which unpaid sick leave commenced: ……

I, ……(full names and capacity)certify that the above particulars are true and correct.

** Attach proof of latest social security contributions/deductions from member's salary.*

…….. ……. …….
EMPLOYER **OFFICIAL STAMP** **DATE**

FOR OFFICIAL USE ONLY

Checked by: _____Date: _____

Remarks: _____
_____