**SICKNESS /TEMPORARY DISABLEMENT BENEFIT CLAIM FOR BENEFIT**

1......................................................

s/w/d of ........................................

Insurance No. ……………...................... hereby say that I was certified sick/temporarily disabled from .......... a.m./p.m. on the .......... day of….......Year…........ and I have not been at work since......... a.m./p.m. on the day of............20........

I no longer claim to be sick/temporarily disabled from ............ day of ............year......... and I shall/did not take up any work for remuneration prior that day.\*

I claim advantage accordingly. I want cash payment at local office/by money order present/last employer .................. Department ............Occupation ............ shift (if any)............ present address .........

Signature or thumb impression

Local Office ...............

\* Strike out if not applicable, and then, before resuming work, a final certificate must be got.