

Industrial Injury Benefit - Claim Pack.

(form 01 of 04).

This is form 01 of 04. Please read through this page carefully, and complete the section below.

IMPORTANT - PLEASE NOTE: YOU MUST KEEP THIS PAGE.

To qualify for Industrial Benefit, a member must have paid at least 52 weeks contributions before the date of the accident.

When a member has been off work with an Industrial Injury for a period of eight days, the member will be entitled to five days benefit. The member will also be entitled to pay for all subsequent odd days linked with the five days.

Industrial Injury Benefit will not be paid for holidays.

When a member has received six weeks Industrial Injury Benefit, the member's benefit must cease until the member has commenced work and made 30 weekly full contributions when the member will be free to claim benefit for any subsequent Industrial Injury/Disease.

All preceding benefits shall count in reckoning the prescribed number of weeks during which members can receive benefit unless they have been clear of benefits for a period of 30 weeks and made 30 weekly full contributions.

This benefit will only be paid to members who have notified Unity of the relevant accident by completing a Unity Accident Form and returned the Accident Confirmation Form signed by the responsible person stating the accident has been properly recorded in the Accident Book.

No benefit will be paid for any time lost that has not occurred within 3 years of the actual date on which the accident happened, unless the member has already started to receive injury benefit for the accident prior to the end of the 3 year period.

For accidents that occur before 19th May 2006:

Benefits will be:	ADULTS	£10.00	per week (for 8 weeks)	£15.00	per week (for 4 weeks)
	JUVENILES	£7.50	per week (for 8 weeks)	£10.00	per week (for 4 weeks)

For accidents that occur after 19th May 2006:

Benefits will be:	ALL MEMBERS	£25.00	per week (for 6 weeks)
-------------------	--------------------	---------------	-------------------------------

WHEN ALL PAGES OF THESE FORMS ARE COMPLETED AND YOU HAVE DATED THE FINAL PAGE, PLEASE RECORD BELOW THE DATE THAT YOU SEND THE FORMS BACK TO UNITY.

You will normally hear from us within 14 days of receipt of these forms. If you do not receive a letter informing you that your details are with us within this time, then please contact us by completing and returning the tear off slip below as soon as it is possible,



Surname Mr/Mrs/Miss/Ms Address

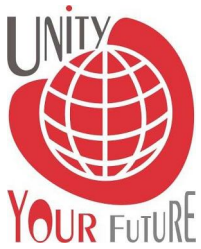
Forename (s)

Company

Please confirm receipt of my accident forms completed and sent to you on:

____ / ____ / ____





Industrial Injury Benefit - Claim Pack. (form O2 of O4 - Claim for Injury Benefit).

THIS IS FORM O2 OF O4 - CLAIM FOR INJURY BENEFIT.

PLEASE READ THROUGH THIS PAGE CAREFULLY, AND COMPLETE THE SECTION BELOW.

SURNAME: _____ (Mr/Mrs/Miss/Ms)

FORENAME (S): _____

ADDRESS: _____

TELEPHONE No: (_____) _____

FACTORY: _____

CLOCK NUMBER: _____

DATE OF INJURY: _____ / _____ / _____

SIGNED: _____

FOR HEAD OFFICE USE ONLY.

Claim checked by: _____

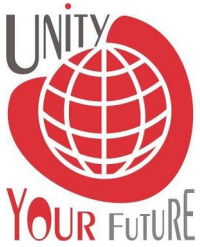
Date: _____ / _____ / _____

No payment can be made until membership has been verified by Head Office.

Membership Number: _____

Geoff Bagnall - General Secretary





Industrial Injury Benefit - Claim Pack. (form 03 of 04).

THIS IS FORM 03 OF 04 - CLAIM FOR INJURY BENEFIT.

THIS FORM IS TO BE COMPLETED BY THE HEAD OF YOUR DEPARTMENT

FACTORY: _____

NATURE OF INJURY: _____

PLEASE COMPLETE ONE OF THE FOLLOWING SECTIONS

PLEASE USE BLOCK CAPITALS

I CONFIRM THERE IS AN ENTRY IN THE WORKS ACCIDENT BOOK.

DATED: _____ / _____ / _____ RECORDING THE FACT THAT

NAME: _____ IS ENTERED AS REPORTING AN INJURY

ON _____ / _____ / _____

NAME: _____ POSITION: _____

PLEASE USE BLOCK CAPITALS

I AM UNABLE TO CONFIRM AN ENTRY IN THE WORKS ACCIDENT BOOK IN RELATION TO:

NAME: _____ FOR THE REASON OUTLINED BELOW

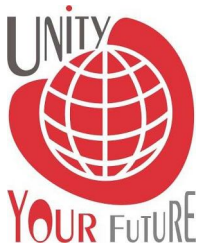
NAME: _____ POSITION: _____

SIGNED: _____

Date: _____ / _____ / _____

N.B: THIS FORM IS TO RETURNED TO HEAD OFFICE BY THE CLAIMANT.





Industrial Injury Benefit - Claim Pack. (form O4 of O4).

THIS IS FORM O4 OF O4 - CLAIM FOR INJURY BENEFIT.

PLEASE READ THROUGH THIS PAGE CAREFULLY, AND COMPLETE THE SECTIONS BELOW.

ACCIDENT PARTICULARS FORM - PART ONE.

Surname	Mr/Mrs/Miss/Ms
<input type="text"/>	
Forename (s)	
<input type="text"/>	
Address	
<hr/> <hr/> <hr/>	
National Insurance Number:	Date Of Birth:
<input type="text"/>	<input type="text"/>
Average Weekly Wage: Gross	£ _____
Take Home	£ _____

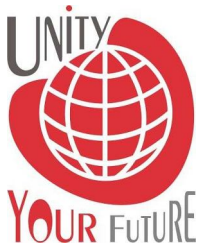
Telephone Numbers:	Home _____
	Mobile _____

Company	<input type="text"/>
Address	<hr/> <hr/> <hr/>
Occupation	<input type="text"/>
How long have you worked there ?	
Years: _____	Months: _____

Copies of Sick Notes / Medical Certificates covering the relevant period MUST be forwarded to Unity Head Office to establish entitlement to Industrial Injury Benefit.

Nature of injuries
<input type="text"/>
Have you reported the injury to your employer ? YES/NO
Their Name and Position
<input type="text"/>
Is the injury recorded in the Accident Book ? YES/NO
If No, is it recorded elsewhere ?
<input type="text"/>
Area where the accident occurred
<input type="text"/>
Names and Addresses of any witnesses
<input type="text"/>
Onset date of injury/disease, or date of accident
Date <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Time <input type="text"/>
Date you ceased work
Date <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Time <input type="text"/>
Sick Notes started from <input type="text"/>
Have you started back to work ? YES/NO
If YES, when <input type="text"/>
Are you doing the same job ? YES/NO
If No, please state below your job ?
<input type="text"/>
At the same rate of pay ? YES/NO
If No, please state your new rate of pay £ _____





Industrial Injury Benefit - Claim Pack. (form O4 of O4).

THIS IS FORM O4 OF O4 - CLAIM FOR INJURY BENEFIT.

PLEASE READ THROUGH THIS PAGE CAREFULLY, AND COMPLETE THE SECTIONS BELOW.

ACCIDENT PARTICULARS FORM - PART TWO.

<p>Name of your own Doctor</p> <input type="text"/>	<p>Name/Address of Hospital (if treated)</p> <hr/> <hr/>
<p>Address</p> <hr/> <hr/> <hr/>	<p>Name of Doctor or Surgeon</p> <input type="text"/>

In the box below please explain how the accident happened:

PLEASE CAREFULLY READ A & B BELOW, AND SIGN AND DATE THE APPROPRIATE BOX:

A) I CONSIDER that my injury / disease during the course of my employment was due to negligence, and I request help from the Union's Solicitors in pursuing a claim for compensation.

SIGNED: _____

Date: ____ / ____ / ____

B) I DO NOT CONSIDER that my injury / disease during the course of my employment was due to negligence, and no not wish to attribute blame for my injury / disease.

SIGNED: _____

Date: ____ / ____ / ____

PLEASE RE-READ ALL FIVE PAGES (FOUR FORMS) THAT YOU HAVE COMPLETED, AND MAKE SURE THAT THEY ARE CORRECT.
SEND THE COMPLETED FORMS AND ANY OTHER RELEVANT DOCUMENTATION TO THE ADDRESS STATED BELOW.

