## APPENDIX A

**LONG TERM SICKNESS INSURANCE**

**CLAIM FORM**

NAME OF SCHOOL..........................................................................................................

MEMBER OF STAFF CLAIMED FOR............................................................................

TEACHER/SCHOOL ADMINISTRATOR/NURSERY NURSE / OTHER (Please specify)

……………………………………………………………………………………………………………

FULL TIME/PART TIME (If part time please specify days worked in the week and no. of hours)

……………………………………………………………………………………………… .

FIRST DAY OF SICKNESS ABSENCE (Please attach copy of medical certificate)

…………………………………………………………………………………………………………….

DATE OF RETURN TO WORK (If known)....................................................................

IS THIS THE FIRST CLAIM FOR THIS ABSENCE.......................YES/NO

DATES COVERED BY THIS CLAIM: FROM........................... TO............................

TOTAL NUMBER OF DAYS..........................................................................................

DATES OF TERMS COVERED BY SUMMER.................................................

THIS CLAIM: AUTUMN.................................................

 SPRING....................................................

SIGNED:-....................................................(Head teacher) DATE........................

Please return to: Schools HR, 5th Floor SW, Perceval House, 14 – 16 Uxbridge Road, Ealing W5 2HL

Please Note: All claims received will be processed and paid at the end of each term, the exception being at the end of the financial year, when forms need to be submitted by the end of February.