NORTHAMPTONSHIRE POLICE FEDERATION
UNSOCIABLE HOURS BENEFIT CLAIM FORM

1. The unsociable hours benefit is payable to members for any period of sickness where you were due to be working unsocial hours i.e. between the hours of 20:00 and 06:00 (subject to the 14 day deferred period and applicable policy limits).
2. The benefit is payable for a maximum of 24 weeks **after** the 14 day excess period.
3. The benefit payable is £1.00 per hour up to a limit of £60 per week. Payment of the benefit will be made by BACS transfer.
4. Please enclose a copy of your medical certificates covering your period of absence
5. Please ensure your supervisory officer signs the appropriate declaration before you submit your claim form.
6. Please enclose a copy of your pay slips, for each month you are claiming and for the 2 months before your claim date.
7. Please return this form to **Northamptonshire Police Federation, Wakefield House, Wootton Hall Park, Northampton, NN4 0JA**

Claim Details: - **Serving Officer / Police Staff*** **(Delete as applicable)**

Surname: _____ Forename(s): _____

Date of Birth: _____Rank:_____ Collar Number: _____

Home Address: _____

_____

_____ Postcode: _____

Email Address: _____ Tel No: _____

First date of absence from duty: _____ / _____ / _____

First date of claim **(this must be after 14 days of absence)**: _____ / _____ / _____

Last date of absence from duty: _____ / _____ / _____

Details of illness causing absence: _____

Declaration: -

- I declare that during the above period of sickness the total number of unsocial hours I am claiming is: _____

  (Based on the hours I was scheduled to work at the time of onset of disablement)
- I confirm that as a result of not being able to work these hours I have suffered a loss of unsocial hours pay
- I have been off sick during this period and have been in receipt of Statements of Fitness to Work confirming I am not fit to work from my doctor

Insured Members Signature: _____ Date: _____

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To be completed by your Supervisory Officer: -

I certify that the above was scheduled to work the unsocial hours as detailed above and has been off work during this time due to sickness.

Supervisory Officer Signature: _____ Date: _____

Please print name: _____ Rank: _____

When your claim has been approved the payment will be credited direct to your bank account. Please complete the following details:-

Name and Address of your Bank:

_____ Account Number: _____

_____ Sort Code: _____

_____ Account Name: _____

To be completed by a Trustee of the Scheme: -

I certify that the claimant is a member of the Scheme

Date of Joining Scheme: - _____/_____/_____

Signed: _____ **Date:** _____

Name: _____

DATA PROTECTION NOTICE

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Privacy Notice

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A hard copy can be provided upon request.

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