

WORKER REQUEST FOR PAYMENT

THIS SECTION SHOULD BE COMPLETED BY THE WORKER

Incolink Member No

First Name _____

Surname _____

Address _____

 _____ Postcode

Contact Telephone

Mobile Phone

Email Address _____

Date of Birth / /

Employer Company Name _____

Tax File No

(Please supply your personal 9-digit Tax File Number. It is not against the law for you to not give Incolink your tax file number (TFN). However, if you do not supply your TFN any taxable portion of claim will be taxed at the marginal tax rate, plus the Medicare levy.)

DECLARATION

I understand that to be eligible to claim my redundancy funds I must be made genuinely redundant, and if not genuinely redundant I may not be eligible to claim my funds until age 66. I understand that the redundancy benefit to be paid by Incolink from my Genuine Redundancy Account will be the balance in my account at the date of claim less any tax required to be withheld. The tax free amount will be calculated in accordance with the ATO's Genuine Redundancy Rules.

Signed: _____

Date / /

PROOF OF IDENTITY

Please provide a certified copy of at least one (1) of the below documents as Proof of Identity.

- Valid drivers's license
- Birth Certificate
- Passport
- Medicare Card

CERTIFICATION OF DOCUMENTS

All copies of identity documents must be certified by one of the following:

- Justice of the Peace
- Pharmacist
- Principal of a registered school
- Veterinarian
- Lawyer
- Accountant
- Medical Practitioner
- Bank manager
- Dentist
- Police officer

PREFERRED PAYMENT OPTION

Please nominate how you wish to receive payment by:

- Paid directly into my Bank Account via EFT (Complete Electronic Funds Transfer section)
- Cheque

ELECTRONIC FUNDS TRANSFER

Incolink is able to pay your redundancy benefit as cleared funds directly into your bank account.

This will give you direct access to the funds the following day, instead of having to wait for cheque to be cleared.

Please note: We depend on the accuracy of the details you are providing to us. If insufficient bank details are provided, a cheque will be forwarded to your address. If this form is not completed correctly and information is missing, your claim may be delayed.

Name of Bank _____

Branch _____

BSB No (must be a 6-digit number)

Bank Account No
(not card number)

Type of Account Please note: credit card accounts are not accepted

Savings Cheque Other (specify)

Names in which account is held and for which you are registered

CLAIM FORM CHECKLIST

- Had my Employer fill in the Confirmation of Termination section (reverse side) or provide an acceptable form of confirmation as outlined in this form
- Completed the Worker Request for Payment section
- Signed and dated the form (see left)
- Provided certified copy of proof of identity
- Completed the Preferred Payment Option section

PLEASE NOTE: Information provided by Incolink is of a general nature, we recommend you seek your own independent advice. For further information about the Incolink Genuine Redundancy Account, including possible payment triggers, please refer to the Genuine Redundancy Account brochure.

Office use only

Date received / /

CONFIRMATION OF TERMINATION

THIS SECTION SHOULD BE COMPLETED BY THE EMPLOYER

ONLY THE FOLLOWING PEOPLE ARE AUTHORISED TO SIGN THIS CLAIM FORM ON BEHALF OF THE EMPLOYER.

- A current director of the company
- A partner of the business
- An authorised contact for the business as previously advised in writing to Incolink.

Confirmation of termination will only be accepted in the form of the following:

- Completion of the section below which is to be signed by an authorised officer of the company as listed above. The company seal or stamp also needs to be affixed in the section provided at the bottom of this form.
- If no company stamp is available, a letter on company letterhead signed by an authorised officer as listed above, confirming the workers' date of termination and stating the worker is genuinely redundant.

If you have any questions or require any assistance, please contact our office and have your Incolink Member Number ready.

EMPLOYER DETAILS

Incolink Employer No

Employer Company Name _____

WORKER DETAILS

Full Name of Worker _____ Incolink Member No _____

Worker's Start Date / / Worker's Termination Date / /

PORTABLE SICK LEAVE SCHEME (PSLI)

If you contribute to the PSLI scheme for this worker please advise the actual number of sick days taken (not hours) during the employment or if you paid out the workers sick leave under the terms of an industrial agreement (EBA).

Sick days taken

We declare that the reason for the workers termination is due to a genuine redundancy

(if the reason for termination is other than a genuine redundancy **do not** complete this form)

SIGNED ON BEHALF OF THE EMPLOYER BY:

Signature _____

Full Name _____

Position _____

Date / /

Company Seal or Stamp to be affixed:

PLEASE NOTE: Employers should ensure that they have appropriate evidence on their file to demonstrate a genuine redundancy. Incolink recommends employers seek their own independent advice on whether a genuine redundancy has arisen before completing the above declaration.