FURNITURE BARGAINING COUNCIL

Suite 1 & 2 ♦ Reitz Park ♦ 80 President Reitz Avenue ♦ Westdene ♦ Bloemfontein ♦ 9301
Correspondence to be addressed to: THE PROVINCIAL MANAGER ♦ Post Office Box 3914 ♦ Bloemfontein ♦ 9300
Telephone (051) 447-1807 ♦ Facsimile (051) 447-2554 ♦ e-mail freestate@furnbed.co.za ♦ Website www.furnbed.co.za

CIRCULAR 03/18

TO ALL EMPLOYERS AND EMPLOYEES

(Falling under the Free State Provincial Office)

Sir/Madam

COLLECTION AND PAYMENT OF FURNMED SICK BENEFIT SOCIETY CONTRIBUTIONS

In terms of a resolution reached at a special Furnmed Sick Benefit Society Trustees meeting held on Friday, 16 February 2018, the Council shall as from **1 April 2018** no longer act as the collecting agent for Furnmed Sick Benefit Society contributions.

All establishments must as from **1 April 2018** pay all current and future members' Furnmed Sick Benefit Society contributions directly to **Eminent Wealth Consult (Pty) Ltd** and not to this Council. Any queries regarding this matter must be directed to:

Eminent Wealth Consult (Pty) Ltd contact details and postal address are as follows:

Telephone Number	:	(086) 163 6840
Fax Number	:	(086) 577 1151
Email Address	:	annamarie@eminentwealth.co.za
Postal Address	:	Private Bag X2, Weltevreden Park 1715

NB: The bank account details to which payment must be made in respect of Furnmed Sick Benefit Society contributions is:

Name of Bank	:	FNB (First National Bank)
Branch	:	Clearwater Mall
Branch Code	:	251105
Account Name	:	**Furnmed Sick Benefit Society**
Account Number	:	62319619188
Reference Number	:	CB No (will be provided on pro-form billing statement)

No payments must be made to any other bank account in respect of Furnmed Sick Benefit Society contributions.

Attached please find a copy of the new member application form and an example of the monthly return form, which is to be used from **1 April 2018**, in respect of contributions for March 2018. Take note that Eminent Wealth Consult (Pty) Ltd will email your monthly return form to your establishment on a monthly basis.

Kindly ensure that the provisions of this Circular are complied with. Do not hesitate to contact the Council's Inspectorate Department should you require any additional information. Please do not contact any junior staff members of the Council in this regard.

A COPY OF THIS CIRCULAR MUST BE DISPLAYED ON YOUR ESTABLISHMENT'S NOTICE BOARD

5 March 2018

FURNMED SICK BENEFIT SOCIETY NEW MEMBER APPLICATION FORM

OPTION:	☐ Standard Compulsory	☐ Standard Voluntary	**JOIN DATE:**	D D M M Y Y Y Y	
REGION:	☐ JHB / PTA	☐ Free State	**INDUSTRY NO:**		

MEMBER DETAILS

TITLE: _____ **INITIALS:** _____ **GENDER:** M F **SURNAME:** _____

NAME (s): _____ **NATIONALITY:** _____

ID / PASSPORT NO: _____

CELL NUMBER: _____ **WORK NUMBER:** _____

EMAIL: _____

ADDRESS: _____

_____ **CODE:** _____

DEPENDANT DETAILS

NAME	SURNAME	GENDER	RELATIONSHIP TO MEMBER	DATE OF BIRTH
		M F		D D M M Y Y Y Y
		M F		D D M M Y Y Y Y
		M F		D D M M Y Y Y Y
		M F		D D M M Y Y Y Y

NB: Copies of your ID, your dependant's ID or birth certificates and affidavits are required.

MEDICAL DECLARATION

Supply full details on questions below. Where an answer to a question is "Yes", please provide details in the space provided below. Questions pertain to applicant and ALL BENEFICIARIES.

Non-disclosure of information may result in termination of membership or non-payment of some medical treatment.		**Answer**	
Have you/your dependants ever experienced any of the following? Please mark your answer (X) in the relevant box.		**Y**	**N**
1	Are you or your dependants suffering from, or have suffered from any chronic or recurring illness or any serious ailments?		
2	Have you or your dependants received any medical attention of any nature (e.g. hospitalisation, operations) in the last 2 years?		
3	Are you or your dependants expecting to undergo any procedure, operation or receive any major dental treatment in the next 12 months?		
4	Are you, your spouse or any dependants currently pregnant? If "Yes", when is the expected date of delivery?		

If the answer to any of the above questions is "Yes", please give a short summary. (Dependant, date, treatment received, condition/illness)

NOTE there will be waiting periods imposed on pregnancy, optometry and dentistry. A 3 Month general waiting period will also apply. Pre-existing conditions may be excluded for 12 months.

I, _____, hereby certify that to the best of my knowledge, as at the date of this application, that the above information is true and correct. I further agree to familiarise myself with the benefits I am entitled to and to abide by the rules and regulations of the Society as may be amended from time to time.

SIGNED AT: _____ **ON:** D D M M Y Y Y Y

MAIN MEMBER SIGNATURE:

EMPLOYER SECTION

EMPLOYER NAME: _____ **CONTACT NO:** _____

SHOP STEWARD: _____ **CELL NO:** _____

SIGNED AT: _____

ON: D D M M Y Y Y Y

EMPLOYER SIGNATURE:

Employer's Official Stamp

FURNMED SICK BENEFIT SOCIETY

BILLING SCHEDULE FOR: 2018-03-01

Sick Fund	Employer Code	Company Name	Communication Detail	FURNMED Current Month Billed Amount	Arrears / Credit Total	TOTAL DUE	Company Pay Amount	Difference
FURNMED	99999	COMPANY NAME	company@email.co.za	**R 3 828.00**	**R 0.00**	**R 3 828.00**	**R 0.00**	**R 3 828.00**

ID Number / DOB	Member No	Surname	Init	Dependants	Option	Weeks Charged	Weeks Worked	Employee Portion Per Week	Employee Additional Weekly Cost	Employer Portion Per Week	Total Weekly Premium	FURNMED Current Month Billed Amount	ARREARS / CREDIT	TOTAL PREMIUM	Employer Deduction Amount	Non / Short / Over Payment Reason
00000	11111	Buthelezi	MD	0	Standard	4	4	R 57.50	R 0.00	R 60.50	R 118.00	R 472.00	**R 0.00**	R 472.00		
00000	22222	Clarke	JJ	0	Standard FS	4	4	R 40.00	R 0.00	R 71.00	R 111.00	R 444.00	**R 0.00**	R 444.00		
00000	33333	MKHIZE	SI	1	Standard	4	4	R 57.50	*R 45.00*	R 60.50	R 163.00	R 652.00	**R 0.00**	R 652.00		
00000	44444	Mokoatedi	MP	1	Standard FS	4	4	R 40.00	*R 45.00*	R 71.00	R 156.00	R 624.00	**R 0.00**	R 624.00		
00000	55555	Mophuthi	BJ	2	Standard	4	4	R 57.50	*R 90.00*	R 60.50	R 208.00	R 832.00	**R 0.00**	R 832.00		
00000	66666	Windvogel	DN	2	Standard FS	4	4	R 40.00	*R 90.00*	R 71.00	R 201.00	R 804.00	**R 0.00**	R 804.00		
											***Total Other Arrears:**			R 0.00		

Please enter NEW member details below

ID Number / DOB	Member No	Surname	Init	Dependants	Option	Weeks Charged		Employee Portion Per Week	Employee Additional Weekly Cost	Employer Portion Per Week	Total Weekly Premium	FURNMED Current Month Billed Amount	ARREARS	TOTAL PREMIUM	Employer Deduction Amount	

Banking Details:	
Bank:	FNB
Code:	251105
Acc No:	62319619188
Name:	FURNMED
Ref:	CB no 99999

Sick Fund Returns To Be Sent To:	
Fax:	086 577 1151
Email:	annamarie@eminentwealth.co.za
Postal:	Private Bag X2, Weltevreden Park, 1715
Physical Address:	Palms Office Court, Block C, Kudu Str, Allen's Nek, Ext 27, Roodepoort.

***For members who have left and for which contributions are still due to the FURNMED Sick Benefit Society.**