COVID-19

5 days COVID-19 Positive Supplement (Dependant)

Annex 1 - Employer Application form

Applicant's Details

Applicant(s) Name	
Trading as (if applicable)	
Business address	
Telephone number	
E-mail address	
Tax Reference Number	
Business type	

Applicant's Bank Details

Principal Bank Account with Standard Chartered Bank, Stanley: • Account name • Account number	

Employee Details

Please provide the following details for each employee where the COVID-19 Positive supplement is being claimed (additional employees can be entered in Annex 3):

Employee Name			
Dependant(s) Name			
Number of days claimed			
Dependant(s) COVID-19 sick dates			
LFT Code (not needed if PCR)			
Did the employee work from home during the dates above?		☐ Yes / No	☐

Accompanying Documents

Please include the following documents with your application:-

Declaration, at Annex 2, by each employee claiming the COVID –19 Positive Supplement (Dependant)	☐
New Creditor Form - If Employer is not already registered on FIGs Account Payable System	☐
Evidence of a positive LFT/PCR This may include a photo of the positive test or confirmation from KEMH. DO NOT send the tests with the application	☐

COVID-19

5 days COVID-19 Positive Supplement (Dependant)

Annex 1 - Employer Application form

In consideration of the payment to *me/the applicant** of Scheme Payments, I, the undersigned (as Employer/for and on behalf of the Employer of the Employee(s) referred to in this application form), hereby certify, accept and undertake (as Employer/having been duly authorised by the Employer to do so on its behalf*) that:-

*please delete as appropriate.

Please note: If purporting to give this undertaking on behalf of the Employer named above without being duly authorised to do so, the undersigned may be personally liable for any breach of this declaration

- To the best of *my/the applicant's** knowledge and belief (having made all reasonable enquiries), all information contained in *my/its** application(s) and in the accompanying documents or otherwise provided in connection with the Scheme, is true, accurate, up-to-date and complete.

- *I am/the applicant* is* eligible to claim Scheme Payments under the Scheme as an Employer of the Employee(s) specified in the application(s).

- *I/the applicant** shall comply with the Terms.

- *I/the applicant** will pay a minimum of £60 a day to the Employee(s) included in this application for the dates included in this application.

- Each Employee listed in *my/its** application(s) satisfies the criteria for an Employee under the Scheme, as set out in the Terms. *I have/the applicant has** provided with this application a declaration (in the form of Annex 2 below) completed and signed by each Employee included in this application.

- Any Scheme Payments *I/the applicant** receive(s) under the Scheme will be taxable income and will be subject to income or other tax in accordance with the terms of the Taxes Ordinance (as amended) and any other relevant tax legislation, depending on *my/the applicant's** individual circumstances.

- Any breach by *me/the applicant** of the Terms or the requirements of the Scheme or any of the above undertakings, or the provision by *me/the applicant** of any false or misleading information in, or in connection with, *my/its** application(s) will entitle FIG to reclaim and recover any Scheme Payments awarded under the Scheme (in whole or part).

Name(s): _____

Signature(s)*:_____

Capacity signed in: _____

Date: _____ * Documents can be signed electronically or in hard copy

COVID-19

5 days COVID-19 Positive Supplement (Dependant)

Annex 2 - Employee Declaration

I, the undersigned, hereby certify and undertake as follows:

- I am employed by, * _____.

  * Please complete

- My dependant(s) tested positive for COVID-19 as evidenced by a positive LFT or PCR and I did not work during the period for which the claim is being made.

- I confirmed to the above Employer whether I also work for other employers; and if so, I have given the above Employer the name, address and description of each other employer for whom I work and confirmed, so far as I am aware, whether they have made, or intend to make, any claim in respect of me under the Scheme.

- Not withstanding the provisions of the Taxes Ordinance 1997 (as amended) or any other relevant legal, regulatory or other requirements or policies, I hereby consent to the disclosure of details of my wages, salary or other employment benefits and tax position within FIG as necessary to verify the claim made by my Employer under the scheme in respect of myself.

- Notwithstanding the provisions of the Access to Health Records Ordinance 1995 or any other relevant legal, regulatory or other requirements or policies, I hereby consent to the disclosure of my health records within KEMH and by KEMH to any other department of FIG as necessary to verify the claim made by my Employer under the scheme in respect of myself.

- Any payments I receive from my Employer which are funded by scheme payments will be in the nature of remuneration, will be taxable income and will be subject to income or other tax in accordance with the terms of the Taxes Ordinance 1997 (as amended) and any other relevant tax legislation, and to other deductions (such as pension contributions) in the normal, way depending on my individual circumstances.

Name(s): _____

Signature(s)*: _____

Date: _____ * Documents can be signed electronically or in hard copy

COVID-19

5 days COVID-19 Positive Supplement (Dependant)

Annex 3 - Employer Application form - extra employees

Employee Details

Please provide the following details for each employee where the COVID-19 Positive supplement is being claimed:

Employee Name	
Dependant(s) Name	
Number of days claimed	
Dependant(s) COVID-19 sick dates	
LFT Code (not needed if PCR)	
Did the employee work from home during the dates above?	☐ Yes / No ☐

Employee Details

Please provide the following details for each employee where the COVID-19 Positive supplement is being claimed:

Employee Name	
Dependant(s) Name	
Number of days claimed	
Dependant(s) COVID-19 sick dates	
LFT Code (not needed if PCR)	
Did the employee work from home during the dates above?	☐ Yes / No ☐

Employee Details

Please provide the following details for each employee where the COVID-19 Positive supplement is being claimed:

Employee Name	
Dependant(s) Name	
Number of days claimed	
Dependant(s) COVID-19 sick dates	
LFT Code (not needed if PCR)	
Did the employee work from home during the dates above?	☐ Yes / No ☐