NO. R. 1434

DEPARTMENT OF LABOUR

28 DECEMBER 2018

UNEMPLOYMENT INSURANCE ACT, 2001 (ACT NO. 63 OF 2001)

AMENDMENT OF UNEMPLOYMENT INSURANCE ACT REGULATIONS

The Minister of Labour has, in terms of section 54 of the Unemployment Insurance Act, 2001 (Act No. 63 of 2001), and after consultation with the Unemployment Insurance Board, made the regulations in the Schedule that will come into operation on a date of publication of the notice.

aid NT, MP M. N. OLIPH **MINISTER OF LABOUR** DATE: /2/12/20/8

SCHEDULE

Definition

In this Schedule "the Regulations" means the regulations published by Government Notice No. R.
 400 of 28 March 2002 as amended by Government Notice No. 536 of 23 April 2004, Government Notice No. R. 823 of 10 August 2005, and Government Notice No. R. 948 of 5 October 2009.

Amendment of regulation 1 of the Regulations

 Regulation 1 of the Regulations is hereby amended by the insertion after the definition of "official" of the following definition:

"small enterprise" means a small enterprise contemplated in section 1 of the National Small Enterprise Act, 1996 (Act No. 102 of 1996)."

Insertion of regulation 3 in the Regulations

3. The following regulation is hereby inserted after regulation 2 of the Regulations:

"Reduced working time benefits in terms of section 12(1B) of the Act

3. (1) The income derived from continued employment contemplated in section 12(1B) of the Act plus the amount of benefits calculated, may not exceed the benefits that would have been paid if the contributor had become wholly unemployed.

(2) Reduced working time benefits must be calculated based on the remuneration of the contributor."

Amendment of regulation 7 of the Regulations

4. Regulation 7 of the Regulations is hereby amended by the addition of the following sub-regulation:

"(3)(a) A contributor may nominate a beneficiary in terms of section 30(2A) of the Act by submitting the nomination form UI 53 to the Fund immediately on commencement of employment.

(b) A contributor may change the nomination at any time by submitting a new nomination on form UI 53.

(c) If a contributor did not in terms of paragraph (a), complete a nomination form at the commencement of new employment, the Fund must accept as valid, a nomination form completed at the previous employer.

Repeal of regulations 10, 11 and 12 of the Regulations

5. Regulations 10, 11 and 12 of the Regulations are hereby repealed.

Amendment of regulation 13 of the Regulations

6. The following regulation is hereby substituted for Regulation 13 of the Regulations:

"Providing information in terms of section 56

(1) An employer must, within seven days of the end of the month in which it commences activities as an employer, submit a completed declaration, UI 19 to the Commissioner.

(2) Every employer must provide the Commissioner with all information in terms of sections 56(2) or

(3) of the Act and must do so by submitting declarations of their employees electronically or by completing form UI 19.

(3) Any information submitted to the Commissioner in terms of sub- regulations (1) and (2) must be submitted to the Unemployment Insurance Fund, 230 Lillian Ngoyi Street; ABSA Building, Pretoria, 0001 or to Private Bag x 0052, Pretoria, 0001

(4) Domestic and small enterprise employers may declare employees and pay contributions annually provided that the contributor's services are not terminated, in which case, the declaration must be done upon termination."

New forms

- 7.(1) Forms UI 2.1, 2.2, 2.3, 2.4, 2.5, 2.6, 2.7, 3, 4, 5,6A and 19 are hereby substituted for the evenly numbered forms in the Annexure.
- (2) Form UI 53 is hereby inserted in the Regulations.

Short title

8. These regulations are called the Unemployment Insurance Amendment Act Regulations, 2017.

| APPLICATIO | UNEMPLICATION FOR UNEMPLOYMENT INSURANCE ACT 63 OF 2001 APPLICATION FOR UNEMPLOYMENT BENEFITS IN TERMS OF SECTION 1/ | JRANCE ACT | 63 O | F 2001 | UNEMPLOYMENT INSURANCE ACT 63 OF 2001 OYMENT BENEFITS IN TERMS OF SECTION 17(1) - Read with Regulation 3(1) |
|---|---|-------------------|-----------------|--------|---|
| 13 Digit Bar-Coded Identity Document/Passport Number | Date of Birth (dd/mm/yy) | Gender | | | |
| Tree Namoe | | Male | Surname | Fe | Fenaic |
| -11-31 1-411(C) | | | A REAL PROPERTY | | |
| Postal Address | | | | | Code /Telephone No |
| | | Code | _ | | |
| Residential Address | | Code | | | Cell No |
| Occupation | | E-Mail Address | | | Fax number |
| | | CON PRIME TIMES | | _ | |
| Education | | | | | |
| SPECIAL SCHOOL CERT. | GRADE 8-9 | GRADE 12 | 2 | | |
| BELOW GRADE 8 Use the UI-2.8 form for Banking Details Details of Drevious application | GRADE 10 - 11 | ABOVE GRADE 12 | RADE | 112 | |
| a) Name and ID No under which you applied: | | | | | |
| FURTHER REQUIREMENTS | FURTHER REQUIREMENTS FOR REDUCED WORK TIME in term of section 12(1B) | RK TIME in term o | f section | | IMPORTANT: READ THIS SECTION BELOW: |
| 1. Are you registered as a workseeker with a Labour | 1. Are you currently employed | | Yes | No | I declare that I and was unemployed/1'm working reduced hours In the event of my application being successful, the Claims Officer will |
| Contre established by the DOL | No 2. Are / Were you on Reduced Work Time: | | Yes | No | authorisee the payment of benefits. I also undertake to inform the Claims Officer as soon as I am re-employed or receiving "full/normal pay" and |
|] | 3. Has your employer completed a UL2.7? | | Yes | No | understand that failure to do so will constitute fraud. |
| Are <u>you capable</u> and available for work? Y_{ver} <u>No</u> | | | | | In the event of an overpayment occurring as a result of this application I undertake that I will refund the full amount to the Fund. |
| | | | 1 | Г | I declare that the above information is true and correct. |
| If you are not capable of and available for work. please explain: | | | | | SIGNATURE OF APPLICANT: |
| Signature of applicant: | | | | | Date:// |
| | | | | 1 | |
| Signature of Official | Claim approved from: | | | | OFFICE STAMP |
| | Application refused in terms of: | | | - | |
| Date: / / | Claims officer (Please Print): | | | | |
| COMPLETE YES NO | Signature: | | | | |
| | Date: | | | | |

GOVERNMENT GAZETTE, 28 DECEMBER 2018

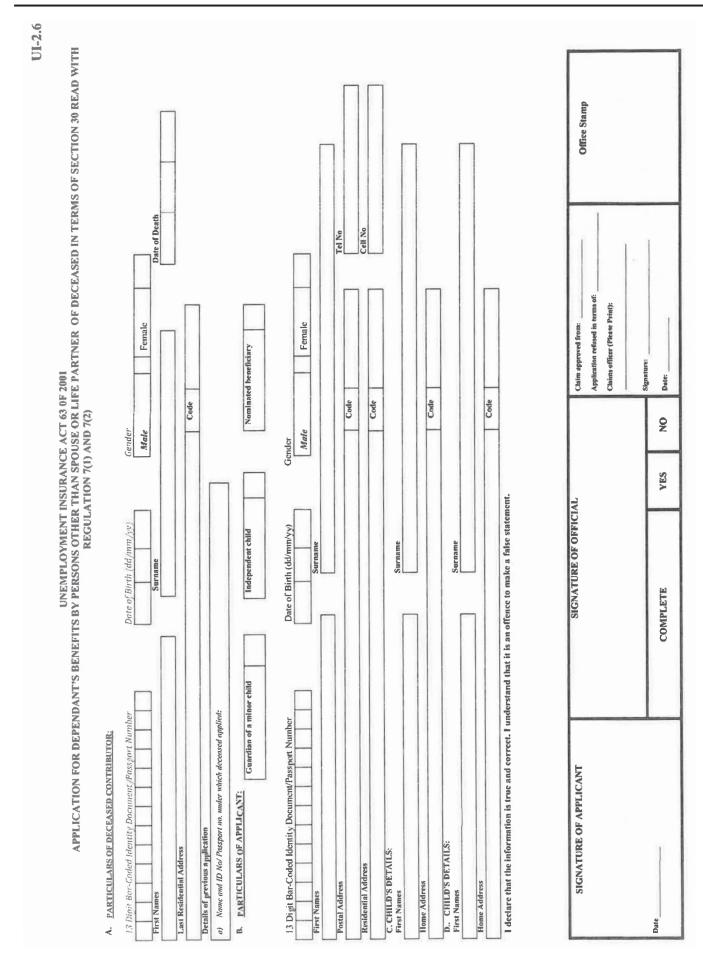
| APPLI | UN APPLICATION FOR ILLNESS BEI | EMPLOY VEFITS IN | MENT INS V TERMS (| UNEMPLOYMENT INSURANCE ACT 63 OF 2001 BENEFITS IN TERMS OF SECTION 22(1)- Read with Regulations 4(1), 4(5) and 4(7) | |
|---|---|----------------------------|---------------------------------|--|---|
| 13 Digit Bar-Coded Identity Document/Passport Number | | Date of Birth (dd/mm/97) | (14/6 | Gender Male Femalc Surname | |
| Postal Address | | | | Code /Telephone No | |
| Residential Address | | | | Celt No | |
| Occupation | | | E-Mail Address | | |
| Education | | | | | |
| SPECIAL SCHOOL CERT. BELOW GRADE 8 | GRADE 8-9 GRADE 10 - 11 | | | CRADE 12 ABOVE GRADE 12 | |
| Use the U1-2.8 form for Banking Details Details of previous application a) Name and ID No/ passport number under which you applied: | applied: | | | | |
| | | | | | |
| ARE YOU STILL EMPLOYED YES NO NB: IF YOU ARE STILL EMPLOYED, FORM UI 2.7 MUST ALSO BE COMPLETED. | UST ALSO BE COMPLETED. | | | MEDICAL CERTIFICATE (To be completed by an authorised practitioner in terms of section 20(1)(c) of the UI Act 63 of 2001. | _ |
| IF YOU HAVE RETURNED TO WORK. STATE DATE: | | | | onfirm that | |
| IMPORTANT: READ THIS SECTION BELOW: | | | | This patient was not capable of performing work from to | |
| In the event of my application being successful, the Claims Officer will authorise the payment of benefits. I also undertake to inform the Claims Officer as soon as I am re-employed and understand that failure to do so will constitute fraud. | laims Officer will authorise the pa um re-employed and understand th | yment of b at failure t | enefits. I also o do so will | Signature Date Date | |
| In the event of an overpayment occurring as a result of this application I undertake that I will refund the full amount to the Fund. | of this application I undertake tha | ıt I will refu | nd the full | Address | - |
| I declare that the above information is true and correct. | | | | | |
| Where a Proxy was appointed by Doctor or Legal Representative proof will be required | gal Representative proof will b | e required | | | 1 |
| SIGNATURE OF APPLICANT / PROXY | SIGNATURE OF OFFICIAL | | | Claim approved from: Office Stamp | |
| | | | | Application refused in terms of: Claims officer (Please Print): | |
| Date | COMPLETE | YES | ON | Segnature:DAle:AAle:AA | |

| UI-2.3 UNEMPLOYMENT INSURANCE ACT 63 OF 2001 APPLICATION FOR MATERNITY BENEFITS IN TERMS OF SECTION 25(1) - Read with Regulation 5(1) and 5(4) | Document/Passport Number Date of Birth (dd/mm/yy) | Code /Telephone No | Cell No | E-Meil Address Eav Number | | GRADE 8-9 GRADE 12 GRADE 10 - 11 ABOVE GRADE 12 | ng Details on to under which you applied: | YES NO MEDICAL CERTIFICATE (to be completed by a medical practitioner or registered midwife) | DYED, FORM UL-2.7 MUST ALSO BE COMPLETED. I. am a qualified . Qualifications K. STATE DATE: | | e expected due date of bi | ent occurring as a result of this application I undertake that I will refund the full | tation is true and correct. Signature Date Tel No. Address | APPLICANT SIGNATURE OF OFFICIAL Claim approved from: Office Stamp | Application refused in terms of: Claims officer (Please Print): | COMPLETE VES NO |
|--|--|--------------------|---------------------|---------------------------|-----------|---|---|--|---|-------------------------------------|--|--|--|---|--|-----------------|
| APPLIC | 13 Digit Bar-Coded Identity Document/Passport Number | Postal Address | Residential Address | Oromootion | Оссарания | Education SPECIAL SCHOOL CERT. BELOW GRADE 8 | Use the U/-2.8 form for Banking Details Details of previous application a) Name and ID / Passport No under which you applied: | ARE YOU STILL EMPLOYED YES NO | NB: IF YOU ARE STILL EMPLOYED, FORM UL27 MUST ALSO BE COMPLETED. IF YOU HAVE RETURNED TO WORK STATE DATE: | IMPORTANT: READ THIS SECTION BELOW: | In the event of my application being successful, the Ch undertake to inform the Claims Officer as soon as 1 ar constitute fraud. | In the event of an overpayment occurring as a result of this application I underta amount to the Fund. | I doctare that the above information is true and correct. | SIGNATURE OF APPLICANT | | Dote |

60 No. 42140

| | UNE APPLICATION FOR ADO | MPLOYM PTION BEN | ENT INS IEFITS IN | UNEMPLOYMENT INSURANCE ACT 63 OF 2001 APPLICATION FOR ADOPTION BENEFITS IN TERMS OF SECTION 28 Read with Regulation 6(1) | U12.4 |
|--|--|-------------------------------------|------------------------------|--|---------------------------|
| 13 Digit Bar-Coded Identity Document/Passport Number | | d no of adopted child | | Date of Birth (dd/mm/yy) Male Female | |
| First name | | | | Surname | |
| Postal Address | | | | Code /Telephone No | |
| Residential Address | | | | | |
| | | | | Code | |
| Occupation | | | | E-Mail Address Fax Number | |
| Education SPECIAL SCHOOL CERT. BELOW GRADE 8 | CRADE 8-9 GRADE 10 - 11 | | | GRADE 12 ABOVE GRADE 12 | |
| Use the UI-2.8 for Banking Details Details of previous application a) Name and ID No / Passport under which you applied: | ed: | | | | |
| 10A | | | | | |
| NB: IF YOU ARE STILL EMPLOYED, FORM UL-2.7 MUST ALSO BE COMPLETED IF YOU HAVE RETURNED TO WORK, STATE DATE:/ | MUST ALSO BE COMPLETED | | | | |
| IMPORTANT: READ THIS SECTION BELOW: | | | | | |
| In the event of my application being successful, the Claims Officer will authorise the payment of benefits. I also undertake to inform the the event of an overpayment occurring as a result of this application I undertake that I will refund the full amount to the Fund. | ms Officer will authorise the payment this application I undertake that I | tt of benefits. I will refund th | also underta e full amour | In the event of my application being successful, the Claims Officer will authorise the payment of benefits. I also undertake to inform the Claims Officer as soon as I am re-employed and understand that failure to do so will constitute fraud. In the event of an overpayment occurring as a result of this application I undertake that I will refund the full amount to the Fund. | vill constitute fraud. In |
| I declare that the above information is true and correct. | 1 | | | | |
| | | | | | |
| SIGNATURE OF APPLICANT | SIGNATURE OF OFFICIAL | | | Claim approved from: | Office Stame |
| | | | | 96- | demos s |
| | | | | Claims officer (Please Print): Signature: | |
| Date | COMPLETE | YES | NO | Date | |

| | | | UI-2.5 |
|---|--|---|---|
| APPLICATION FOR DE A. <u>Particulars of deceased contributor;</u> | UNEMPLOYMENT PENDANT'S BENEFITS BY SURVIVING SPO | UNEMPLOYMENT INSURANCE ACT 63 OF 2001 BY SURVIVING SPOUSE OR LIFE PARTNER IN 1 | UNEMPLICATION FOR DEPENDANT'S BENEFITS BY SURVIVING SPOUSE OR LIFE PARTNER IN TERMS OF SECTION 30 Read with Regulation 7(1) ECEASED CONTRIBUTOR: |
| 13 Dic _g it Bar-Coded Identity Document /Passport Number | ler Date of Birth (dd/mm/yy) | Gender Male | Female |
| Last Residential Address | | Code | |
| Details of previous a pylication a) Name and 1D/ passport Nn under which deceased applied: | di: | | |
| B. PARTICULARS OF SURVIVING SPOUSE OR LIFE | PARTICULARS OF SURVIVING SPOUSE OR LIFE PARTNER: (NOTE: In the case of a surviving spouse(s), a marriage certificate or proof of customary marriage, or religious union is required) | rriage certificate or proof of | customary marriage, or religious union is required) |
| 13 Digit Bar-Coded Identity Document /Pass port Number | umber Date of Birth (dd/mm/yy) | Gender Male | Female |
| Postal Address | | Code | Tet No |
| Residential Address | | Code | Cell No |
| Occupation | E-Mail | E-Mail Address | |
| Use the UI-2.8 form for Bauking Details | | | |
| I declare that I am one of | I declare that I am one of | ving spouse or lif document is true | surviving spouses or the only surviving spouse or life partner of the abovementioned deceased contributor, r and that information given in this document is true and correct. make a false statement. |
| Signature of applicant | Date / / | | |
| | | | |
| SIGNATURE OF APPLICANT | SIGNATURE OF OFFICIAL | | Claim approved fram: Office Stamp Application refused in terms of: Claims officer (Please Print): |
| | | | Simulature- |
| Date | COMPLETE | YES NO | Date: |
| | | | |



UI-2.7

UNEMPLOYMENT INSURANCE FUND REMUNERATION RECEIVED BY THE EMPLOYEE WHILST STILL IN EMPLOYMENT

To: The Claims Officer

Statement in respect of payment made to the undermentioned Contributor who is still in my employment but is unable to work due to Illness; Maternity leave; Adoption of a child or is on Reduced Work Time (RWT)

| Full names of contributor: | | | | |
|-----------------------------|------|------|---|--|
| Name of Employer: | | | | |
| Employers UIF Reference No. | | | / | |
| ID No of contributor | | | | |

(A) In terms of section 12(1)b, 19(1), 24(2) and 27(3) of the abovementioned Act,

I hereby certify that the contributor would receive less than 100% of his/her remuneration as from ____/ (full date) due to

| Illness Leave Ma | ternity Leave Adoptio | n Leave Reduced | working time | |
|------------------|-----------------------|-----------------|--------------|--|
|------------------|-----------------------|-----------------|--------------|--|

| Gross remuneration (prior to confinement/RWT) Per Month / Per Week | Periods durin | g which different rates of remuneration wer received | e Gross remuneration received whilst on leave/RWT (PM/PW) |
|---|---------------|---|--|
| | From | То | |

(B) The contributor is expected to return to work / full time on ____/___/____.

(C) The contributor returned to work on / full time on

______.

BUSINESS STAMP

DATE

SIGNATURE OF EMPLOYER OR AUTHORISED AGENT

Contact Details of employer:

No. 42140 65

| UI- UNEMPLOYMENT INSURANCE ACT 63 OF 2001 ILLNESS BENEFITS IN TERMS OF SECTION 22 | 3 |
|--|-----|
| | |
| ID NO/PASSPORT. | |
| 1. Sumame: | |
| | |
| 2. Previous surname: (Only if it changed since your previous application) | |
| | |
| 3. First names; | |
| 4. Telephone number: | |
| | |
| IN THE EVENT OF A CHANGE OF ADDRESS INDICATE YOUR NEW DETAILS | |
| 5. Postal address: | |
| | |
| 6. Residential address: (If different from postal address) Postal code | |
| | L |
| 7. Date returned to work: //// | _ |
| I declare, except as stated in item 7, that I have not worked since the date of my application for illness benefits and have not been entitled to my normal remuneration/or will receive a portion of my normal remuneration as declared by my employer on prescribed form UI-2.7 submitted with my application form. I furthermore declare that the information given is true and correct. I am aware that it is an offence to willfully make a false statement. In the event of an overpayment occurring as a result of this application I undertake that I will refund the full amount to the Fund. | / |
| In the event of an overpayment occurring as a result of this application r undertake that r will return the full anount to the rund. | |
| Signature of applicant /Proxy Date | |
| NB: IF YOUR BANKING DETAILS HAVE CHANGED, FORM UI-2.8 MUST BE COMPLETED Where the forms are signed by a Proxy attach proof of appointment. | |
| NB! > THIS FORM MUST BE SUBMITTED TO YOUR NEAREST DEPARTMENT OF LABOUR OFFICE. | |
| NO POST DATED FORMS WILL BE ACCEPTED OR PROCESSED. IN THE EVENT OF YOU RESUMING EMPLOYMENT YOU ARE REQUIRED TO INFORM THE DEPARTMENT OF LABOUR OFFI | CES |
| IMMEDIATELY AND TO REQUEST THE NEW/CURRENT EMPLOYER TO SUBMIT A DECLARATION (UI-19). | |
| MEDICAL CERTIFICATE (To be completed by an authorized practitioner in terms Section 20(1)(c) of Act 63 of 2003 | |
| I, am a qualified | |
| qualifications My registration number is | |
| I confirm that is suffering from | |
| This patient was not capable of performing work from to | |
| Signature Date Tel No | _ |
| Address | - |
| Date Received | _ |
| Date Received | |

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| l, | am a qualified | Qualifications | - |
|---|--|--|---|
| My registration number is | . 1 confirm that | is under my treatment and is pregnant. | |
| The expected due date of birth is OR I confirm that | gave birth/ stillhorn / miscarriage_on | · | |
| Signature Date | Tel No | | |
| Address | | | |

Date Received

UI5

UNEMPLOYMENT INSURANCE ACT 63 OF 2001 APPLICATION FOR CONTINUATION OF PAYMENT FOR ADOPTION BENEFITS IN TERMS OF REGULATION 6(3)

| ID NO/ PASSPORT. |
|--|
| 1. Sumame: |
| |
| 2. Previous surname: (Only if it changed since your previous application) |
| |
| 3. First names: |
| |
| 4. Telephone number: (a) Cell Number (b) Landline Number |
| |
| IN THE EVENT OF A CHANGE OF ADDRESS INDICATE YOUR NEW DETAILS |
| 5. Postal address: |
| |
| 6. Residential address: (If different from postal address) Postal code |
| |
| 7. Date of Commencement of Adoption Leave:// |
| 8. If you have commenced work indicate date:// |
| |
| > NB IF YOUR BANKING DETAILS HAVE CHANGED FORM UI-2.8 MUST BE COMPLETED AND SUBMITTED |
| |
| I declare that : |
| I declare, except as stated in item 7, that I have not worked since the date of my application for adoption benefits and have not been entitled to my normal remuneration/or will receive a portion of my normal remuneration as declared by my employer on prescribed form UI-2.7 submitted with my application |
| form. |
| I furthermore declare that the information given is true and correct. I am aware that it is an offence to willfully make a false statement. |
| In the event of an overpayment occurring as a result of this application I undertake that I will refund the full amount to the Fund. |
| |
| NB! > THIS FORM MUST BE SUBMITTED TO YOUR NEAREST DEPARTMENT OF LABOUR OFFICE. |
| > NO POST DATED FORMS WILL BE ACCEPTED OR PROCESSED. |
| IN THE EVENT OF YOU RESUMING EMPLOYMENT OR BACK TO YOUR NORMAL WORKING HOURSYOU ARE REQUIRED TO INFORM THE DEPARTMENT OF LABOUR OFFICES IMMEDIATELY AND TO REQUEST THE NEW/CURRENT EMPLOYER |
| TO SUBMIT A DECLARATION. |
| |

Date Received

Date Received:

UI6A

UNEMPLOYMENT INSURANCE ACT 63 OF 2001 DECLARATION TO CONFIRM UNEMPLOYMENT STATUS IN TERMS OF SECTION 17(4) READ WITH REGULATION 3

| ID NO/PASSPORT. |
|---|
| 1. Sumame: |
| |
| 2. Previous surname: (Only if it changed since your previous application) |
| |
| 3. First names: |
| |
| 4. Telephone number: (a) Cell Number (b) Landline Number |
| |
| IN THE EVENT OF A CHANGE OF ADDRESS INDICATE YOUR NEW DETAILS |
| 5. Postal address: |
| |
| 6. Residential address: (If different from postal address) Postal code |
| |
| 7. (a) If you have commenced work indicate date: |
| (b) Name of new employer: Contact number: (c) If the Reduced Work Time period has come to an end indicate the date // / |
| (c) If the Reduced Work Time period has come to an end indicate the date |
| CONFIRM YOUR BANKING DETAILS (This portion to be completed by applicant and is not necessary to be completed by Financial Institute) |
| Name of account holder |
| Name of Financial Institution |
| Branch code Account number |
| |
| > NB IF YOUR BANKING DETAILS HAVE CHANGED FORM UI-2.8 MUST BE COMPLETED AND SUBMITTED |
| I declare that : |
| • I am unemployed and have not been employed since I last completed a continuation form and that I have not received remuneration or payment |
| in kind for any work performed without notifying the Claims Officer. I am on Reduced Work Time |
| • I am aware of the fact that it is an offence to complete this continuation form while I am in employment/ not ou Reduced Work Time without |
| informing the Claims Officer that I have resumed work. I furthermore declare that the information given is true and correct. I am aware that it is an offence to willfully make a false statement. |
| с, , |
| |
| Signature of applicant Date |
| NB! > THIS FORM MUST BE SUBMITTED TO YOUR NEAREST DEPARTMENT OF LABOUR OFFICE. > NO POST DATED FORMS WILL BE ACCEPTED OR PROCESSED. |
| NO POST DATED FORMS WILL BE ACCEPTED OR PROCESSED. IN THE EVENT OF YOU RESUMING EMPLOYMENT OR BACK TO YOUR NORMAL WORKING HOURS YOU ARE REQUIRED |
| TO INFORM THE DEPARTMENT OF LABOUR OFFICES IMMEDIATELY AND TO REQUEST THE NEW/CURRENT EMPLOYER TO SUBMIT A DECLARATION (UI-19). |
| |
| |

| U1-19 | 26S 22.7 | 5286; | | | | | | J *** If non- Contributor state reason (Use codes at bottom of page) | | | | |] | | | | |
|---------------------------------------|---|--|---|--------------------------------------|--|---------------------------|------------------|---|-----|---|------------------|---|---|---|--|------------------------------|---|
| | information to be supplied in terms of Section 56(1&3) read with Regulation 13(1&2) An employer must by the seventh day of each month provide the Commissioner with all the information for the previous month regarding the employer's contact details or employees | 1580/81/82 or submit same at any branch of the UIF which is closest to the employer. The completed form can also be faxed to any of the following numbers: Pta (012) 39 5142/5286; Jhb (011) 497 3293; Dbn (031) 366 2156; Polokwane (015) 290 1670; Mmabatho (018) 384 2658; East Ldn (043) 701 3263; Blftn (051) 447 9353; CT (021) 441 8024; Wtb (013) 656 0233; PE (041) 586 1541; Gmn (011) 873 2219; George (044) 873 2568; Pmb (033) 394 5069. | | | | **[00 | | 1 Indicate whether contributor or non- contributor (YES OR NO) | | | | | orrect. I | | *** | | |
| Γ | ontact detail | of service. The employed must forward this form to the Onemproyneur fuscinance rund at (012) 327-194-3/ est to the employer. The completed form can also be faxed to any of the following numbers: Pta (012) 309 51/ 1670; Mmabatho (018) 384 2658; East Ldn (043) 701 3263; Blftn (051) 447 9353; CT (021) 441 8024; Wtb (044) 873 2568; Pmb (033) 394 5069. | | | | 1.11. Authorised person** | | H Reason for Termination (Use Codes as supplied at the bottom of the page) | | | | | declare that the above information is true and correct. | | DATE UATE Temporary employees (less that 24 hours per month) No income paid for the payroll period | | |
| | yer's c | numbe 3, CT | S) | | - | .11Au | | | 7 | | | - | tion is | | 1.24 hour 1.24 hour period | | |
| 503 | mplo | wing 7 935 | PAYE Reference No (If registered with SARS) | | | | | n Date | M Y | - | + | | 1 mat | | DALE UALES (US Reported for the payroll period No income paid for the payroll period | | - a |
| 23 5 | the er | follor 1) 44 | with | | | | | G Termination Date | W | + | H | + | info | | L vyees (li | | Business Closed Death of Domestle Employer Voluntary Severance Package Reduced Work Time |
| FAX: 0866 323 | ding | f the 1 (05) | ered | | - | | | Тсги | 9 | | | | bove | | emplo | | d sstie En erance c Time |
| 080 | regar | Blft | regist | | | | | | ٩ | | | | the a | | porary | | Business Closed Death of Domes Voluntary Sever Reduced Work |
| X | 2) Instruction | d to 2 263; | o (If 1 | 1 | Postal address Co. Reg.No (CIPRO No) | | | of | > | - | | - | that | | Tem No ii | | usines leath o olunta educed |
| FA | 3(1& us mo | faxee 01 3 | ce No | SS | IPRO | | | F Commencement date of Employment | > | - | \square | - | lare | | 2 2 | | 26> 2 |
| 4 | on 13 evior | 43) 7 | eren | ddre | o (C] | 1 | | F mencement d Employment | M N | | + | - | dec] | | 0 | | 14 15 16 17 |
| | ulati he pr | in als | E Ref | cal A | l add | le No | | Emtre | 9 | + | H | + | | | | | |
| 000 | Reg for t | st Lo | AYI | Physical Address | Postal address Co. Reg.No (C | Phon | | Ŭ | - | | | | 1 | | | ODES | ranch |
| UNEMPLOYMENT INSURANCE ACT 63 OF 2001 | to be supplied in terms of Section 56(1&3) read with Regulation 13(1&2) nonth provide the Commissioner with all the information for the previous mon | Terinuteration details including new appointances and reminiation of service. The employer must forward 1580/81/82 or submit same at any branch of the UJF which is closest to the employer. The completed for Jhb (011) 497 3293; Dbn (031) 366 2156; Polokwane (015) 290 1670; Mmabatho (018) 384 2658; Eas (013) 656 0233; PE (041) 586 1541; Gmn (011) 873 2219; George (044) 873 2568; Pmb (033) 394 5069. 1. EMPLOYER DETAILS | 1.2 1 | | 1.6 1 | 1.10 Phone No | | E* Total Hours Worked during Month | | | | |] | | st carry (filing) | REASON FOR TERMINATION CODES | Illness /Medically boarded Retrenched/Staff Reduction Transfer to another Branch Absconded |
| ACT | 6(1&3) 6(1&3) | The con The con 118) 384 1b (033) | | | | | | oss) m paid e Per | J | | | |] | | person mu | FOR TERN | Illness /Mer Retrenched Transfer fo Absconded |
| NCE / | Section 5 Section 5 oner with 8 | . the current smployer. tabatho ((2568; Pn | | | Address where employees listed in Item 2 work (if different to the address in 1.4) | | | D* Total (Gross) Remuneration paid to Employee Per Month | × | | | | (Name of Employer), ID No | | JOYEK SIGNATURE DAYER SIGNATURE If the employer is not resident in the RSA, or is a budy corporate not registered in the RSA, an authorised person must carry out the durities of the employer in terms of this Act. Remuneration means remuneration as specified by the Unemployment Insurance Contributions Act I paid Weeky, convert remuneration to monthly salary (veckly remuneration X 52/12) T carl Hours Worked (e. Actual hours worked during the month Employers may also submit these details electronically from payrolls or on the UIF's website at <u>www.lahour.cov.za</u> (Ufiling) Tet. no (012) 337 1680/1790 Can only be determined by CCMA: Bargaining Council or Labour Court Can only be determined by CCMA: Employers For Domestic Employers provide Surname and Initials | REASON | 11 12 13 |
| JRA | ns of nissic |); Mim () 873 | | | addre | I | | | Ч | | | | (er),] | | RSA, a RSA, a ttions Ac 2) 2) website me and | | : |
| NSI | Lerr Comi | 01 se est to 1670 1670 | | | o the | | | | | _ | | _ | lold | 4 | i in the ontribu X 52/12 VIF's VIF's | | Resigned Constructive Dismissal **** Insolvency/Liquidation Maternity/Adoption |
| I I | information to be supplied in ay of each month provide the C | auton s clos 290 eorge | | | rent t | Fax No | | (0) | | + | + | | fEn | nt. | DESCRIPTIONS rate not registered why remuneration ' shy remuneration' bayrolls or on the abour Court | | Resigned Constructive Dismis Insolvency/L/quidat Maternity/Adoption |
| EN | y er s uppli ovide | (015) 9;G | 2 | | diffe | | | C ID Number (13 Digit har-coded RSA ID No) | | | | | neo | eme | CRIP not reg nt finsu reanunc plfs or yvers p | | ned ructiv ency/l rnity/A |
| N | be su the pro- | F wh ame 3 221 | | | k (if | 1.9 | | mher led RS | | | $\left \right $ | - | - Sai | stat | DES loyme veckly ith a payr Labor | | Resigned Construc Insolvenc Maternif |
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| EM | nforr y of e | anch 2156 3mn | | | in It | | | £1) | | | | - | | mal | A, or is of this crifted mont wheed electr gens. F | | |
| 5 | in in da | iy bra 366 341;(LS | .0 | 1 | isted | | | | | + | $\left \right $ | + | | ce to | the RS. erms of as spo tion to ours wo details details A; Bau | | |
| _ | event | at ar 031) 86 1: TAI | ce N | ness | ces | | rs | | | | | | 1 | ffend | KIE entine cention cention aunera tunal ho tunal | | |
| | the so | same bbn (dbn (d1) 5 d1) 5 d1) 5 d1) 5 | feren | busi | Coldu | 1 | TAI | B Initials | | | | | | an o | V.I.U. tresid tresid tremur tremur ert ren ert ren lie. Ao 0/1700 0/1700 0/1700 0/1700 | | pired |
| | st by | ation details including new 82 or submit same at any b 1) 497 3293; Dbn (031) 360 6 0233; PE (041) 586 1541 EMPLOYER DETAILS | er Re | ne of | ere en | SS | EDE | Ini | | | | _ | | it is | CrNV of the of the nucans y, conv y also y also ble for de for etermine | | Deceased Retired Dismissed Confract Expired |
| | mus | or sul 7 32 33;P | ploy | g nar | s whe | addre | OYE | | | | | | | that | LK SJ duties cuation Weekt lours V ers ms curs ms (012) 3 | | Deceased Retired Dismissed Contract I |
| | mployer | Terinutization details including new appointations and terinitation 1580/81/82 or submit same at any branch of the UIF which is clos Jhb (011) 497 3293; Dbn (031) 366 2156; Polokwane (015) 290 (013) 656 0233; PE (041) 586 1541; Gmn (011) 873 2219; George 1. EMPLOYER DETAILS | 1.1 UIF Employer Reference No | O1.3 Trading name of business | Address | 1.8 E-mail address | EMPLOYEE DETAILS | A Surname | | | | | | understand that it is an offence to make a false statement. | E.M.PLOX E.K. SIGNATIUKE. DESCRIPTIONS If the employer is not resident in the RSA, or is a body corporate not registered in the RSA, an authoout the duries of the employer in terms of this Act. Remuneration means remuneration as specified by the Unemployment insuance Contributions Act if paid Weekly, convert remuneration to monthly salary (weekly remuneration X 52/12) Total Hours Worked et. Actual hours worked during the month Employers may also submit these details electronically from payrolls or on the ULF's website at <u>www</u> Tet. no (10.12) 3377 168017190 Only Applicable for Commercial Employers. For Domestic Employers provide Surname and Initials Can only be determined by XCM As. Bargaining Council or Labour Court | | 0 M 4 W |
| | Ane | Jhb (013 | 1.1 | 01.3 | 1.5 | 1.8 | 5 | Ø | | | | | | pun | E: E: E: | | |
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| (CONFIRM) | | Ö | | Office Stamp | |
|---|------------------------|----------------|--------|--------------|--|
| | | Date: | _ | | |
| | | | _ | | |
| Dear Sir/Madam | | | | | |
| UNEMPLOYMENT INSURANCE AC PAYMENTS TO DEPENDANTS/NOM DECEASED NAME: | INEE OF DECE | ASED CONT | RIBUTO | KS | |
| IDENTITY NUMBER: | | | | | |
| COMPANY NAME/REFERENCE: | | | | | |
| In order that the application for payment to may be considered, kindly and without de office. | | | | | |
| | | | | | |
| Details of his/her dependants (Name/Ad | dresses/Relations | hip and ID n | 0's) | | |
| Details of his/her dependants (Name/Ad Child/Children's details: | | - | | | |
| - | | - | | | |
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| Child/Children's details: | ee indicate percen | tage allocatio | | | |
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CLAIMS OFFICER