Contents

GOVERNMENT NOTICES • GOEWERMENTSKENNISGEWINGS

DEPARTMENT OF LABOUR

NO. R. 1131   02 SEPTEMBER 2019

DEPARTMENT OF EMPLOYMENTS AND LABOUR

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

CALL FOR COMMENTS ON THE AMENDMENTS TO THE REGULATIONS TO THE UNEMPLOYMENT INSURANCE ACT,2001

I, Thembelani Waltermade Nxesi, MP Minister of Employment and Labour, under Section 55 (1) of the Unemployment Insurance Act, 2001 (Act No 63 of 2001) intend to make amendments to the Regulations to the Unemployment Insurance Act, 2001 as set out in the Schedule.

Interested persons or organisations are hereby invited to submit written comments on the draft regulations within 14 calendar days from the date of publication. Comments shall be forwarded to :

(a) Post to:

The Department of Employment and Labour (UIF)

P O Box 1851

Pretoria

0001

(b) Hand Delivery to:

The Department of Employment and Labour (UIF)

Directorate: Legal Services

230 Lillian Ngoyi Street;

Pretoria

0001;

Any enquiries in connection with the Notice can be directed to M.C. Phathela at

Cornelius.phathela@labour.gov.za, Tel: 012 337 1775 / 1411 or Thembisile Mokoena at

Thembisile.Mokoena@labour.gov.za; Tel: 012 337 1441 / 1747

Comments received after the closing date may not be considered.

T. W. NXESI, MP

MINISTER OF EMPLOYMENT AND LABOUR

DATE: 26/08/2019

SCHEDULE

Definition

1.   In this Schedule "the Regulations" means the regulations published under 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, Government Notice No. R. 948 of 5 October 2009 and Government Notice No. R. 1434 of 28 December 2018.

Insertion of regulation 5A in the Regulations

2.   The following regulation is hereby inserted after regulation 5 of the Regulations:

"Application for parental benefits in terms of section 26B of the Act

5A. (1) An application for parental benefits in terms of section 26B of the Act must be made at an employment office and must be in the form of a complete UI 2.9.

(2)   An applicant for parental benefits, when making the application, must submit -

(a) an identity document;

(b) a full birth certificate of the child with full details of parents;

(c) a surrogate motherhood agreement in terms of the Children's Act, 2005 (Act No. 38 of 2005); or

(d) an interim court order placing the child in the care of the prospective adoptive parent pending the finalisation of an adoption order in respect of that child ;

(e) details of a valid bank account, in the form of UI 2.8; and

(f) remuneration received by the employee whilst still in employment, in the form of UI 2.7 "

Insertion of regulation 5B in the Regulations

3.   The following regulation is hereby inserted after regulation 5A of the Regulations:

"Application for commissioning parental benefit in terms of section 29B of the Act

5B (1) An application for commissioning parental benefits in terms of section 29B of the Act must be made at an employment office and must be in the form of a complete UI 2.9.

(2) An applicant for commissioning parental benefits, when making the application must submit -

(a) an identity document;

(b) a surrogate motherhood agreement in terms of the Children's Act, 2005 (Act No. 38 of 2005);

(c) details of a valid bank account in the form of UI 2.8;

(d) remuneration received by the employee whilst still in employment, in the form of UI 2.7; and

(e) birth certificate of the child with full details of parents."

Amendment of regulation 6 of the Regulations

4. Regulation 6 of the Regulations is hereby amended by the insertion of the following paragraph after paragraph (e) of sub-regulation (2):

"(f) interim court order placing the child in the care of the prospective adoptive parent pending the finalisation of an adoption order in respect of that child."."

Amended forms

5.   Forms 2.1; 2.2; 2.3; 2.4; 2.5; 2.6; 2.7; 2.8; 53 are hereby substituted for the evenly numbered forms in the Annexure.

New forms

6.   Forms 2.1P; 2.2P; 2.3P; 2.4P; 2.9P; 2.12P; 2.9; and 2.12

Short title

7.   These regulations are called the Unemployment Insurance Act Amendment Regulations, 2019.

UI-2.4P

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

Identity Document

1. Surname:

2. Previous surname: *(Only if it changed since you current applications)*

3. First names:

4. Contact 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. 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 refnnd the full amonnt to the Fund.

_____   _____
Signature of Applicant   Date

NB! ➢ THIS FORM MUST BE SUBMITTED TO YOUR NEAREST DEPARTMENT OF EMPLOYMENT AND LABOUR OFFICE.
     ➢ 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 EMPLOYMENT AND LABOUR IMMEDIATELY AND TO REQUEST THE NEW/CURRENT EMPLOYER TO SUBMIT A DECLARATION.

Date Received

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 Leave, Commissioning Parental leave, Parental leave or is on Reduced Working Time (RWT)

Full names of contributor: _____

Identity Document.														

Name of Employer: _____

Employers UIF Reference No. [ ][ ][ ][ ][ ][ ][ ] / [ ]

(A)   In terms of section 12(1)b, 19(1), 24(2), 26A(1), 27(3) and 29A(1) 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

Parental Leave		Commissioning Parental leave (SURROGACY)		Illness Leave		Maternity Leave		Adoption Leave		Reduced working time	

Periods during which different rates of remuneration were received while on leave/RWT (TO BE INDICATED IN CALANDER MONTHS)			Gross remuneration received whilst on leave/RWT (Per month)
From		To	
From		To	
From		To	
From		To	
From		To	
From		To	
From		To	
From		To	
From		To	

(B)   The contributor is expected to/has resume/d full working hours on _____/_____/_____.

SIGNATURE OF EMPLOYER OR AUTHORISED AGENT

DATE:_____/_____/_____

EMPLOYER STAMP
(if available)

UI-2.9P

UNEMPLOYMENT INSURANCE ACT 63 OF 2001 AS AMENDED
APPLICATION FOR PAYMENT OF PARENTAL BENEFITS
IN TERMS OF REGULATIONS 6(3)

Identity Document

---

1. Surname:

2. Previous surname: *(Only if it changed since submission of current claim)*

3. First names:

4. Contact 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: _____ _____   Employer Contact number: __

   (c) If the Reduced Work Time period has come to an end indicate the date   /   / _____

➢   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 submitted my applications/ 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 *(if applicable)*
- I am aware of the fact that it is an offence to complete this continuation form while I am in employment/ not on 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.

_____   _   _____ / ____ / _____
Signature of applicant   Date

NB!	➢	THIS FORM MUST BE SUBMITTED TO YOUR NEAREST DEPARTMENT OF EMPLOYMENT AND LABOUR OFFICE.
	➢	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 EMPLOYMENT AND LABOUR OFFICES IMMEDIATELY AND TO REQUEST THE NEW/CURRENT EMPLOYER TO SUBMIT A DECLARATION (UI-19).

Date Received:

UI-2.12P

UNEMPLOYMENT INSURANCE ACT 63 OF 2001AS AMENDED
APPLICATION FOR PAYMENT OF COMMISSIONING PARENTAL BENEFITS
IN TERMS OF REGULATION 6(3)

Identity document

1. Surname:

2. Previous surname: *(Only if it changed since you current applications)*

3. First names:

4. Contact 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. 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 refnnd the full amount to the Fund.

Signature of Applicant   Date

NB!   ➢   THIS FORM MUST BE SUBMITTED TO YOUR NEAREST DEPARTMENT OF EMPLOYMENT AND LABOUR OFFICE.
     ➢   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 EMPLOYMENT AND LABOUR IMMEDIATELY AND TO REQUEST THE NEW/CURRENT EMPLOYER TO SUBMIT A DECLARATION.

Date Received

labour

Department:
Labour
REPUBLIC OF SOUTH AFRICA

UI-53

UIF
WORKING FOR YOU

NOMINATION FORM FOR UIF DEPENDANTS BENEFITS (PLEASE NOTE THAT NO ALTERATIONS ARE ACCETED ON THIS FORM)

I _____, Identity Document
(Employee's full name & surname)

Currently employed at _____ UIF Ref Number _____, hereby nominate the below individual(s) indicated to have access to my UIF Dependants Benefits in the event of my death.

1. SPOUSE / LIFE PARTNER

Surname	Full Names	Relationship to employee	Date of Birth	Identity Document

2. CHILD/REN UNDER THE AGE OF 21 ORLEARNER OR DEPENDANT CHILD

Surname	Full Names	Date of Birth	Identity Document

3. NOMINATED BENEFICIARY OF YOUR CHOICE *(if more than 1 nominee, the percentage must be allocated per nominee)*

Surname	Full Names	Date of birth	Valid ID/Passport/Permit Number	Relationship to employee	Allocated percentage
Total Percentage					**100%**

I, _____ the undersigned understand that my circumstances and those of the persons shown above as dependents and/or nominees may change. In the event there is a change, I undertake to complete and re-submit the form UI-53 to my Employer for submission to the Department of Employment & Labour

Signed at: _____ on the _____

EMPLOYEE'S SIGNATURE

FULL NAME OF EMPLOYER REPRESENTATIVE   *EMPLOYERS SIGNATURE*   *DATE*
  • *PLEASE NOTE THAT NO ALTERATIONS ARE ACCEPTED ON THIS FORM*

UNEMPLOYMENT INSURANCE ACT 63 OF 2001 AS AMENDED
APPLICATION FOR UNEMPLOYMENT BENEFITS IN TERMS OF SECTION 17(1) – Read with Regulation 3(1) and 12(1) B

Identity Document

Date of Birth (dd/mm/yy)

Gender

Male		Female	

First Names

Surname

Postal Address

Code

Code /Telephone No.

Residential Address

Code

Cell No.

Occupation

E-Mail Address

Fax number

Education

SPECIAL SCHOOL CERT.		GRADE 8-9		GRADE 12	
BELOW GRADE 8		GRADE 10 - 11		ABOVE GRADE 12	

Details of previous application if Identity Document differs to current.

a) Name and ID No under which you applied:

FURTHER REQUIREMENTS (NOT MANDATORY TO REDUCED WORK TIME)			ONLY APPLICABLE TO REDUCED WORK TIME APPLICANTS			IMPORTANT: READ THIS SECTION BELOW:
1. Are you registered as a workseeker with a Labour Centre established by the DOL?	*Yes*	*No*	1. Are you currently employed?	Yes	No	I declare that I am / was unemployed/ I am working reduced hours from _____ (indicate date). In the event of my application being successful, the Claims Officer will authorise the payment of benefits.
			2. Are / Were you on Reduced Work Time?	Yes	No	
			3. Has your employer completed a UI-2.7?	Yes	No	I also undertake to inform the Claims Officer as soon as I am re-employed or receiving "full/normal pay" and understand that failure to do so will constitute fraud.
2. Are you capable and available for work?	Yes	No				
3. If you are not capable of and available for work, please explain:						In the event of an overpayment occurring as a result of any application I have submitted, I undertake that I will refund the full amount to the Fund.

I declare that the above information is true and correct. SIGNATURE OF APPLICANT	SIGNATURE OF OFFICIAL		DEPARTMENT OF EMPLOYMENT AND LABOUR OFFICE STAMP
		Claim approved from _____	
		Application refused in terms of _____	
		Claims Officer (please print) _____	
DATE: _____/_____/_____	DATE: _____/_____/_____	Signature _____	
		Date	

UI-2.8

UNEMPLOYMENT INSURANCE FUND

AUTHORISATION TO PAY BENEFITS INTO BANKING ACCOUNT

To be completed by the Financial Institution (Bank/Post Office)

NB: No alterations should be made on this form

Name of account holder _____ ,
(Full name and surname in block letters)

Identity Document

Name of Financial Institution   _____

Branch code   Account number

Indicate with an "X"

Savings account		**Current account**		**Transmission account**	

Dormant:		**Active**	

I declare that the abovementioned information is correct and complete in every aspect and that the Unemployment Insurance Commissioner will not be held liable for any incorrect payment which might arise due to incorrect/incomplete information supplied by me.

Name of bank / Post Office official _____

_____
Signature of Bank/ Post Office Official   Bank Stamp

Date: _____

To be completed by the Applicant

I, _____
(Full name and surname in block letters)

Identity Document

Hereby authorise the Unemployment Insurance Commissioner/Claims Officer to pay my benefits, if approved, into the abovementioned account held at the Financial Institution, unless otherwise instructed in writing.

I declare that the information as furnished by the abovementioned Financial Institution is to my knowledge accurate and complete. I indemnify the UIC of any liability in the event of payment being made into the provided banking account should this account be incorrect or incomplete.

_____   _____
Signature of applicant   Date

UI-2.1P

UNEMPLOYMENT INSURANCE ACT 63 OF 2001AS AMENDED (UI ACT 10 OF 2016)
APPLICATION FOR PAYMENT OF UNEMPLOYMENT BENEFITS
IN TERMS OF SECTION 17(4) READ WITH REGULATION 3

Identity Document

1. Surname:

2. Previous surname: *(Only if it changed since submission of current claim)*

3. First names:

4. Contact 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: _____   Employer Contact number: _____

   (c) If the Reduced Work Time period has come to an end indicate the date: _____ / _____ /

➢ 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 submitted my applications/ 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 (*if applicable*)
- I am aware of the fact that it is an offence to complete this continuation form while I am in employment/ not on 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.

_____   _____ / _____ /
Signature of applicant   Date

NB! ➢ THIS FORM MUST BE SUBMITTED TO YOUR NEAREST DEPARTMENT OF EMPLOYMENT AND LABOUR OFFICE.

   ➢ 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).

Date Received:

UNEMPLOYMENT INSURANCE ACT 63 OF 2001 AS AMENDED
APPLICATION FOR ILLNESS BENEFITS IN TERMS OF SECTION 22(1)

Identity Document

Date of Birth (dd/mm/yy)

Gender

Male		Female	

First Names

Surname

Postal Address

Code /Telephone No

Code

Residential Address

Cell No

Code

Occupation

E-Mail Address

Fax Number

Education

SPECIAL SCHOOL CERT.		**GRADE 8-9**		**GRADE 12**	
BELOW GRADE 8		**GRADE 10 - 11**		**ABOVE GRADE 12**	

Details of previous application if Identity Document differs to current

a)   Name and ID No under which you applied:

ARE YOU STILL EMPLOYED | **YES** | | **NO** |

NB: IF YOU ARE STILL EMPLOYED, FORM UI 2.7 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 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 as a result of any application I submitted, I undertake that I will refund the full amount to the Fund.

MEDICAL CERTIFICATE (To be completed by a registered medical practitioner)

I,   am a qualified   Qualifications

My Registration number is   I confirm that

is suffering from _____   (optional)

This patient was not capable of performing work from _____ / _____ / _____ to _____ / _____

Signature   Date

Medical Practice Stamp (if available)

Tel No. _____   Address

Where a Proxy was appointed by Doctor or Legal Representative proof must be attached.

FOR OFFICIAL USE ONLY:

I declare that the above information is true and correct. **SIGNATURE OF APPLICANT**	**SIGNATURE OF OFFICIAL**	Claim approved from: _____ Application refused in terms of: _____ Claims officer (Please Print): _____ Signature: _____	**Department of Employment and Labour** **Office Stamp**
Date: _____ / _____	Date: _____ / _____	Date: _____ / _____	

UI-2.2P

UNEMPLOYMENT INSURANCE ACT 63 OF 2001 AS AMENDED
APPLICATION FOR PAYMENT OF ILLNESS BENEFITS
ILLNESS BENEFITS IN TERMS OF SECTION 22

Identity Document

1. Surname:

2. Previous surname: *(Only if it changed since the submission of your current application*

3. First names:

4. Contact 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 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 for payment I undertake that I will refund the full amount to the Fund.

_____/____/_____

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 EMPLOYMENT AND 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 OFFICES IMMEDIATELY AND TO REQUEST THE NEW/CURRENT EMPLOYER TO SUBMIT A DECLARATION (UI-19).**

MEDICAL CERTIFICATE (To be completed by a registered medical practitioner.)

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

Medical Practice Stamp (if available)

UNEMPLOYMENT INSURANCE ACT 63 OF 2001 AS AMENDED
APPLICATION FOR MATERNITY BENEFITS IN TERMS OF SECTION 25(1)

Identity Document

Date of Birth (dd/mm/yy)

First Names

Surname

Postal Address

Code /Telephone No

Code

Residential Address

Cell No

Code

Occupation

E-Mail Address

Fax Number

Education

SPECIAL SCHOOL CERT.	GRADE 8-9	GRADE 12
BELOW GRADE 8	GRADE 10 - 11	ABOVE GRADE 12

Details of previous application if Identity Document differs to current.

a) *Name and ID No under which you applied:*

ARE YOU STILL EMPLOYED   [*YES*]   [*NO*]

NB: IF YOU ARE STILL EMPLOYED, FORM UI-2.7 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 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 any application I submitted, I undertake that I will refund the full amount of the Fund.

MEDICAL CERTIFICATE (to be completed by a registered medical practitioner or midwife)

I,   am a qualified   Qualifications

My registration number is   I confirm that   is under my treatment

and is pregnant. The expected due date of birth is

OR

I confirm that _____   gave birth / stillborn / miscarriage on

Signature _____   Date

Tel No. _____

Address _____

Medical Practice Stamp
(If available)

FOR OFFICIAL USE ONLY:

I declare that the above information is true and correct. **SIGNATURE OF APPLICANT**	SIGNATURE OF OFFICIAL	Claim approved from: _____ Application refused in terms of: _____ Claims officer (Please Print): _____ Signature: _____ Date: ____/____/____	Department of Employment and Labour Office Stamp
Date: ____/____/____	Date: ____/____/____		

UI-2.3P

UNEMPLOYMENT INSURANCE ACT 63 OF 2001AS AMENDED
APPLICATION FOR PAYMENT OF MATERNITY BENEFITS
IN TERMS OF SECTION 26

Identity Document

1. Surname:

2. Previous surname: *(Only if it changed since the submission of your current application)*

3. First names:

4. Contact 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 returned to work:* _____/_____/

8. **DECLARATION:**

I declare, except as stated in item 7, that I have not worked since the date of my application for maternity 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 for payment I undertake that I will refund the full amount to the Fund.

_____/_____/_____
Signature of applicant   Date

NB: IF YOUR BANKING DETAILS HAVE CHANGED, FORM UI-2.8 MUST BE COMPLETED

NB!   ➢   THIS FORM MUST BE SUBMITTED TO YOUR NEAREST DEPARTMENT OF EMPLOYMENT AND 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
          OFFICES IMMEDIATELY AND TO REQUEST THE NEW/CURRENT EMPLOYER TO SUBMIT A DECLARATION (UI-19).

Date Received

UNEMPLOYMENT INSURANCE ACT 63 OF 2001 AS AMENDED
APPLICATION FOR ADOPTION BENEFITS IN TERMS OF SECTION 26A (1), 27(3) and 29A(1) Read with Regulation 6(1)

Identity document

Identity document of child

Date of Birth (dd/mm/yy)

Gender

Male ☐ Female ☐

First name

Surname

Postal Address

Code

Code /Telephone No

Residential Address

Code

Cell No

Occupation

E-Mail Address

Fax Number

Education

| *SPECIAL SCHOOL CERT.* | GRADE 8-9 | GRADE 12 |
| BELOW GRADE 8 | GRADE 10 - 11 | ABOVE GRADE 12 |

Details of previous application if Identity Document differs from current
a)   *Name and Identity number under which you applied:*

ARE YOU STILL EMPLOYED   *YES*   *NO*

NB: IF YOU ARE STILL EMPLOYED, FORM UI 2.7 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 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 as a result of any application I submitted, I undertake that I will refund the full amount to the Fund.

FOR OFFICIAL USE ONLY:

| I declare that the above information is true and correct.

SIGNATURE OF APPLICANT

Date:_____/_____:_____ | **SIGNATURE OF OFFICIAL**

Date:_____/_____/_____ | Claim approved from:

Application refused in terms of:

Claims officer (Please Print):

Signature:

Date:_____/_____/_____ | Department of Employment and Labour
Office Stamp |

UNEMPLOYMENT INSURANCE ACT 63 OF 2001 AS AMENDED
APPLICATION FOR DEPENDANT'S BENEFITS BY SURVIVING SPOUSE OR LIFE PARTNER IN TERMS OF SECTION 30 Read with Regulation 7(1)

A. PARTICULARS OF DECEASED CONTRIBUTOR:

Identity Document

Date of Birth (dd/mm/yy)

Gender

| Male | Female |

First Names

Surname

Date of Death

Last Residential Address

Code

Details of previous application if Identity Document differs to current

a) Name and ID/ passport No under which deceased applied:

B. PARTICULARS OF SURVIVING SPOUSE OR LIFE PARTNER

Identity Document

Date of Birth (dd/mm/yy)

Gender

| Male | Female |

First Names

Surname

Postal Address

Code

Tel No

Residential Address

Code

Cell No

E-Mail Address

I declare that I am one of _____ surviving spouses or the only surviving spouse or life partner of the abovementioned deceased contributor, that I was not divorced from him/her and that information given in this document is true and correct.

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.

I understand that it is an offence to make a false statement.

FOR OFFICIAL USE ONLY:

I declare that the above information is true and correct. SIGNATURE OF APPLICANT	SIGNATURE OF OFFICIAL	Claim approved from: _____ Application refused in terms of: _____ Claims officer (Please Print): _____ Signature: _____	Department of Employment and Labour Office Stamp
Date: _____/_____/_____	Date: _____/_____/_____	Date: _____/_____/_____	

UNEMPLOYMENT INSURANCE ACT 63 OF 2001 AS AMENDED
APPLICATION FOR DEPENDANT'S BENEFITS BY A GUARDIAN / DEPENDANT CHILD OR NOMINATED BENEFICIARY IN TERMS OF SECTION 30 READ WITH REGULATION 7(1) AND 7(2)

A.   PARTICULARS OF DECEASED CONTRIBUTOR:

Identity Document   Date of Birth (dd/mm/yy)   Gender

Male   Female

First Names   Surname   Date of Death

Last Residential Address   Code

Details of previous application if Identity Document differs from current

a)   Name and Identity Document under which deceased applied:

B.   PARTICULARS OF APPLICANT:

Guardian of a minor child   Dependant child   Nominated beneficiary

Identity Document   Date of Birth (dd/mm/yy)   Gender

Male   Female

First Names   Surname

Postal Address   Code   Tel No

Residential Address   Code   Cell No

C. CHILD'S DETAILS:
First Names   Surname

Residential Address   Code

D.   CHILD'S DETAILS:
First Names   Surname

Residential Address   Code

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.

I understand that it is an offence to make a false statement.

FOR OFFICIAL USE ONLY:

| I declare that the above information is true and correct.

SIGNATURE OF APPLICANT

Date: _____ / _____ / _____ | **SIGNATURE OF OFFICIAL**

Date: _____ / _____ / _____ | Claim approved from:

Application refused in terms of:

Claims officer (Please Print):

Signature:

Date: _____ / _____ / _____ | **Department of Employment and Labour Office Stamp** |

UNEMPLOYMENT INSURANCE ACT 63 OF 2001 AS AMENDED
APPLICATION FOR PARENTAL BENEFITS IN TERMS OF SECTION 26A (1), 27(3) and 29A (1) Read with Regulation 6(1)

PLEASE SELECT THE TYPE OF BENEFITS YOU WISH TO APPLY FOR:

Parental		Adoption		Commissioning Parental	

Identity Document

Identity Document of child

Date of Birth *(dd/mm/yy)*

Gender

Male		Female	

First name

Surname

Postal Address

Code

Code /Telephone No

Residential Address

Code

Cell No

Occupation

E-Mail Address

Fax Number

Education

SPECIAL SCHOOL CERT.	GRADE 8-9	GRADE 12
BELOW GRADE 8	GRADE 10 - 11	ABOVE GRADE 12

Details of previous application if Identity Document differs from current

a) *Name and Identity Document under which you applied:*

ARE YOU STILL EMPLOYED

YES		NO	

NB: IF YOU ARE STILL EMPLOYED. FORM UI 2.7 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 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 as a result of any application I submitted, I undertake that I will refund the full amount to the Fund.

FOR OFFICIAL USE ONLY:

I declare that the above information is true and correct. **SIGNATURE OF APPLICANT** Date:_____ /_____ /_____	SIGNATURE OF OFFICIAL Date:_____ /_____ /_____	Claim approved from: Application refused in terms of: Claims officer (Please Print): Signature: Date:_____ /_____ /_____	Department of Employment and Labour Office Stamp

UNEMPLOYMENT INSURANCE ACT 63 OF 2001 AS AMENDED
APPLICATION FOR COMISSIONING PARENTAL BENEFITS IN TERMS OF SECTION 26A (1), 27(3) and 29A (1) Read with Regulation 6(1)

Identity Number

Identity document of child

Date of Birth (dd/mm/yy)

Gender
Male   Female

First name

Surname

Postal Address

Code

Code /Telephone No

Residential Address

Code

Cell No

Occupation

E-Mail Address

Fax Number

Education

| SPECIAL SCHOOL CERT. | GRADE 8-9 | GRADE 12 | |
| BELOW GRADE 8 | GRADE 10 - 11 | ABOVE GRADE 12 | |

Details of previous application Identity document differs from current

a) Name and Identity document under which you applied:

ARE YOU STILL EMPLOYED   YES   NO

NB: IF YOU ARE STILL EMPLOYED, FORM UI 2.7 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 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 as a result of any application I submitted, I undertake that I will refund the full amount to the Fund.

FOR OFFICIAL USE ONLY:

| I declare that the above information is true and correct.
SIGNATURE OF APPLICANT

Date: _____ / _____ / _____ | SIGNATURE OF OFFICIAL

Date: _____ / _____ / _____ | Claim approved from: _____
Application refused in terms of: _____
Claims officer (Please Print): _____
Signature: _____
Date: _____ / _____ / _____ | Department of Employment and Labour
Office Stamp |

UNEMPLOYMENT INSURANCE ACT 63 OF 2001

UI-19

Employers Declaration of Employees for the month of

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 inform the Commissioner with all the information during the previous month regarding the employer's contact details or employees remuneration details including new appointments and termination of service. The employer must forward this form to the **Unemployment Insurance Fund** at (012) 337-1943/44 or 337-1580/81/82 **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) 309 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) 506 5142;Gmn (011) 873 2219;George (044) 873 2568; Pmb (033) 394 5069.** Or mail to: uif.declarations@labour.gov.za

1. EMPLOYER DETAILS

1.1 UIF Employer Reference No   Branch No   1.2 PAYE Reference No (If registered with SARS)

1.3 Trading name of business _____   1.4 Physical Address _____

1.5 Address where employees listed in Item 2 work (if different to the address in 1.4)   1.6 Postal address _____

1.7 Co. Reg.No (CIPRO No)

1.8 E-mail address _____   1.9 Fax No _____   1.10 Phone No _____   1.11Authorised person** _____

2. EMPLOYEE DETAILS

A Surname	B Initials	C Identity Document Number	D* Total (Gross) Remuneration paid to Employee Per Month		E* Total Hours Worked during Month	F Commencement date of Employment						G Termination Date						H Reason for Termination (Use Termination Codes as supplied at the bottom of the page)	I Indicate whether contributor or non-contributor (YES OR NO)	J*** If non-Contributor state reason (Use codes at bottom of page)
			R	c		D	D	M	M	Y	Y	D	D	M	M	Y	Y			

I, _____ (Name of Employer), ID No _____ , declare that the above information is true and correct. I understand that it is an offence to make a false statement.

EMPLOYER SIGNATURE   **DATE**

	DESCRIPTIONS	Code	(J) Reason for Non-Contribution ***	
**	If the employer is not resident in the RSA, or is a body corporate not registered in the RSA, an authorised person must carry out the duties of the employer in terms of this Act.	1	Temporary employees (less than 24 hours per month	Employer Stamp (if available)
		2	Employees who earn commission only	
D*	Remuneration means actual basic salary plus payment in kind (Declare actual gross salary)	3	No income paid for the payroll period	
	If paid Weekly, convert wages to monthly salary (weekly wages X 52/12)			
E*	Total Hours Worked ie. Actual hours worked during the month			
	Employers may also submit these details electronically from payrolls or on the UIF's website at www.labour.gov.za			
*	Only Applicable for Commercial employers, Domestic employers – provide Surname and initials			
****	Constructive dismissal can only be determent by the CCMA : Bargaining-Council or Labour Court			

REASON FOR TERMINATION CODES

2	Deceased	6	Resigned	10	Illness /Medically boarded	14	Business Closed	18	Commissioning Parental
3	Retired	7	Constructive Dismissal****	11	Retrenched/Staff Reduction	15	Death of Domestic Employer	19	Parental Leave
4	Dismissed	8	Insolvency/Liquidation	12	Transfer to another Branch	16	Voluntary Severance Package		
5	Contract Expired	9	Maternity/Adoption	13	Absconded	17	Reduced Work Time		

STAATSKOERANT, 2 SEPTEMBER 2019

No. 42678 25