



National Diploma Animal Farm Staff Management

Handout 2 UIF Forms

Emerging Farmers: Module 3: Staff Management	LEARNER MANUAL
UIF RELATED FORMS	

UIF RELATED Forms

Forms used by the Employer

On registration

Form UI-8 - Application for registration as an employer with the UIF

Form UI7 - UIF Payment Advice

Form UI.19 - UIF - Information of employee

Form UI 2.7 - Remuneration Received By The Employee Whilst Still In Employment

Form UI.8D - Application for Registration as an employer of Domestic Workers with the UIF

Form UI-19 - WVF inligting ten opsigte van werknemer

Form UI-19D - Information of employee (Domestic Workers)

Forms used by the Employee:

Claims

Form UI-2.2 - Application for illness benefits

Form UI-2.3 - Application for maternity benefits

Form UI.2.4 - Application for adoption benefits

Form UI-2.5 - Application for dependant's benefits by surviving spouse or life partner

Form UI-2.6 - Application for dependant's benefits by child, children of deceased

Form UI-2.8 - Application to pay UIF benefits into banking account

Form UI-3 - Application for continuation of payment for illness benefits

Form UI-4 - Application for continuation of payment for maternity benefits

Form UI-5 - Application for continuation of payment for adoption benefits

The above can be obtained from the website of the Department of Labour / or at the offices of the Department of Labour.



labour

Department: Labour REPUBLIC OF SOUTH AFRICA

Unemployment Insurance Fund • Werkloosheidsversekeringsfonds

Church Street 94 Kerkstraat, Pretoria. Postal Address/ Posadres: UIF/WVF, Pretoria, 0052. Enquiries/Navrae: (012) 337-1680 Fax/Faks No. (1) UI-7 returns and Proof of Payment/UI-7 opgawes en Bewys van Betaling: (012) 337-1932/1804/1929 (2) Postage Payments Only/Posgeld Betalings Alleenlik: 0866366981 Web: www.labour.gov.za uFiling: www.ufiling.gov.za Enquiries/Navrae: 0860345464 or e-mail/e-pos: support@ufiling.co.za

Code [] Kode []

UIF Reference [] WVF Verwysing []

UNEMPLOYMENT INSURANCE CONTRIBUTIONS ACT, 2002

RETURN ONLY FOR OPGAWE SLEGS VIR

[]

PAYABLE ON OR BEFORE BETAALBAAR VOOR OF OP

[]

PAYMENT OF CONTRIBUTIONS TO THE UNEMPLOYMENT INSURANCE COMMISSIONER IN TERMS OF SECTION 9(1) OF THE ACT

BETALING VAN BYDRAES AAN DIE WERKLOOSHEIDVERSEKERINGSKOMMISSARIS INGEVOLGE ARTIKEL 9(1) VAN DIE WET

Table with 5 main columns (A.1, A.2, B, C, D, E) and sub-columns for R and c. Includes instructions for contributions payable and total payable.

Payment of contributions can be done as follows:

Betaling van bydraes kan soos volg gedoen word:

Direct Deposit/Electronic Transfer via any of the following Banks:

Direkte Deposito/Elektroniese Oordrag via enige van die volgende Banke:

Table with bank details for ABSA, FNB, NEDBANK, and STANDARD.

IMPORTANT – NEW INFORMATION BELOW

BELANGRIK – NUWE INLIGTING HIERONDER

In order to improve service delivery, a new secure on-line facility for submitting employee declarations and paying of contributions has been introduced.

Ten einde dienslewering te verbeter, is 'n nuwe veilige aanlyn fasiliteit geskep vir die verklaring van werknemer inligting en die betaling van bydraes.

ALL EMPLOYERS

- 1. Employers must at all times quote the UI reference number when payments are made or when communicating with this office. 2. The Act only allows for the payment of contributions on a monthly basis... 3. It is the duty of employers to calculate the amount due to the Fund... 4. Postage is payable on all envelopes mailed to this office.

ALLE WERKGEWERS

- 1. Werkgevers moet te alle tye die WV verwysingsnommer meld wanneer betalings gemaak word of wanneer daar met hierdie kantoor gekommunikeer word. 2. Die Wet maak slegs voorsiening vir die betaling van bydraes op 'n maandelikse basis... 3. Dit is werkgevers se plig om die bedrag wat aan die Fonds verskuldig is te bereken... 4. Posgeld is betaalbaar op alle koeverte wat aan hierdie kantoor gepos word.

BUSINESSES ONLY

- 1. Employers who are NOT required to pay UIF contributions to SARS with effect from April 2002, must complete the UI-7 form and forward their payments to the Fund. 2. If you are receiving an EMP201 from SARS, it means that you are required to submit your UIF contributions to SARS for periods from April 2002 onwards... 3. It is the duty of employers to calculate the amount due to the Fund... 4. Postage is payable on all envelopes mailed to this office.

BESIGHEDE ALLEENLIK

- 1. Werkgevers wat NIE verplig is om WVF bydraes vanaf April 2002 aan SAID te betaal nie, moet die UI-7 vorm voltooi en hul betalings aan die Fonds stuur. 2. Indien u 'n EMP201 vanaf SAID ontvang, beteken dit dat u verplig is om WVF bydraes vir tydperke vanaf April 2002 aan SAID te betaal... 3. Dit is werkgevers se plig om die bedrag wat aan die Fonds verskuldig is te bereken... 4. Posgeld is betaalbaar op alle koeverte wat aan hierdie kantoor gepos word.

I certify that all particulars furnished herein are true and correct.

Ek sertifiseer dat alle besonderhede hierin verstrekkend waar en juis is.

DATE / DATUM

SIGNATURE OF EMPLOYER / HANDEKENING VAN WERKGEWER

**UNEMPLOYMENT INSURANCE ACT 63 OF 2001
APPLICATION FOR ILLNESS 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/yy)

Gender Male 5 Female 0

First Names **Surname**

Postal Address **Code**

Code/Telephone No

Residential Address **Code**

Cell No

Occupation **Occ. Code**

E-Mail Address **Fax Number**

Method of Payment

Use the UI-2.8 form for Banking Details

CHEQUE **BANK TRANSFER** **OTHER**

PAYPOINT

Details of previous application

a) Name and ID No under which you applied:

b) Date of Application:

c) Office of application:

ARE YOU STILL EMPLOYED YES NO

NB: IF YOU ARE STILL EMPLOYED, FORM UI 2.7 MUST ALSO BE COMPLETED.

DATE OF COMMENCEMENT OF SICK LEAVE:

IF YOU HAVE RETURNED TO WORK, STATE DATE:

IMPORTANT: READ THIS SECTION BELOW:

If your application is successful the claims officer will authorise the payment of benefits. You must inform the claims officer as soon as you resume work. I declare that the above information is true and correct. I understand that it is an offence to make a false statement.

SOURCES OF OTHER INCOME (mark X were applicable)	
1. Monthly Pension from State (Excluding Disability grant)	<input type="checkbox"/>
2. Benefit from Compensation Fund for temporary or total disablement	<input type="checkbox"/>
3. Benefits from an Unemployment Fund established by a bargaining or statutory council	<input type="checkbox"/>
4. None	<input type="checkbox"/>

If applicable mark X on 1-4:

When did you begin to receive this income?

Do you continue to receive this income?

If you no longer receive this income when did it come to an end?

MEDICAL CERTIFICATE (To be completed by an authorised practitioner in terms of section 20(1)(c) of the UI Act 63 of 2001.

I, am a qualified .

Qualifications . My practice number is .

I confirm that has been under my treatment from to and is suffering from .

This patient was not capable of performing work from to .

If the nature of the illness is described in this medical certificate in uncertain terms or as "disease - entity" or "symptom complex", please furnish a clinical report describing the symptoms and nature of the complaint.

Signature **Date** **Tel No.**

Address

SIGNATURE OF APPLICANT: **DATE:**

DOCUMENTS/INFORMATION SUBMITTED		Signature of Official	Claim approved from: <input type="text"/>	Application refused in terms of: <input type="text"/>	Claims officer (Please Print): <input type="text"/>	Signature: <input type="text"/>	Date: <input type="text"/>	OFFICE STAMP
1. UI-19 (If Applicable) <input type="checkbox"/>	8. Telephonic Verification Contact Person <input type="checkbox"/>	REMUNERATION/SALARY						
2. Certified Copy of ID <input type="checkbox"/>			<i>Gross pay (before deductions)</i>	<i>Payment frequency (PW or PM)</i>				
3. Payslips <input type="checkbox"/>								
4. Proof of banking details - UI-2.8 <input type="checkbox"/>								
5. UI-2.7 (If Applicable) <input type="checkbox"/>	Designation: <input type="text"/>							
6. SARS Number: <input type="text"/>	Tel. No.: <input type="text"/>							
7. Other (Specify) <input type="text"/>								

**UNEMPLOYMENT INSURANCE ACT 63 OF 2001
APPLICATION FOR MATERNITY BENEFITS IN TERMS OF SECTION 25(1) - Read with Regulation 5(1) and 5(4)**

13 Digit Bar-Coded Identity Document/Passport Number

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Date of Birth (dd/mm/yy)

--	--	--

Gender

Female	0
--------	---

First Names

--

Surname

--

Postal Address

--

Code

--

Code /Telephone No

--

Residential Address

--

Code

--

Cell No

--

Occupation

--

Occ. Code

--

E-Mail Address

--

Fax Number

--

Method of Payment

--

Use the UI-2.8 form for Banking Details

CHEQUE

--

BANK TRANSFER

--

OTHER

--

PAYPOINT

--

Details of previous application
a) Name and ID No under which you applied:

--

b) Date of Application: ___/___/___

c) Office of application:

ARE YOU STILL EMPLOYED YES NO

NB: IF YOU ARE STILL EMPLOYED, FORM UI-2.7 MUST ALSO BE COMPLETED.

DATE OF COMMENCEMENT OF MATERNITY LEAVE: ___/___/___

IF YOU HAVE RETURNED TO WORK, STATE DATE: ___/___/___

IMPORTANT: READ THIS SECTION BELOW:

If your application is successful the claims officer will authorise the payment of benefits. You must also inform the claims officer as soon as you resume employment I declare that the above information is true and correct. I understand that it is an offence to make a false statement.

SOURCES OF OTHER INCOME (mark X were applicable)	
1.	Monthly Pension from State (Excluding Disability grant)
2.	Benefit from Compensation Fund for temporary or total disablement
3.	Benefits from an Unemployment Fund established by a bargaining or statutory council
4.	NONE
<i>If applicable mark X on 1-4:</i>	
<i>When did you begin to receive this income? _____</i>	
<i>Do you continue to receive this income? _____</i>	
<i>If you no longer receive this income when did it come to an end? _____</i>	

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

I, _____ am a qualified _____.

Qualifications _____. My practice 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 on _____. \ The baby was stillborn on _____ \ the patient had a miscarriage on _____.

Signature _____ **Date** _____ **Tel No.** _____

Address _____

SIGNATURE OF APPLICANT: _____ **DATE:** _____

FOR OFFICIAL USE ONLY

DOCUMENTS/INFORMATION SUBMITTED	
1. UI-19 (If Applicable)	<input type="checkbox"/>
2. Certified Copy of ID	<input type="checkbox"/>
3. Payslips	<input type="checkbox"/>
4. Proof of banking details - UI-2.8	<input type="checkbox"/>
5. UI-2.7 (If Applicable)	<input type="checkbox"/>
6. SARS Number: _____	Designation: _____
7. Other (Specify) _____	Tel. No.: _____

Signature of Official	
REMUNERATION/SALARY	
Gross pay <i>(before deductions)</i>	Payment Frequency <i>(PW or PM)</i>

Claim approved from: _____

Application refused in terms of: _____

Claims officer (Please Print): _____

Signature: _____

Date: _____

OFFICE STAMP

**UNEMPLOYMENT INSURANCE ACT 63 OF 2001
APPLICATION FOR ADOPTION BENEFITS IN TERMS OF SECTION 28(1)
Read with Regulation 6(1)**

13 Digit Bar-Coded Identity Document/Passport Number <input type="text"/>	Id no of adopted child <input type="text"/>	Date of Birth (dd/mm/yy) <input type="text"/>	Gender Male <input type="checkbox"/> 5 Female <input type="checkbox"/> 0
First Names <input type="text"/>		Surname <input type="text"/>	
Postal Address <input type="text"/>		Code <input type="text"/>	Code /Telephone No <input type="text"/>
Residential Address <input type="text"/>		Code <input type="text"/>	Cell No <input type="text"/>
Occupation <input type="text"/>	Occ. Code <input type="text"/>	E-Mail Address <input type="text"/>	Fax Number <input type="text"/>
Method of Payment <i>Use the UI-2.8 form for Banking Details</i>			
CHEQUE <input type="checkbox"/>	BANK TRANSFER <input type="checkbox"/>	OTHER <input type="checkbox"/>	PAYPOINT
Details of previous application a) <i>Name and ID No under which you applied:</i> <input type="text"/>		b) <i>Date of Application:</i> ___/___/___	c) <i>Office of application:</i> <input type="text"/>

ARE YOU STILL EMPLOYED	<input type="checkbox"/> YES	<input type="checkbox"/> NO
NB: IF YOU ARE STILL EMPLOYED, FORM UI-2.7 MUST ALSO BE COMPLETED		
DATE OF COMMENCEMENT OF ADOPTION LEAVE: ___/___/___		
IF YOU HAVE RETURNED TO WORK, STATE DATE: ___/___/___		
IMPORTANT: READ THIS SECTION BELOW		
If your application is successful then the claims officer will authorise the payment of benefits. You must also inform the claims officer as soon as you resume work. I declare the above information is true and correct. I understand that it is an offence to make a false statement.		
SIGNATURE OF APPLICANT: _____		DATE: _____

SOURCES OF OTHER INCOME (mark X were applicable)	
1. Monthly Pension from State (Excluding Disability grant)	<input type="checkbox"/>
2. Benefit from Compensation Fund for temporary or total disablement	<input type="checkbox"/>
3. Benefits from an Unemployment Fund established by a bargaining or statutory council	<input type="checkbox"/>
4. NONE	<input type="checkbox"/>
<i>If applicable mark X on 1-4:</i>	
When did you begin to receive this income? _____	
Do you continue to receive this income? _____	
If you no longer receive this income when did it come to an end? _____	

FOR OFFICIAL USE ONLY

DOCUMENTS/INFORMATION SUBMITTED	Signature of Official	Claim approved from: _____	OFFICE STAMP
1. UI-19 (If Applicable) <input type="checkbox"/>	8. Copy of Adoption Order <input type="checkbox"/>	Application refused in terms of: _____	
2. Certified Copy of ID <input type="checkbox"/>	9. SARS Number: _____	Claims officer (Please Print): _____	
3. Payslips <input type="checkbox"/>	10. Other (Specify) _____	Signature: _____	
4. Affidavit – Period Spent caring for child <input type="checkbox"/>	11. Telephonic Verification <input type="checkbox"/>	Date: _____	
5. Proof of banking details - UI-2.8 <input type="checkbox"/>	Contact Person _____		
6. UI-2.7 (If applicable) <input type="checkbox"/>	Designation: _____		
7. Birth certificate of Child <input type="checkbox"/>	Tel. No.: _____		
REMUNERATION/SALARY			
Gross pay (before deductions) Payment Frequency (PW or PM)			
<input type="text"/>			

UNEMPLOYMENT INSURANCE ACT 63 OF 2001
APPLICATION FOR DEPENDANT'S BENEFITS BY SURVIVING SPOUSE OR LIFE PARTNER IN TERMS OF SECTION 31(1) Read with Regulation 7(1)

A. PARTICULARS OF DECEASED CONTRIBUTOR:

13 Digit Bar-Coded Identity Document/Passport Number <input style="width:100%; height:15px;" type="text"/>	Date of Birth (dd/mm/yy) <input style="width:100%; height:15px;" type="text"/>	Gender <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; text-align:center;">Male</td> <td style="width:5%; text-align:center;">5</td> <td style="width:50%; text-align:center;">Female</td> <td style="width:5%; text-align:center;">0</td> </tr> </table>	Male	5	Female	0	Date of Death <input style="width:100%; height:15px;" type="text"/>
Male	5	Female	0				
First Names <input style="width:100%; height:15px;" type="text"/>	Surname <input style="width:100%; height:15px;" type="text"/>						
Last Residential Address <input style="width:100%; height:15px;" type="text"/>		Code <input style="width:100%; height:15px;" type="text"/>					
Details of previous application							
a) <i>Name and ID No under which deceased applied:</i> <input style="width:100%; height:15px;" type="text"/>		b) <i>Date of Application:</i> ____/____/____ <input style="width:100%; height:15px;" type="text"/>	c) <i>Office of application:</i> <input style="width:100%; height:15px;" type="text"/>				

B. PARTICULARS OF SURVIVING SPOUSE OR LIFE PARTNER: (NOTE: In the case of a surviving spouse if there is not a marriage certificate recognised as valid in terms of any law relating to marriage in force in the Republic of South Africa, supplementary documents required by the Department regarding the circumstances of the matter should be attached)

13 Digit Bar-Coded Identity Document/Passport Number <input style="width:100%; height:15px;" type="text"/>	Date of Birth (dd/mm/yy) <input style="width:100%; height:15px;" type="text"/>	Gender <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; text-align:center;">Male</td> <td style="width:5%; text-align:center;">5</td> <td style="width:50%; text-align:center;">Female</td> <td style="width:5%; text-align:center;">0</td> </tr> </table>	Male	5	Female	0	Tel No <input style="width:100%; height:15px;" type="text"/>
Male	5	Female	0				
First Names <input style="width:100%; height:15px;" type="text"/>	Surname <input style="width:100%; height:15px;" type="text"/>						
Postal Address <input style="width:100%; height:15px;" type="text"/>		Code <input style="width:100%; height:15px;" type="text"/>	Cell No <input style="width:100%; height:15px;" type="text"/>				
Residential Address <input style="width:100%; height:15px;" type="text"/>		Code <input style="width:100%; height:15px;" type="text"/>					
Occupation <input style="width:100%; height:15px;" type="text"/>	Occ. Code <input style="width:100%; height:15px;" type="text"/>	E-Mail Address <input style="width:100%; height:15px;" type="text"/>					
Method of Payment							
<i>Use the UI-2.8 form for Banking Details</i>							
CHEQUE <input style="width:100%; height:15px;" type="text"/>	BANK TRANSFER <input style="width:100%; height:15px;" type="text"/>	OTHER <input style="width:100%; height:15px;" type="text"/>	PAYPOINT <input style="width:100%; height:15px;" type="text"/>				

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

SIGNATURE OF SURVIVING SPOUSE OR LIFE PARTNER: _____ **DATE:** ____/____/____

FOR OFFICIAL USE ONLY

DOCUMENTS/INFORMATION SUBMITTED	Signature of Official	Claim approved from: _____	OFFICE STAMP								
1. UI-19 (If Applicable) <input type="checkbox"/>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th colspan="2" style="text-align:center;">REMUNERATION/SALARY</th> </tr> <tr> <td style="width:50%; text-align:center;"><i>Gross pay (before deductions)</i></td> <td style="width:50%; text-align:center;"><i>Payment Frequency (PW or PM)</i></td> </tr> <tr> <td style="height:20px;"></td> <td></td> </tr> <tr> <td style="height:20px;"></td> <td></td> </tr> </table>	REMUNERATION/SALARY		<i>Gross pay (before deductions)</i>	<i>Payment Frequency (PW or PM)</i>					Application refused in terms of: _____	
REMUNERATION/SALARY											
<i>Gross pay (before deductions)</i>		<i>Payment Frequency (PW or PM)</i>									
2. Certified Copy of ID (Deceased & Dependant) <input type="checkbox"/>	8. SARS Number: _____	Claims officer (Please Print): _____									
3. Payslips/Database <input type="checkbox"/>	9. Telephonic Verification Contact Person: _____	Signature: _____									
4. Affidavit from Life Partner <input type="checkbox"/>	Designation: _____	Date: _____									
5. Proof of banking details – UI-2.8 <input type="checkbox"/>	Tel. No.: _____										
6. Marriage certificate or certified copy <input type="checkbox"/>											
7. Certified Copy of ONE of the following documents <input type="checkbox"/>											
(i) Death certificate <input type="checkbox"/>											
(ii) Post-mortem certificate <input type="checkbox"/>											
(iii) Burial order relating to the death of such contributor <input type="checkbox"/>											

UNEMPLOYMENT INSURANCE ACT 63 OF 2001
APPLICATION FOR DEPENDANT'S BENEFITS BY CHILD/CHILDREN OF DECEASED IN TERMS OF SECTION 31(1) READ WITH REGULATION 7(1) AND 7(2)

A. PARTICULARS OF DECEASED CONTRIBUTOR:

13 Digit Bar-Coded Identity Document/Passport Number <input type="text"/>	Date of Birth (dd/mm/yy) <input type="text"/>	Gender Male <input type="text" value="5"/> Female <input type="text" value="0"/>		Date of Death <input type="text"/>
First Names <input type="text"/>	Surname <input type="text"/>			
Last Residential Address <input type="text"/>				Code <input type="text"/>
Details of previous application				
a) Name and ID No under which deceased applied: <input type="text"/>		b) Date of Application: ____/____/____ <input type="text"/>		c) Office of application: <input type="text"/>

B. PARTICULARS OF APPLICANT: RELATIONSHIP OF APPLICANT TO DECEASED: _____

13 Digit Bar-Coded Identity Document/Passport Number <input type="text"/>	Date of Birth (dd/mm/yy) <input type="text"/>	Gender Male <input type="text" value="5"/> Female <input type="text" value="0"/>		
First Names <input type="text"/>	Surname <input type="text"/>			
Postal Address <input type="text"/>				Code <input type="text"/>
Residential Address <input type="text"/>				Code <input type="text"/>
Occupation <input type="text"/>	Occ. Code <input type="text"/>	E-Mail Address <input type="text"/>		
Method of Payment				
<i>Use the UI-2.8 form for Banking Details</i>				
CHEQUE <input type="text"/>	BANK TRANSFER <input type="text"/>	OTHER <input type="text"/>		

C. CHILD'S DETAILS:

First Names <input type="text"/>	Surname <input type="text"/>			Date of Birth (dd/mm/yy) <input type="text"/>
Home Address <input type="text"/>				Code <input type="text"/>

I declare that the information is true and correct. I understand that it is an offence to make a false statement..

SIGNATURE OF APPLICANT: _____ **DATE:** ____/____/____

FOR OFFICIAL USE ONLY:

DOCUMENTS/INFORMATION SUBMITTED	SIGNATURE OF OFFICIAL	Claim approved from: _____	OFFICE STAMP								
1. UI-19 (If Applicable) <input type="checkbox"/>	REMUNERATION/SALARY	Application refused in terms of: _____									
2. Certified Copy of ID (Deceased/Applicant & Child) <input type="checkbox"/>		Claims officer (Please Print): _____									
3. Payslips <input type="checkbox"/>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; text-align: center;"><i>Gross pay (before deductions)</i></td> <td style="width:50%; text-align: center;"><i>Payment Frequency (PW or PM)</i></td> </tr> <tr> <td style="height: 20px;"> </td> <td style="height: 20px;"> </td> </tr> <tr> <td style="height: 20px;"> </td> <td style="height: 20px;"> </td> </tr> <tr> <td style="height: 20px;"> </td> <td style="height: 20px;"> </td> </tr> </table>	<i>Gross pay (before deductions)</i>		<i>Payment Frequency (PW or PM)</i>							Signature: _____
<i>Gross pay (before deductions)</i>	<i>Payment Frequency (PW or PM)</i>										
4. Proof of banking details - UI-2.8 <input type="checkbox"/>		Date: _____									
5. Certified copy of birth certificate of child <input type="checkbox"/>											
6. Supplementary documents proving guardianship and relationship of child to deceased <input type="checkbox"/>											
7. Certified Copy of ONE of the following documents <input type="checkbox"/>											
(i) Death certificate <input type="checkbox"/>											
(ii) Post-mortem certificate <input type="checkbox"/>											
(iii) Burial order relating to the death of such contributor <input type="checkbox"/>											

**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 or the Adoption of a child.

Full names of contributor: _____

Employers UIF Reference No.

--	--	--	--	--	--

 /

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ID No of contributor																			
----------------------	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

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

I hereby certify that since (full date) ____ / ____ / ____, the contributor is on

	Sick leave
--	------------

	Maternity leave
--	-----------------

	Leave due to the adoption of a child and
--	--

	has
--	-----

	will
--	------

 receive(d) the following remuneration

Gross remuneration (prior to confinement) Per Month / Per Week	Periods during which different rates of remuneration were received				Gross remuneration received whilst on leave (PM/PW)
	From		To		
	From		To		
	From		To		
	From		To		
	From		To		
	From		To		

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

(C) The contributor returned to work on ____ / ____ / ____.

DATE: _____

SIGNATURE OF EMPLOYER OR AUTHORISED AGENT

BUSINESS STAMP



labour

Department:
Labour
REPUBLIC OF SOUTH AFRICA

UNEMPLOYMENT INSURANCE FUND

94 Church Street, Pretoria / Postal Address: UIF, Pretoria, 0052 / Tel: (012) 337-1680

APPLICATION FOR REGISTRATION AS AN EMPLOYER OF DOMESTIC EMPLOYEES

Unemployment Insurance Contributions Act, 2002

Completed form can be posted to the **UIF**, or faxed to (012) 337-1636 or submitted at any branch of the UIF which is closest to the employer. The 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; **Biftn** (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; **Kimberley** (053) 832 7218

PRIVATE HOUSEHOLD

EMPLOYER INFORMATION TO BE PROVIDED:

1. Identity / Work Permit / Passport number of employer:

2. First names of employer:

3. Surname of employer:

4. Date on which the first contributor (employee) was employed (Cannot be prior to April 2003):

5. Number of employees employed:

6. Tel. number during office hours: Code: Number:

7. Tel. number after hours: Code: Number:

8. Cell phone number:

9. Fax number (if applicable): Code: Number:

10. Personal or other e-mail address (if applicable):

11. Language preference: 1= English, 2 = Afrikaans

12. Postal address:

Postal code:

13. Residential address:

Postal code:

14. Magisterial district in which residential address is situated:

15. Municipality:

⇒ **N.B. A completed form UI-19 in respect of employees must accompany this form.**

• I hereby declare that all the information furnished on this form, is true and correct.

Date: Signature of employer or authorised agent: