

UNEMPLOYMENT INSURANCE ACT 63 OF 2001
APPLICATION FOR CONTINUATION OF PAYMENT FOR ILLNESS BENEFITS IN TERMS OF REGULATION 4(4)

FORM MUST BE COMPLETED ON OR AFTER

ID NO.

1.	Surname:	<input type="text"/>																					
2.	Previous surname: <i>(Only if it changed since your previous application)</i>	<input type="text"/>																					
3.	First names:	<input type="text"/>																					
4.	Identity number:	<input type="text"/>										5.	Telephone number:	<input type="text"/>									
6.	Postal address:	<input type="text"/>																					
7.	Residential address: <i>(If different from postal address)</i>	<input type="text"/>															Postal code	<input type="text"/>					
8.	Date returned to work:	____/____/____																					
9.	Kindly state whether you are in receipt of income from other sources. Tick (✓) where applicable.																						
1.	Monthly Pension from State (Excluding Disability grant)	<input type="checkbox"/>	<p>I declare, except as stated in item 8, 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.</p> <p>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.</p> <p>_____/_____/_____ Signature of applicant Date</p>																				
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"/>																					
<p><i>If any of above is applicable complete the following questions:</i></p> <p>When did you begin to receive this income? _____</p> <p>Do you continue to receive this income? _____</p> <p>If you no longer receive this income when did it come to an end? _____</p>																							

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

MEDICAL CERTIFICATE

(To be completed by an authorised practitioner in terms Section 20(1)(c) of 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 _____
 Signature _____ Date _____ Tel No. _____
 Address _____