

# Government Gazette Staatskoerant REPUBLIC OF SOUTH AFRICA

EPUBLIEK VAN SUID AFRIKA

**Regulation Gazette** 

No. 10981

Regulasiekoerant

Vol. 651

SeptemberSeptember

2019

No. 42678

N.B. The Government Printing Works will not be held responsible for the quality of "Hard Copies" or "Electronic Files" submitted for publication purposes AIDS HELPLINE: 0800-0123-22 Prevention is the cure

#### **IMPORTANT NOTICE:**

THE GOVERNMENT PRINTING WORKS WILL NOT BE HELD RESPONSIBLE FOR ANY ERRORS THAT MIGHT OCCUR DUE TO THE SUBMISSION OF INCOMPLETE / INCORRECT / ILLEGIBLE COPY.

No future queries will be handled in connection with the above.

#### Contents

No.		Gazette No.	Page No.
	GOVERNMENT NOTICES • GOEWERMENTSKENNISGEWINGS		
Labour, De	partment of/ Arbeid, Departement van		
R. 1131	Unemployment Insurance Act (63/2001): Call for comments on the amendments to the Regulations to the Unemployment Insurance Act 2001	42678	4

#### 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

 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)

				Id	enti	ity D	ocı	ıme	ent																												
1.	Su	ırnar	ne:																																		
П		Τ	П	П			Т	П							Γ	Г	Г			Г		Γ	Τ		Π	Г	Π	Τ	Г		Π						
2.	Pr	evio	us surn	ame: (	Only	y if it	cha	inge	ed sinc	e you	ı cu	rren	t ap	plic	atio	ns)	_	_			_	_	_			_	_	_	_			_			_		
П	T	T	$\Box$	П		Ť	T	Ī		П						T	П	Τ	Г	Г	T	T	T	T	Τ	Т	T	T	T	T	Т	П	Г	П	П		
3.	Fi	rst na	ames:					_		_			_	_	1	-		_	_	_	_	-		1	_		_	_	_	_	_						
Н	Т		П	П	Т	Т	T	Т		П						T	Г	T	Г	Т	Τ	T	Т	T	T		Τ	T	Τ	Τ	Г						
4.	Co	ontac	t Numl	per			_			_		_	_		_	_	_	_	_	_	_	1	_	_	1	_	_	_	_	1		_		_			_
	T								T			T					7																				
	_	_				II	T	HE	EVE	NT C	)F A	CI	IAI	IGE	E OI	F AJ	DDI	ŒS	S IN	ΙDΙ	CA	re y	YO	UR 1	VEV	V DI	ET/	AILS	3				_		_		_
5.	Po	stal	address	i:						-																											
	T	Τ	П	П	T		T	T		П				Г	Γ	Г	Т	Τ	T	Τ	T	T	Т	T	T	Τ	T	T	T	T	T	Т	П	П	П	Г	П
6.	Re	side	ntial ad	dress:	(If a	liffere	ent ,	fron	n posta	ıl adı	dres	s)		_	_	_	_	1	_	_			_	1	_	_	_	Pos	tal	code			╁	Τ	Τ	1	Н
	Т	I		П	Ť	Ť	Ť	T	Ť			Ĺ			T	Г	П		Τ	Т	Τ	T	T	T	Т	Т	T	T	Τ	Τ	Т		十	ľ	Τ		П
7	If wo	n ho	ve con		od v	vork	in	diad	sto dot	<u> </u>			_	_		_	-	_	_	_	-	+	_			_	1	1	1	+		_	_	_	1		
<i>'</i> .	ii yu	шпа	ve com	menc	eu v	MOLK	1111	uica	ile uai	e.	_	—′	_		_′_			-																			
l ⊳	MD	IE V	OUR I	D A NIL	TNI	' DE	тл	TT C	TITA \$7	Tr C	ET A 7	NOT	ומוק	rΛτ	) N/I	TIT.	9 0 1	METET 1	et i	) TF (	റവ	MDI	וויסו ז	TED.	A INT	D CI	TIDI	итт	TE	n							
ŕ	ND.	11. 1	OUKI	J2511J5	1110	מען צ	IA	ULLE	JUAN	E C	IIA	101	1	OI	XIVI.	01-	4.0	VIU	311	-	COI	VIII I		ED	AIN.	יטע	UDI	VII I	IL				_				
I de	clare	tha	t:																																		
I de	clare	exc	ept as	stated	in i	item '	7. fl	hat	I have	not	woi	rked	l sin	ce f	he a	late	of	mv s	annl	icat	tion	for	ado	ntio	n h	enel	fife	and	hav	e no	of he	en e	ntit	led	to m	v no	rmal
rem	uner		n/or wi																																		
forn	1.																																				
			e decla of an o																														ıt.				
111 (1	ic cv	cht (	71 411 0	vei pa	THE	nt oc	cui	1111	gasa	i csu	10 01	tillis	, ap	piic	atio	, II I	unu	CI LZ	inc	. 1141	. 1 **	111 1	CIII	iiu t	ne n	ш а	1110	IIII (	.0 1	ic i	ullu	•					
Sion	afur	e of	Applic	ant			_				=	Date	ρ.			_							_														
Jign	atuı	. 01	иррис								,	Dutt																									
NB:	. >	>	THIS	FOR	M N	/UST	ГВ	E S	UBMI	TTE	D 1	03	O	JR I	NE.	ARE	ST	DE!	PAF	RTN	1EN	T C	)F I	EMI	LO	ΥM	EN	ΤA	ND	LAI	BOU	IR C	)FF	ICE			
	>	>	NO P	OST I	OAT	r <b>ed</b> i	FO	RM	IS WII	LL B	E A	CC	EP	TEI.	O O	R PI	RO	CES	SEI	).																	
	>	>	IN T	HE EV	EN	T 0	FΥ	OU	RES	UMI	NG	EM	IPL	ΟY	ME	NT	OR	BA	CK	TC	) Y(	OUF	R N	ORI	VIA.I	W	OR	KIN	G:	ЮН	JRS,	, YC	)U A	<b>IRF</b>	RE	QU	IRED
									RTM						ME	CNT	AN	DI	LAB	OU	R	IMN	MEI	OIA'	ΓEL	Y A	NI	TC	R	EQU	JEST	ΓTI	HE I	NEV	W/C	URI	RENT
			LIVIP.	LOYE	KI	USI	J <b>R</b> I	IVIII I	ΓADI	LCL.	AK	<b>A11</b>	UN.	•																							
	_	_			_		_	_	_	_	_	_	_	-	-	_		_		_			_	_		_	_	_	_	_	_	_	_	_	_	_	
_														_																							
- [1	Date	e R	eceiv	ed										1																							

**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. In terms of section 12(1)b, 19(1), 24(2), 26A(1), 27(3) and 29A(1) of the abovementioned Act, (A) I hereby certify that the contributor would receive less than 100% of his/her remuneration as from \_\_\_\_\_ / \_\_\_\_ (full date) due to: Parental Commissioning Illness Maternity Adoption Reduced Leave Parental leave Leave Leave Leave working (SURROGACY) time Periods during which different rates of remuneration were received while on leave/RWT Gross remuneration received whilst (TO BE INDICATED IN CALANDER MONTHS) on leave/RWT (Per month) То From From To From То From To From To То From From То From To From To (B) The contributor is expected to/has resume/d full working hours on \_\_\_\_/\_\_\_/ EMPLOYER STAMP (if available) SIGNATURE OF EMPLOYER OR AUTHORISED AGENT DATE:\_\_\_\_/ \_\_\_\_\_/

UI-2.9P

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

	1	Identi	ty Docu	ment																					
							_								-										
1. S	Surname:	П		П		П					$\neg$	_	П	Т		Т	П	$\neg$	_	Т	Т		$\neg$	_	٦
2. P	Previous surna	me: (Onli	v if it cha	nged since	e suhmi	ssion o	of curre	ent clain	7)				Ш				Ш			1_					J
TT			y to colum	T T		II	1		7			T	П		Т	T	П	Т	T	T	Τ	П	Т	T	٦
3. F	irst names:									_						_				_	1				7
TT				T		П				П	П	Т	П	T		Т	П	Т	T	Τ	П	П	П	T	1
4. C	Contact numb	er:												_				_							-1
			INT	IE EVEN	TOF	A CH	ANCE	OF AD	DDEC	C TNI	DICA	TEX	/OIII	) NIE	W/D	ET A	II C			_				_	-
5. P	ostal address:		INII	<u>IE EVEN</u>	VI OF	ACIL	ANGE	OF AD	DKES	ЭШ	DICA		1001	X IVE	VV D	<u>LIA</u>	IILS								
				TT		П				Т		Т	П	Т	Т	Т	П	Т		T	Т	П	П	T	٦
6. R	Residential add	ress: (If a	lifferent fi	rom posta	ıl addre.	ss)							ш		-	_	Post	al co	de	Ť	$^{\dagger}$	Т	Т	1	1
		П	ΪΤ	ΤŤ	П	ÍΤ				П		Т	П	Т	T	T	П	Т	T	1	Ť	$\Gamma$	П	T	1
	Name of new of the Reduced										/		Empl	oyer _/_	Con	tact	num	ber:						-3	
> NB	IF YOUR B	ANKINO	G DETAI	LS HAV	Е СНА	NGEI	D FOR	M UI-2	.8 MU	ST B	E CO	MPL	ETE.	D Al	ND S	UBN	1IT1	ED							
declar	re that: I am unen received r I am on R I am awa informing I furthern	emunera educed V e of the f the Clair	tion or pa Vork Tim fact that i ms Office	ayment in ne ( <i>if appo</i> nt is an of er that I l	n kind f licable) fence to nave res	for an comp sumed	y work plete th work,	perfor	med w	ithou	noti m wh	ifying	the (	Clair emp	ns Oi oloyn	fficei nent/	not	on Re	educ	ed V	Vork	Tim	ie wi		
Signatur	re of applicant			_	/	/_ ate																			
NB!	> THIS I > NO PO > IN TH	FORM M OST DAT E EVEN FORM T	MUST BE TED FOR T OF YO THE DER	MS WIL OU RESU PARTME	TTED  LL BE A  MING  NT OF	TO YO ACCE EMP	PTED LOYM PLOYN	OR PR IENT C MENT A	OCES OR BAC AND L	SED CK 1 ABO	'O Y ( UR ()	)UR	NOR	MAI	L WC	)RK	ING	HOU	IRS '	YOU	J <b>AR</b>	E R	EQU	IRE	)
Г	Date Rec	eived:	T																						

UI-2.12P

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

					Ide	nti	ty (	doc	um	ent																											-							
1.	Su	rnaı	ne:																																									
		Γ	П	Т		Т	П			Τ	Τ	Γ	Τ	Γ	П		Τ	Τ	Τ	Т				Т	T		T			Π	Ī		T				T	T				T	T	
2.	Pro	evio	us sum	nam	e: (C	nly	if i	it ch	ian;	ged	sinc	e yo	и си	rren	t ap	plic	atio	ns)	_	_	_		_	_	_		_	_		_	_	_				_						_	_	
П	Τ	Τ	П	T	T	T	T		Г	T	Τ	T	Τ	Г	Ė	Г	T	T	T	T				T	T	T	T		П		Т	T	T			Т	T	T			Γ	T	T	7
3.	Fir	st n	ames:	_				-	_	_		_	_	_	_	_	_	_	-				_	_	_		_	_		_				_	_	_		_			_	_	-	
	T	T	П	Т	T	T	П			Τ	T	Т	T	Г	Г	Π	T	Т	T	T				T	T	T	T				Γ	T	T	П		Τ	Τ	Т			Γ	T	T	
4.	Co	ntac	t Nur	her		_		_	_	_	_	_	_	_	_		_	_	_		_			_	_		_	_	_			1	1	_	_	_	1				_	1	1	
	T	11444	11001		Ť		T		T		T	T		1			Т																											
├		_		_		_	1	IN '	TH	E E	VE	VT (	OF.	A C	FF A 1	VCI	E O	FΑ	DE	)RE	225	IN	DI	C' A'	TR	vc	TII.	2 N	FW	/ DI	T.	AII	2			_		_		_		_	_	-
5.	Pos	sta1	addres	s:			,		111		1 1 101		01.	x C	LLZ	101		A 24		<i>-</i> 1	200	, 111	DI.	UA	112	10	,01	W 14		ועוו	417	TALL.	11.59											
H	T	T	П	T	Т	T	П		Г	Т	T	Т	T	Т	П	Т	Т	Т	T	Т				Т	Т	Т	Т			Т	Т	T	Т			Τ	Т	Т			Т	Т	Т	$\neg$
6.	Re	side	ntial a	ddr	-ee- /	Tf d	iffo	гон	t fir	om:	nosta	al ac	ldro	(6)	_		_	_	_			_	_	_	1		_				_	D,	nete	1.0	nde	1	╁	ᅥ		4	4	_	┰	$\dashv$
ļ.,	T	T	T	T	J. (.	J u	J	ren	.,,,	T	T	T	T	1		Т	T	Т	T	Т				Т	T	Т	Т			Т	Т	T	7510	11 01	Juc	Т	╁	ᅱ	_	1	┰	Т	+	$\dashv$
		_	Ш	_	_	1	_	Ш	Щ	1_	_	_	_	_	Н	_	1	_	_	4			_		_			_	_		L	_		_		_	_			_	_	1	1	_
7. 1	f you	u ha	ve coi	nm	ence	d w	ori	k ii	ndi	cate	dat	e:	-		/		_/_			_																								
<u> </u>	NB I	IF Y	OUR	BA	NKI	NG	D	ETA	AII	SI	IAV	E C	HA	NG	ED	FO	RM	UI-	-2.8	8 M	US	T B	E	CO	MP	LE	TE	D A	INI	) SI	J <b>B</b> I	MI'	TT.	ED		_		_		_	_	_		
I dec		41	٠.																																									
								_																																				
remu	iare, nera	, exc atio	ept as n/or w	sta ill 1	ited i receiv	n ii ve a	tem 1 po	ı 7, Ortic	tha on (	of n	have ny ne	not orm	t wo al r	rke( emu	i sii ner	ice i atio	the n a:	date s de	e oi	t my red	y aj l by	ppli my	cat 7 en	ion npl	i toi oye	r ad er o	opi n pi	tion reso	: bo erib	ener	its for	and m (	i ha JI-2	ave 2.7	no sub	t b omi	een itte	en d w	titl vith	ed m	to r y a j	ny opli	nor cat	mal ion
form							-															-		•			•															•		
			e decl																																			ent.						
In th	e eve	ent (	of an o	ver	payı	mer	ıt o	ccu	ırri	ng a	as a	resu	ılt o	f thi	sap	plic	catio	on I	un	ıder	rtal	ke t	hat	IW	vill	refi	ınd	l th	e fu	ll a	mo	unt	to	the	e Fu	unc	l.							
_										_				_										-																				
Signa	ture	e of	Applic	can	t									Dat	е																													
NB!	>		THIS	S F	ORM	1 M	IUS	T F	BE	SUI	вмт	TTI	ED T	07	YOI	JR I	NE.	ARI	ES	TD	EP	AR	TN	Œ	T	OF	EN	/PI	O	YM	EN	T A	NI	D I	AF	301	ΠR	OI	FFI	CF		_	_	
	>		NO I																						-							- 1		_										
	<b>&gt;</b>	•	IN T																					ΥO	UF	R NO	OR	MA	L	wo	RK	IN	G I	HO	UR	RS.	ΥO	U	AR	Œ l	RE	οU	IRE	ED
			TO I	NF	ORN	1 T	HE	DI	EP/	AR	ГМЕ	ENT	OF	EM	PL	OY	ME	NT	Al	ND	LA	BO	UF	R II	MIN	4EI	) I A	TE	LY	AN	D	TO	RI	EQ	UE	SŤ	TI	ΗE	NE	W	CU	RI	Œ	T
			EMP	LU	YER	( I)	US	UE	JVL	EI Z	z DF	LUL	AK	AII	UN	•																												
			_		-	-	_	_	-	_	-	_	-	-	-	_	_	-	-	-	-	-	-	-	-		-	-	-	-	-	-	_	-	-	-	-		_	_	_	_	-	
	_	_			=						_			_		-																												
Ī	ate	R	eceiv	red																																								





NOMINATION FORM FORM)	FOR	UIF DEPENDAN	rs Benefits	6 (PLE	ASE NOTE	THAT	NO.	AL'	TER	ATI	ON:	S AR	E ACC	ETE	ED O	N TH	S	
(Employee's full name &	2	, lo	lentity Docum	ent												$\mathbb{L}$		
Currently employed at nominate the below in	divid	ual(s) indicated to	have cooses t	UI	F Ref Nu	mber	te B	201	ofit	c ir	o fh		ont a	of n	, h	erek	у	
			lave access i	.O IIIy	OIF Depe	iluali	ilo D	) CI	ient	.S II	ı u	ie e	ent	וו וג	ily de	taui.		
1. SPOUSE / LIF	E P	ARTNER																
Surname	F	ull Names	Relationsh employee	ip to	Date o	f Birth	1	le	den	tity	Do	cun	ent					
	-								_		_	_						
2. CHILD/REN U	INDE	R THE AGE OF 2	1 ORLEARN	ER OF	R DEPEN	DAN	ТС	HII	LD									
Surname		Full Names		Date	of Birth		1	lde	enti	ty [	Doc	cume	ent					
							+											
							1											
							+	_	_					_				
3. NOMINATED	BEN	EFICIARY OF YO	UR CHOICE	(if more	e than 1 no	minee	, the	e pe	ercer	ntag	ge n	nust	be allo	cat	ted pe	er no	mine	e)
Surname	Full	Names	Date of bi		Valid ID/Pa Number	sspor	t/Per	rmi	t			elation mplo	onshi <sub>l</sub> yee	o to			cent	
				-			_			_	+					$\vdash$		
																		_
				_						_	-					-		
											t							
Total Percentage																10	0%	
EMPLOYEE'S SIGNATURE	it the	form UI-53 to my	Employer for	may c submi	hange. In	n the he De	eve	ent	t the	ere of	is En	a c nplo	hang	je, it &	l un Lab	ndert	of take	the to
FULL NAME OF EMPLOYE	R REF	PRESENTATIVE	• PI		EMPLOYE. <b>NOTE THA</b>					101	IS A	RE A	CCE		ATE D ON	I THI:	s FO	RM

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								_9		
(Full i	name and sur	name in l	block l	etters)						
Name of Financial Institution										
Branch code	Account n	umber						.v		
									_	
Indicate with an "X"  Savings account  Curr	ent account			Transn	nission :	accoun	t			
Dormant:	ctive									
I declare that the abovementioned in Unemployment Insurance Commissi might arise due to incorrect/incomple	ioner will no	t be hel	d liab	le for						
Name of bank / Post Office official										
Signature of Bank/ Post Office Officia	āl					Banl	k Star	np		
Date:										
To be	e completed	by the	Appli	icant						
I,										
Hereby authorise the Unemployment approved, into the abovementioned ac in writing.		ommissio	oner/C	laims						
I declare that the information as fu knowledge accurate and complete. It made into the provided banking account	indemnify the	UIC of	any li	ability	in the	event (	of pay			
Signature of applicant		Dat	te							

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			_					
1.	Sur	man	ne:																																												
						T		T					T							I	T					Γ	T	T			T					T	T			Τ	T			Ī	T	T	
2.	Pre	viou	เร รเ	ırna	me:	(0)	ıly i	if it	ch	ang	ed:	sin	ce s	ubi	niss	ion	of o	curr	ent	cla	im)																										
3.	Fire	st na	me	S:	_	_	_	_	_		_	_	_	_	_	_	_		_	_	,	_	_			_	_	_	_		_	_	_	_	_	_	_	_,		_	_	_		_	_	_	_
$\perp$	L		L		L	L	L		_			L	1																		L	L								L							
4. 	Con	ntac	t nu	ımb	er:		_	_	_	_	_	_	_			_		_			_																										
									L				L	i			_																														
5.	Pos	tal a	addr	ess:				I	N 1	Н	E E	VE	NT	0	F A	CH	IAN	\GI	E O	F A	DE	RE	SS	IN	DI	CA'	TE	Y	<u>OU</u>	RI	Œ	VΙ	Έ	ſΑ	ILS	3											_
	Π					Г	Τ	T	Т			Τ	T	T	T				Γ	Τ	T	T	Т			T	T	T			T		T		Г	Τ	Т			Τ	T	- 1		Τ	T		
j.	Res	ide	ıtial	add	res	s: (I	f dif	fer	ent	fro	m p	2051	tal	add	ress	) )		_	1	_	1	_	_1					_1							Pos	stal	co	de		t	+		T	-	_	7	$\dashv$
						T	Ť	T	T		ŕ	Γ	T	T	T			Г	Γ	T	T	T	T			T	T	T			T	T	T		Г	Τ	T			T	7		T	Т	T	1	
	If:	_											_								1										L					L											
	If the																							ГВ	E				ETE																		
	are 1	I a rec I a I a inf	: m u eive m o m a orm	ed r n R war ing	emu edu e of the	ced the	ratio Wo fac sim	on ork et t s O	or Ti ha lffi	pay me t it cer	me ( <i>if</i> is a tha	ent app in o	in I plic ffe ha	kind abl nce ve i	d fo e) to resu n gi	r an	ny v nple d w	te t	k po his	erfo con	rm tin	ed uat	wit	for	it n	otii whi	fyin ile l	ng t I ar	he n ir	Čla 1 e	ain mp	s O	ffi mei	er. nt/	not	oı	ı R	edı	ıce	d V	Woı	rk '	Tir	ne	wit		ut
Signa	ture	of a	pplic	ant								_			Dat				_																												
NB!	A A A		TH NO IN	IS I PC TH	FOI ST E E FO	DA VE RM	TE NT TE	D I OH HE I	FO F Y DE	RN OU PA	IS V	WI ESI IMI	LL UM EN	BI IIN T (	C AC G E OF I	CCI EMI LAI	EPT PLC	TEI DYN	O ME	R P NT	RC	CE R B	ESS ACI	ED K 1	O	ΥO	UR	R N	OR	M.	AL	W	OR	KI	NG	6 H	O	J <b>R</b> !	s Y	/OI	U A	\R	E R	E(			ED YER
Γ		Cat	a D	ec	o i v	hod	_		T			_									7																										

UL-2.2

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

Gender Male Female Surname	Code / Telephone No	Code	E-Mail Address Fax Number	GRADE 12 ABOVE GRADE 12		MEDICAL CERTIFICATE (To be completed by a registered medical practitioner)  1,  My Registration number is 1 confirm that	is suffering from This patient was not capable of performing work from Signature	Tel No. Address		Claim approved from:  Application refused in terms of:  Claims officer (Please Print):  Signature:	Date:
Date of Birth (dd/mm/yy)			E-Ma	GRADE 8-9 GRADE 10 - 11	o current	SO BE COMPLETED.	fficer will authorise the payment of benefits. I re-employed and understand that failure to do	I submitted, I undertake that I will refund tl	egal Representative proof must be attached. FOR OFFICIAL USE ONLY:	SIGNATURE OF OFFICIAL	Date: //
Identity Document First Names	Postal Address	Residential Address	Occupation	Education SPECIAL SCHOOL CERT. BELOW GRADE 8	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)  (NO)	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.	Where a Proxy was appointed by Doctor or Legal Representative proof must FOR OFFICIAL USE ONLY:	I declare that the above information is true and correct. SIGNATURE OF APPLICANT	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 6	
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 O	OF ADDRESS INDICATE YOUR NEW DETAILS
5. Postal address:	ADDRESS INDICATE TOUR NEW DETAILS
Residential address: (If different from postal address)	Postal code
7. Date returned to work: / /	
normal remuneration/or will receive a portion of my normal remuner	date of my application for illness benefits and have not been entitled to my ation 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	and a control to the control of the
In the event of an overpayment occurring as a result of this application for	
Signature of applicant /Proxy Date	
NB: IF YOUR BANKING DETAILS HAVE CHANGED, FORM UI-2.8  Where the forms are signed by a Proxy attach proof	
Where the forms are signed by a riving attack proof	or uppomimon.
NB! > THIS FORM MUST BE SUBMITTED TO YOUR NEAR	REST DEPARTMENT OF EMPLOYMENT AND LABOUR OFFICE.
> NO POST DATED FORMS WILL BE ACCEPTED OR	
	T YOU ARE REQUIRED TO INFORM THE DEPARTMENT OF LABOUR OFFICES RENT EMPLOYER TO SUBMIT A DECLARATION (UI-19).
MEDICAL CERTIFICATE (To be completed by a registered	ed medical practitioner.)
I,	am a qualified
qualifications My	y 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 INSURANC APPLICATION FOR MATERNITY BE	UNEMPLOYMENT INSURANCE ACT 63 OF 2001 AS AMENDED APPLICATION FOR MATERNITY BENEFITS IN TERMS OF SECTION 25(1)	
Identity Document First Names	Date of Birth (dd/mm/yy)	Surname	
1 T T T T T T T T T T T T T T T T T T T			
Postal Address		Code /Telephone No	hone No
Residential Address		Cell No	
		Code	
Occupation		E-Mail Address Fax	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.	to current.		
a) Name and ID No under which you applied:			
ARE YOU STILL EMPLOYED YES NO		MEDICAL CERTIFICATE (to be completed by a registered medical practitioner or midwife)	ioner or midwife)
NB: IF YOU'ARE STILL EMPLOYED, FORM UI-2,7 MUST ALSO BE COMPLETED.	APLETED.	I, am a qualified	Qualifications
		My registration number is	is under my treatment
IMPORTANT: READ THIS SECTION BELOW:		and is pregnant. The expected due date of birth is	ì
In the event of my application being successful, the Claims O	Officer will authorise the payment of benefits. I	OK I confirm that gave birth / stillborn / miscarriage on	miscarriage on
also undertake to inform the Claims Officer as soon as I am re-employed and understand that failure to do so will constitute fraud.	re-employed and understand that failure to do so	Signature Date	Medical Practice Stamp (If available)
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.	application I submitted, I undertake that I will	Tel No.	
		Address	
FOR OFFICIA	FOR OFFICIAL USE ONLY:		
I declare that the above information is true and correct. SIGNATURE OF APPLICANT	SIGNATURE OF OFFICIAL	Claim spproved from: Application refused in terms of:	Department of Employment and Labour Office Stamp
		Claims officer (Please Print):	
		Signature:	
Date: //	Date: //	Date:	
		N. C.	

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 of child  Date of Birth (dd/mm/yy)  Male  Female	Surname	Code /Telenhone No	Code	Cell No	Code	E-Mail Address Fax Number		GRADE 8-9 GRADE 12	GRADE 10 - 11 ABOVE GRADE 12	Identity Document differs from current ler which you applied:	YES NO	YED, FORM UI 2.7 MUST ALSO BE COMPLETED. SECTION BELOW:	u 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 onstitute fraud.	n 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:	ation is true and correct. SIGNATURE OF OFFICIAL Claim approved from: Department of Employment and Labour	Application refused in terms of: Claims officer (Please Print):	Sknature:	Date: // / Date:
APPLICATION F	dentity document	irst name	ostal Address		Residential Address		Occupation	ducation	PECIAL SCHOOL CERT.	ELOW GRADE 8	tetails of previous application if Identity Document differs from current  Name and Identity number under which you applied:	RE YOU STILL EMPLOYED	B: IF YOU ARE STILL EMPLOYED, FORM UI 2.7 MUST ALSO BE COMPLETED. MPORTANT: READ THIS SECTION BELOW:	n the event of my application being successful, the Claims Constitute fraud.	ı the event of an overpayment as a result of any application FOR OFFICIA	I declare that the above information is true and correct.	SIGNATURE OF APPLICANT		ate:/

30 Read with Regulation 7(1)			Date of Death								Tel No		Cell No			entioned deceased contributor,	nount to the Fund.			Department of Employment and Labour Office Stamp			
UNEMPLOYMENT INSURANCE ACT 63 OF 2001 AS AMENDED S BENEFITS BY SURVIVING SPOUSE OR LIFE PARTNER IN TERMS OF SECTION 30 Read with Regulation 7(1)		Gender Male Female			Code			Gender	Male Female			Code	-	Code		g spouses or the only surviving spouse or life partner of the abovementioned deceased contributor, at information given in this document is true and correct.	a result of this application, I undertake that I will refund the full amount to the Fund.			Claim approved from: Application refused in terms of:	Claims officer (Piense Print):	Signature:	Date:/
UNEMPLOYMENT INSURA ENDANT'S BENEFITS BY SURVIVING SPO		Date of Birth (dd/mm/yy)	Surname		to current		RINER	Date of Birth (dd/mm/yy)	Serial me	The second secon						surviving spouses or the only surviver and that information given in this		nake a false statement.	FOR OFFICIAL USE ONLY:	SIGNATURE OF OFFICIAL CHAPTER	70	Sis	Date: / / Da
APPLICATION FOR DEPENDANT	A. PARTICULARS OF DECEASED CONTRIBUTOR:	Identity Document	First Names	Last Residential Address	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	First Names	O ANTIGO TO CO.	Postal Address		Residential Address		E-Wall Address	I declare that I am one of surviving spouses or the only surviving spouse or life partner of t 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	I understand that it is an offence to make a false statement.	FOR	I declare that the above information is true and correct. SIGNATHIRE OF APPLICANT			Date: / /

APPLICATION FOR DEPENE	ONEMPLO IMENT TANG JANT'S BENEFITS BY A GUARDIAN / DI REGUL	LI INSURANCE ACT 63 OF 2001 AS AMENDED JAN / DEPENDANT CHILD OR NOMINATED BENEFI REGULATION 7(1) AND 7(2)	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	om current		
a) Name and Identity Document under which deceased applied:	2		
B. PARTICULARS OF APPLICANT:  Guardian of a minor child	nor child Dependant child	Nominated beneficiary	
Identity Document First Names	Date of Birth (dd/mm/yy)	Gender Male Female	
Postal Address			Tel No
		Code	
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 understand that it is an offence to make a false statement.	this application, I undertake that I will refund the full amount to the Fundent.	full amount to the Fund.	
FOR OF	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):	Department of Employment and Labour Office Stamp
		Signature:	
Date:	Date: //	Date:	

Commissioning Parental   Commissioning Paren	
Date of Birth (dd/mm/yy)  Male	
	ale
Surname	
Code /Telephone No	
Cell No	
Mail Address	
	7
GRADE 12	
ABOVE GRADE 12	
NO 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.	tand that failure to do so will
In the event of an over payment as a result of any application I submitted, I undertake that I will refund the full amount to the Fund. FOR OFFICIAL USE ONLY:	
SIGNATURE OF OFFICIAL  Application refused in terms of:  Claims officer (Please Print):	Department of Employment and Labour Office Stamp
Signature:	
Date: //	
ne payment of benefits. I also unde ake that I will refund the full amou	ABOVE GRADE 12  rtake to inform the Claims Officer as soon as I am re-employed and undersing approved from:  Int to the Fund.  Depart  phication refused in terms of:  aims officer (Please Print):  ate:

01-2.12

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

Identity Number	Identity document of child	Date of Birth (dd/mm/yy)	Gender Mate Female
First name		Surname	
Postal Address		Code	Code /Telephone No
Residential Address			Cell No
		Code	
Occupation	E-Mail Address	Fax Number	
Education			
SPECIAL SCHOOL CERT.  BELOW GRADE 8	GRADE 8-9 GRADE 10 - 11	GRADE 12 ABOVE GRADE 12	
Details of previous application Identity document differs from current a) Name and Identity document under which you applied:	om current		
ARE YOU STILL EMPLOYED  NB: IF YOU ARE STILL EMPLOYED, FORM UI 2.7 MUST ALSO BE COMPLETED.	SO 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.	Officer will authorise the payment of benefits. I also unde	rtake to inform the Claims Officer as soon as 14	am re-employed and understand that failure to do so will
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.	n I submitted, I undertake that I will refund the full amon	unt to the Fund.	
FOR OFFICIA	FOR OFFICIAL USE ONLY:		
I declare that the above information is true and correct. SIGNATURE OF APPLICANT	SIGNATURE OF OFFICIAL  Ap  Ca	Claim approved from: Application refused in terms of: Claims officer (Please Print):	Department of Employment and Labour Office Stamp
Date:	Sig. Date: D. D.	Signature: Date:	

	IPLOYME	INT INSUR	UNEMPLOYMENT INSURANCE ACT 63 OF 2001	F 2001	ICT 63 OF 2001	50 to 1						UI-19	
			Information to be supplied	upplied in ter	on of Section 56	(1&3) read	nation of Employees for the month of [] in terms of Section 56(1&3) read with Regulation 13(1&2)	3(1&2)					
tails ir me at 31)36	loyer must by t ncluding new a any branch o 6 2156; Polok	the seventh da appointments a of the UIF whi	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 (011) 366 2156; Polokwane (015) 290 1670; Mmabatho (018) 384 2658; East Ldn (043) 701 3263; Blfn (051) 447 9353; CT (021) 441 8024;Wtb (013) 656 0233;PE (041) 506 5142;Gnn	rice. The emple ployer. The cuple of 181 384 2658:	ioner with all the object must forward pmpleted form c East Ldn (043)	information d this form an also be 701 3263; 1	mmissioner with all the information during the previous month regarding the employer's contact details or employees remunerative employer must forward this form to the Unemployment Insurance Fund at (012) 337-1943/44 or 337-1580/81/82 or submit.  The completed form can also be faxed to any of the following numbers: Pta (012) 309 5142/5286, Jhb (011) 497 3293; Dbn 2658; East Ldn (043) 701 3263; Blftn (051) 447 9353; CT (021) 441 8024; Wtb (013) 656 0233; Pt. (041) 506 5142; Gmn	is month regardii ent Insurance F following numb 3; CT (021) 441	und at (012) 3:  ers: Pta (012) 8024:Wtb (01	r's contact det 37-1943/44 or 309 5142/528 3) 656 0233:E	ails or empl 337-1580/8 86: Jhb (01 PE (041) 50	loyees remun 31/82 or subj 1) 497 3293; 6 5142;Gmn	mit Dbn
EMP	(011)873 2219:George (044) 1. EMPLOYER DETAILS	rails 22	(011) 873 2219:George (044) 873 2568: Pmb (033) 394 5069. Or mail to: uif.declarations@labour.gov.za  1. EMPLOYER DETAILS	069. Or mail to	: uif.declarations	@labour.go	v.za						-
1.1 UIF 1.2 Tradi	UIF Employer Reference No	ference No		Branch No	0	1.2		No (If registered	with SARS)				
1.5 Add	1.5 Address where employed	usiness aployees listed	rading name of ousmess. Address where employees listed in Item 2 work (if different to the address in 1.4)	Ferent to the add	fress in 1.4)	1.4 1.6	Physical Address Postal address						
					`	1.7	Co. Reg.No (CIPRO No)	O No)					
1.8 E-m	E-mail address		1.9 F	Fax No		1.10	1.10 Phone No		1.11A	1.11Authorised person**	**uo		, ,
EM	EMPLOYEE DETAILS	TAILS											
A Surname	B Initials	fials	C Identity Document Number	ler.	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 Codes as	I Indicate whether contributor or non- contributor (YES OR	J *** If non- Contributor state reason (Use codes at bottom of page)	
					R		D D M M Y	Y D D	M M Y Y	page)	(Qui		
	EMPLOYER SIGNATURE	SIGNATURI	(Name of Employer), ID No	0	, declare th	at the above in	, declare that the above information is true and correct. I understand that it is an offence to make a false statement.  •••••••••••••••••••••••••••••••••••	rect. I understand th	nat it is an offence to	to make a false st	atement.		
			DESCRIPTIONS			Code		(J) Reason for Non-Contribution ***					
If t	If the employer is not resident in the RSA, or is a tout the duties of the employer in terms of this Act.	esident in the RSA, or	If the employer is not resident in the RSA, or is a body comorate not registered in the RSA, an authorised person must carry out the duties of the employer in terms of this Act.	red in the RSA, an au	thorised person must car	rry 1	Temporary employees (less than 24 hours per month Employees who earn commission only	ess than 24 hours per n	onth		(if available)	otanip ble)	
Rei	muneration means ac	ctual basic salary plu	Remuneration means actual basic salary plus payment in kind (Declare actual gross salary)	al gross salary)		3	No income paid for the payroll period	ayroll period					
Ifp	aid Weekly, convert	t wages to monthly s	If paid Weekly, convert wages to monthly salary (weekly wages X 52/12)										
Tot	tal Hours Worked ie.	. Actual hours work	Total Hours Worked ie. Actual hours worked during the month										
+	plovers may also sur	abmit these details ele	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	the UIF's website at second surname and initials	www.labour.vov.za								
****	nstructive dismissal o	can only be determe	ent by the CCMA; Bargaining-C	ouncil or Labour Cou	ıt								
-					REASON	FOR TERMIN	REASON FOR TERMINATION CODES						
7 10	Retired		o Kesigned 7 Construct	Kesigned Constructive Dismissal***	10	Illness /Medically boarded Refrenched/Staff Reduction	Illness /Medically boarded Retrenched/Staff Reduction	14 Business Closed	Business Closed Death of Domestic Employer	18	Commissioning	Commissioning Parental	
4 4				Insolvency/Liquidation		Transfer to an	Transfer to another Branch		Voluntary Severance Package	7	Falculai Loca	9	
2	Contract Expired	pired		Maternity/Adoption	13	Absconded			ork Time				

Printed by and obtainable from the Government Printer, Bosman Street, Private Bag X85, Pretoria, 0001 Contact Centre Tel: 012-748 6200. eMail: info.egazette@gpw.gov.za Publications: Tel: (012) 748 6053, 748 6061, 748 6065