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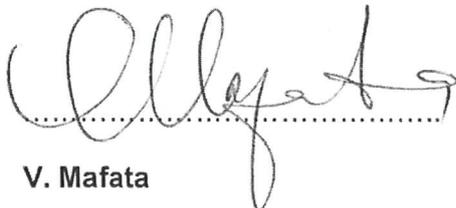
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**GENERAL NOTICES • ALGEMENE KENNISGEWINGS**

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**DEPARTMENT OF EMPLOYMENT AND LABOUR****NOTICE 190 OF 2021****COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993  
(ACT 130 OF 1993 AS AMENDED BY ACT 61 OF 1997)****NOTICE IN TERMS OF SECTION 80 AND 83 OF THE COMPENSATION FOR  
OCCUPATIONAL INJURIES AND DISEASE ACT AS AMENDED.**

In terms of Section 6A (b) of the Compensation for Occupational Injuries and Diseases Act, 1993 (Act 130 of 1993 as amended by Act 61 of 1997) I, Vuyo Mafata, in my capacity as the Compensation Commissioner, and acting in terms of Section 4 (1) (l), hereby publish the CF-1B Application for the Change of the Nature of Business and the CF-2C Application for the Estimation Forms.



**V. Mafata**

**Compensation Commissioner**

**Date:** 06/04/2021



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**CF-1B: COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT 130 OF 1993**

**APPLICATION FOR CHANGE OF NATURE OF BUSINESS**

**Section A – Applicant’s details**

Name of Employer

CF Registration No

UIF Registration No

CIPC Registration No

SARS Tax No

Business Address

City/Town

Province

Code

Employer Telephone No

Mobile Telephone No

Employer’s email address

Consultant’s email address

Consultant’s Telephone No

**Section B – Requirements for the change of nature of business**

*NB: In terms of section 80(3) of COIDA, employers must notify the Commissioner within 7 calendar days of any change in particulars.*

*Any failure to comply with this requirement shall be guilty of an offence. The change in business activities and re-classification of business entity will be effective from the date of receipt of request by the Compensation Fund.*

Date of change of nature of business

Detailed description of the nature of business activities: (if the space is not sufficient, submit on a company’s letter head and signed by the company’s authorised person (with a company’s stamp, if available))

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**Section C – Provide the following documents**

Supporting documents	Please tick		Office use only	
	Yes	No	Yes	No
1. A latest Annual Report/Annual Financial Statement				
2. A proof of business physical address				
3. Pictures of the business operations				

*A failure to fully complete the Form will delay the finalisation of your request*

*I confirm that the information given in this form is true, complete and accurate:*

*Any information submitted may be subjected to verification. Information submitted knowingly is false may result in a legal action by the Compensation Commissioner.*

**NB. If using the service of the Consultant, both the Employer and the Consultant must sign this form**

**Employer Representative/Delegated Official/Employer**

<b>Signature:</b>	
<b>Name and Surname:</b>	
<b>Date:</b>	
<b>Capacity:</b>	

**Consultant**

<b>Signature:</b>	
<b>Name and Surname:</b>	
<b>Date:</b>	
<b>Capacity:</b>	

*for Office Use*

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**CF-2C: COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT 130 OF 1993**  
**APPLICATION FOR THE ESTIMATION**

**Section A – Applicant’s details**

Name of Employer

CF Registration No

Business Address

City/Town

Province

Code

Employer Telephone No

Mobile Telephone No

Employer’s email address

Consultant’s email address

Consultant’s Telephone No

**Section B – Requirements for the Estimation**

*The Name of Employer ..... Contract No.99.....*  
 grant a permission to Compensation Fund to finalise on assessment based on estimation for the following ROE Period:

2020 ROE	<input type="text"/>	(1 March 2020 to 28 February 2021)
2019 ROE	<input type="text"/>	(1 March 2019 to 28 February 2020)
OTHER ROEs	<input type="text"/>	.....

*The employer has a right to apply for the revision of assessment within 180 days of the invoice date. To apply for the revision, the CF-2B Form must be completed and include all required supporting documents.*





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### Section C – Confirmation of Information

*Failure to fully complete the Form will delay the finalisation of your request*

*I confirm that the information given in this form is true, complete and accurate:*

*Any information submitted may be subjected to verification. Information submitted knowingly is false may result in legal action by the Compensation Commissioner.*

*NB. If using the service of the Consultant, both the Employer and the Consultant must sign this form*

#### **Employer Representative/Delegated Official/Employer**

<b>Signature:</b>	
<b>Name and Surname:</b>	
<b>Date:</b>	
<b>Capacity:</b>	

#### **Consultant**

<b>Signature:</b>	
<b>Name and Surname:</b>	
<b>Date:</b>	
<b>Capacity:</b>	

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