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GENERAL NOTICES • ALGEMENE KENNISGEWINGS

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 9 9

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 D D M M Y Y Y Y

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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Employer website (if any)

Is your business registered with any regulatory body? YES NO

If yes, indicate the registration number and the regulatory body's website

List of at least 5 of your clients with their contact details and indicate the goods/services provided to them

List of the key activities of the business

1

2

3

4

5

Please furnish us with at least 8 pictures of the business including the business operation site inside and out.

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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

Signature:	
Name and Surname:	
Date:	
Capacity:	

Consultant

Signature:	
Name and Surname:	
Date:	
Capacity:	

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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 9 9

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 ☐ (1 March 2020 to 28 February 2021)

2019 ROE ☐ (1 March 2019 to 28 February 2020)

OTHER ROEs ☐ .....

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

Signature:	
Name and Surname:	
Date:	
Capacity:	

Consultant

Signature:	
Name and Surname:	
Date:	
Capacity:	

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