

**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  Female

**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

**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: _____ Application refused in terms of: _____ Claims officer (Please Print): _____ Signature: _____ Date: _____	OFFICE STAMP								
1. UI-19 (If Applicable) <input type="checkbox"/>	8. Telephonic Verification Contact Person	<table border="1"> <thead> <tr> <th colspan="2">REMUNERATION/SALARY</th> </tr> <tr> <th>Gross pay (before deductions)</th> <th>Payment frequency (PW or PM)</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> </tr> </tbody> </table>			REMUNERATION/SALARY		Gross pay (before deductions)	Payment frequency (PW or PM)				
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Gross pay (before deductions)	Payment frequency (PW or PM)											
2. Certified Copy of ID <input type="checkbox"/>	Designation:											
3. Payslips <input type="checkbox"/>	Tel. No.:											
4. Proof of banking details - UI-2.8 <input type="checkbox"/>												
5. UI-2.7 (If Applicable) <input type="checkbox"/>												
6. SARS Number: _____												
7. Other (Specify) _____												