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 | 5 | Female | 0

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 ***YES*** ***NO***

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)	
2.	Benefit from Compensation Fund for temporary or total disablement	
3.	Benefits from an Unemployment Fund established by a bargaining or statutory council	
4.	None	

*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:** ________________

FOR OFFICIAL USE ONLY

DOCUMENTS/INFORMATION SUBMITTED			
1.	UI-19 (If Applicable)		8. Telephonic Verification
2.	Certified Copy of ID		Contact Person
3.	Payslips		
4.	Proof of banking details - **UI-2.8**		
5.	**UI-2.7** (If Applicable)		Designation:
6.	SARS Number: ____________________		Tel. No.:
7.	Other (Specify) ____________________		

Signature of Official

REMUNERATION/SALARY	
Gross pay (before deductions)	*Payment frequency (PW or PM)*

Claim approved from: ______________________

Application refused in terms of: ______________________

Claims officer (Please Print): ____

Signature: ________________________________

Date: _______________

OFFICE STAMP