UNEMPLOYMENT INSURANCE ACT 63 OF 2001
APPLICATION FOR CONTINUATION OF PAYMENT FOR ILLNESS BENEFITS IN TERMS OF REGULATION 4(4)

FORM MUST BE COMPLETED ON OR AFTER _____ *ID NO.* _____

1. Surname:
2. Previous surname: *(Only if it changed since your previous application)*
3. First names:
4. Identity number:
5. Telephone number:
6. Postal address:
7. Residential address: *(If different from postal address)* Postal code
8. Date returned to work: _____/_____/_____

9. Kindly state whether you are in **receipt of income from other sources**.
Tick (✓) where 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 any of above is applicable complete the following questions:
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?*
_____

I declare, except as stated in item 8, that I have not worked since the date of my application for illness 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.

_____ _____/_____/_____
Signature of applicant Date

NB: IF YOUR BANKING DETAILS HAVE CHANGED, FORM UI-2.8 MUST BE COMPLETED

MEDICAL CERTIFICATE
(To be completed by an authorised practitioner in terms Section 20(1)(c) of 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 _____

Signature _____ Date _____ Tel No. _____

Address _____