

UNEMPLOYMENT INSURANCE ACT 63 OF 2001
APPLICATION FOR CONTINUATION OF PAYMENT FOR MATERNITY BENEFITS
IN TERMS OF REGULATION 5(3) AND 5(6)

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)	<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 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 maternity 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

NOTIFICATION OF BIRTH (Regulation 5(6))

I, declare that my baby was born on _____ / the baby was stillborn on _____ / I had a miscarriage on _____

Signature of applicant _____ Date _____

MEDICAL CERTIFICATE - Should only be completed once, after confirmation of birth by a medical practitioner/registered midwife.

I, _____ am a qualified _____
qualifications _____. My practice number is _____.

I confirm that _____ gave birth on _____. \ The baby was stillborn
on _____ \ had a miscarriage on _____.

Signature _____ Date _____ Tel No. _____

Address _____