

**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)                             | <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 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 \_\_\_\_\_