

**UNEMPLOYMENT INSURANCE ACT 63 OF 2001
APPLICATION FOR MATERNITY BENEFITS IN TERMS OF SECTION 25(1) - Read with Regulation 5(1) and 5(4)**

13 Digit Bar-Coded Identity Document/Passport Number

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Date of Birth (dd/mm/yy)

--	--	--	--	--

Gender

Female	0
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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

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BANK TRANSFER

--

OTHER

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PAYPOINT

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Details of previous application

a) Name and ID No under which you applied:

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b) Date of Application: ___/___/___

c) Office of application:

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ARE YOU STILL EMPLOYED YES NO

NB: IF YOU ARE STILL EMPLOYED, FORM UI-2.7 MUST ALSO BE COMPLETED.

DATE OF COMMENCEMENT OF MATERNITY 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 also inform the claims officer as soon as you resume employment 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 a medical practitioner or registered midwife)

I, _____ am a qualified _____.

Qualifications _____. My practice number is _____.

I confirm that _____ is under my treatment and is pregnant. The expected due date of birth is _____.

OR

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

Signature _____ Date _____ Tel No. _____

Address _____

SIGNATURE OF APPLICANT: _____ DATE: _____

FOR OFFICIAL USE ONLY

DOCUMENTS/INFORMATION SUBMITTED	
1. UI-19 (If Applicable)	<input type="checkbox"/>
2. Certified Copy of ID	<input type="checkbox"/>
3. Payslips	<input type="checkbox"/>
4. Proof of banking details - UI-2.8	<input type="checkbox"/>
5. UI-2.7 (If Applicable)	<input type="checkbox"/>
6. SARS Number: _____	Designation: _____
7. Other (Specify) _____	Tel. No.: _____

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