

DEPARTMENT OF LABOUR

NO. 670

14 JULY 2017

UNEMPLOYMENT INSURANCE ACT, 2001 (ACT NO. 63 OF 2001)

**CALL FOR COMMENTS ON THE AMENDMENTS TO THE REGULATIONS
TO THE UNEMPLOYMENT INSURANCE ACT, 2001**

I, Nelisiwe Mildred Oliphant, Minister responsible for Department of Labour, under Section 54 (1) of the Unemployment Insurance Act, 2001 (Act No. 63 of 2001) intend to make amendments to the Regulations to the Unemployment Insurance Act, 2001 as set out in the Schedule.

Interested persons or organisations are hereby invited to submit written comments on the draft regulations within 30 calendar days from the date of publication. Comments shall be forwarded to:

(a) Post to:

The Department of Labour (UIF)

P.O. Box 1851

Pretoria

0001

(b) Hand to:

The Department of Labour (UIF)

Directorate: Legal Services

230 Lillian Ngoyi Street;

Pretoria

0001

Any enquiries in connection with the Notice can be directed to M.C. Phathela at Cornelius.phathela@labour.gov.za, Tel: 012 333 1775 or 012 333 1775; Tom Buys at tom.buys@labour.gov.za; Tel: 012 337 1851

Comments received after the closing date may not be considered.



N. M Oliphant (MP)

MINISTER OF LABOUR

DATE: 01/06/2017

SCHEDULE

General explanatory note

[] Words in bold type in square brackets indicate omissions from the existing regulations

 Words underlined with a solid line indicate insertions in the existing regulations

Definition

1. In this Schedule "the Regulations" means the regulations published by Government Notice No. R. 400 of 28 March 2002 as amended by Government Notice No. R363 of 12 March 2003, Government Notice No. R 536 23 of 2004, Government Notice No.R823 of 10 August 2005, Government Notice No 27946 dated 2 September 2005, Government Notice No. R948 of 5 October 2009, and Government Notice No 36674 dated 19 July 2013

Amendment of regulation 1 of the Regulations

2. Regulation 1 of the Regulations is hereby amended by the insertion after the definition of "official" of the following definition:

"small enterprise" means a small enterprise contemplated in section 1 of the National Small Enterprise Act, 1996 (No. 102 of 1996)."

Substitution of regulation 3 of the Regulations

3. Regulation 3 of the Regulations is hereby substituted for the following regulation:

"Reduced working time benefits in terms section 12(1B) of the Act

3. (1) The income derived from continued employment contemplated in section 12(1B) of the Act plus the amount of benefits calculated may not exceed the benefits that would have been paid if the contributor had become wholly unemployed.

(2) Reduced working time benefits must be calculated based on the remuneration of the contributor."

Amendment of regulation 7 of the Regulations

4. Regulation 7 of the Regulations is hereby amended by the addition of the following sub-regulation:

"(3)(a) The contributor may nominate a beneficiary in terms of section 30(2A) of the Act by submitting the nomination form UI 53 to the Fund immediately on commencement of the employment.

(b) A contributor may change the nomination at any time by submitting a new nomination on form UI 53.

(c) If a contributor did not, before his or her death, in terms of paragraph (a) complete the nomination form at commencement of new employment the Fund must accept as valid a nomination form completed at the previous employer.

Repeal of regulations 10, 11 and 12 of the Regulations

5. Regulations 10, 11 and 12 of the Regulations are hereby repealed.

Amendment of regulation 13 of the Regulations

6. The following regulation is hereby substituted for Regulation 13 of the Regulations:

"Providing information in terms of section 56

(1) An employer must within seven days of the end of the month in which it commences activities as an employer submit a completed declaration, **[UI 18] UI 19** to the Commissioner.

(2) Every employer **[who is required to]** must provide **[information to]** the Commissioner with all information in terms of sections 56(2) or (3) of the Act and must do so by submitting declarations of their employees electronically or by completing [a completed] form UI 19 **[to the Commissioner]**.

(3) Any information submitted to the Commissioner in terms of sub-regulations (1) and (2) must be submitted to the Unemployment Insurance Fund, 230 Lillian Ngoyi Street: ABSA Building, [94 Church Street], Pretoria, 0001 or to Private Bag x 0052, Pretoria, 0001

(4) Domestic and small enterprise employers may declare employees and pay contributions annually provided that, the contributor's services are not terminated in which case the declaration must be done upon termination."

New forms

7.(1) Forms UI 2.1, 2.2, 2.3, 2.4, 2.5, 2.6, 2.7, 3, 4, 5, 6A and 19 are hereby substituted for the evenly numbered forms in the Annexure.

(2) Form UI 53 is hereby inserted in the Regulations.

Short title

8. These regulations are called the Unemployment Insurance Fund Act Regulations Amendment Regulations, 2017.

UI-2.1

UNEMPLOYMENT INSURANCE ACT 63 OF 2001
APPLICATION FOR UNEMPLOYMENT BENEFITS IN TERMS OF SECTION 17(1) – Read with Regulation 3(1)

13 Digit Bar-Coded Identity Document/Passport Number

Date of Birth (dd/mm/yy)

Gender

Male Female

First Names

Surname

Postal Address

Code /Telephone No

Residential Address

Cell No

Occupation

E-Mail Address

Fax number

Education

SPECIAL SCHOOL CERT.

BELOW GRADE 8

GRADE 8-9

GRADE 10 - 11

GRADE 12

ABOVE GRADE 12

Use the UI-2.8 form for Banking Details

Details of previous application

a) Name and ID No under which you applied:

FURTHER REQUIREMENTS

1. Are you registered as a workseeker with a Labour

Centre established by the DOL.

Yes

No

2. Are you capable and available for work?

Yes

No

3. If you are not capable of and available for work, please explain:

Signature of applicant:

FURTHER REQUIREMENTS FOR REDUCED WORK TIME in term of section 12(1B)

1. Are you currently employed

Yes

No

2. Are / Were you on Reduced Work Time:

Yes

No

3. Has your employer completed a UI-2.77

Yes

No

IMPORTANT: READ THIS SECTION BELOW:

I declare that I am/ was unemployed/ I'm working reduced hours
 In the event of my application being successful, the Claims Officer will
 authorise the payment of benefits. I also undertake to inform the Claims
 Officer as soon as I am re-employed or receiving "full/normal pay" and
 understand that failure to do so will constitute fraud.

In the event of an overpayment occurring as a result of this application I
 undertake that I will refund the full amount to the Fund.

I declare that the above information is true and correct.

SIGNATURE OF APPLICANT:

Date: / /

Signature of Official

Claim approved from:

Application refused in terms of:

Claims officer (Please Print):

Signature:

Date:

OFFICE STAMP

Date: / /

COMPLETE**YES****NO**

UI-2.2

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/yyyy

Gender Male Female

First Names Surname

Postal Address

Residential Address

Occupation

E-Mail Address

Code/Tel/Phone No

Cell No

Fax Number

Education

SPECIAL SCHOOL CERT.	GRADE 8-9	GRADE 12
BELOW GRADE 8	GRADE 10-11	ABOVE GRADE 12

Use the UI-2.8 form for Banking Details
 Details of previous application

a) Name and ID No/ passport number under which you applied:

ARE YOU STILL EMPLOYED YES NO

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

IF YOU HAVE RETURNED TO WORK, STATE DATE: ____/____/____

IMPORTANT: READ THIS SECTION BELOW:

In the event of my application being successful, the Claims Officer will authorise the payment of benefits. I also undertake to inform the Claims Officer as soon as I am re-employed and understand that failure to do so will constitute fraud.

In the event of an overpayment occurring as a result of this application I undertake that I will refund the full amount to the Fund.

I declare that the above information is true and correct.

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 Registration number is _____ I confirm that _____

is suffering from _____

This patient was not capable of performing work from _____ to _____

Doctor's Stamp

Signature _____

Date _____

Tel No. _____

Address _____

Where a Proxy was appointed by Doctor or Legal Representative proof will be required

SIGNATURE OF APPLICANT / PROXY	SIGNATURE OF OFFICIAL		Office Stamp
	Claim approved from: _____ Application refused in terms of: _____ Claims officer (Please Print): _____ Signature: _____ Date: _____	COMPLETE YES NO	

UI-2.3

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	Date of Birth (dd/mm/yy)

First Names	Surname	
Postal Address	Code / Telephone No	
Residential Address	Code	Cell No
Occupation	Code	Fax Number
E-Mail Address		

SPECIAL SCHOOL CERT.			
BELOW GRADE 8			
		GRADE 8-9	
		GRADE 10 - 11	
		GRADE 12	
		ABOVE GRADE 12	

a) Name and ID / Passport No under which you applied:

ARE YOU STILL EMPLOYED ☐ YES ☐ NO

NOTE: IF YOU ARE STILL EMPLOYED, FORM UI-2.7 MUST ALSO BE SUBMITTED.

IF YOU HAVE RETURNED TO WORK, STATE DATE: _____

IMPORTANT: READ THIS SECTION BELOW:

In the event of my application being successful, the Claims Officer will authorise the payment of benefits. I also undertake to inform the Claims Officer as soon as I am re-employed and understand that failure to do so will constitute fraud.

In the event of an overpayment occurring as a result of this application I undertake that I will refund the full amount to the Fund.

I declare that the above information is true and correct.

MEDICAL CERTIFICATE (to be completed by a medical practitioner or registered midwife)

I, _____ am a qualified _____ . Qualifications _____

My registration 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 / stillborn / miscarriage on _____

Signature _____ Date _____ Tel No. _____

Address _____

Doctor Stamp _____

SIGNATURE OF APPLICANT _____ Date: _____	SIGNATURE OF OFFICIAL			CLAIM approved from: _____ Application refused in terms of: _____ Claims officer (Please Print): _____ Signature: _____ Date: _____	Office Stamp
	COMPLETE	YES	NO		

UI-2.4

UNEMPLOYMENT INSURANCE ACT 63 OF 2001
APPLICATION FOR ADOPTION BENEFITS IN TERMS OF SECTION 28 Read with Regulation 6(1)

13 Digit Bar-Coded Identity Document / Passport Number

Id no of adopted child

Date of Birth (dd/mm/yy)

Gender Male Female

First name

Surname

Postal Address

Code / Telephone No

Residential Address

Code

Cell No

Occupation

Code

E-Mail Address

Fax Number

Education

GRADE 8-9

GRADE 10 - 11

GRADE 12

ABOVE GRADE 12

SPECIAL SCHOOL CERT.

BELOW GRADE 8

Use the UI-2.8 for Banking Details

Details of previous application

a) Name and ID No / Passport under which you applied:

ARE YOU STILL EMPLOYED YES NO

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

IF YOU HAVE RETURNED TO WORK, STATE DATE: ____ / ____ / ____

IMPORTANT: READ THIS SECTION BELOW:

In the event of my application being successful, the Claims Officer will authorise the payment of benefits. I also undertake to inform the Claims Officer as soon as I am re-employed and understand that failure to do so will constitute fraud. In the event of an overpayment occurring as a result of this application I undertake that I will refund the full amount to the Fund.

I declare that the above information is true and correct.

SIGNATURE OF APPLICANT	SIGNATURE OF OFFICIAL		Office Stamp
	Claims approved from: _____ Application refused in terms of: _____ Claims officer (Please Print): _____ Signature: _____ Date: _____		
Date: _____	COMPLETE	YES	NO

UI-2.5

UNEMPLOYMENT INSURANCE ACT 63 OF 2001
APPLICATION FOR DEPENDANT'S BENEFITS BY SURVIVING SPOUSE OR LIFE PARTNER IN TERMS OF SECTION 30 Read with Regulation 7(1)

A. PARTICULARS OF DECEASED CONTRIBUTOR:

13 Digit Bar-Coded Identity Document / Passport Number

First Names

Last Residential Address

Details of previous application

a) Name and ID/ passport No under which deceased applied:

Date of Birth (dd / mm / yy)

Gender Male Female

Surname

Code

Date of Death

B. PARTICULARS OF SURVIVING SPOUSE OR LIFE PARTNER: (NOTE: In the case of a surviving spouse(s), a marriage certificate or proof of customary marriage, or religious union is required)

13 Digit Bar-Coded Identity Document / Passport Number

First Names

Surname

Date of Birth (dd / mm / yy)

Gender Male Female

Postal Address

Residential Address

Occupation

E-Mail Address

Code

Code

Tel No

Cell No

Use the UI-2.8 form for Banking Details

I declare that I am one of _____ surviving spouses or the only surviving spouse or life partner of the abovementioned deceased contributor, that I was not divorced from him/her and that information given in this document is true and correct.

I understand that it is an offence to make a false statement.

Signature of applicant

Date / /

SIGNATURE OF APPLICANT	SIGNATURE OF OFFICIAL		Office Stamp
	COMPLETE	YES NO	
Date	Claim approved from: _____ Application refused in terms of: _____ Claims officer (Please Print): _____ Signature: _____ Date: _____		

UI-2.6

UNEMPLOYMENT INSURANCE ACT 63 OF 2001
APPLICATION FOR DEPENDANT'S BENEFITS BY PERSONS OTHER THAN SPOUSE OR LIFE PARTNER OF DECEASED IN TERMS OF SECTION 30 READ WITH
REGULATION 7(1) AND 7(2)

A. PARTICULARS OF DECEASED CONTRIBUTOR:

13 Digit Bar-Coded Identity Document/Passport Number

First Names

Date of Birth (dd/mm/yy)

Surname

Gender

Male

Female

Date of Death

Last Residential Address

Code

Details of previous application

a) Name and ID No/ Passport no. under which deceased applied:

B. PARTICULARS OF APPLICANT:

Guardian of a minor child

Independent child

Nominated beneficiary

13 Digit Bar-Coded Identity Document/Passport Number

First Names

Date of Birth (dd/mm/yy)

Surname

Gender

Male

Female

Postal Address

Code

Tel No

Residential Address

Code

Cell No

C. CHILD'S DETAILS:

First Names

Surname

Home Address

Code

D. CHILD'S DETAILS:

First Names

Surname

Home Address

Code

I declare that the information is true and correct. I understand that it is an offence to make a false statement.

SIGNATURE OF APPLICANT

SIGNATURE OF OFFICIAL

Office Stamp

Date

Chain approved from:

Application refused in terms of:

Claims officer (Please Print):

Signature:

Date:

COMPLETE

YES

NO

UI-2.7

UNEMPLOYMENT INSURANCE FUND
REMUNERATION RECEIVED BY THE EMPLOYEE WHILST STILL IN EMPLOYMENT

To: The Claims Officer

Statement in respect of payment made to the undermentioned Contributor who is still in my employment but is unable to work due to Illness; Maternity leave; Adoption of a child or is on Reduced Work Time (RWT)

Full names of contributor: _____

Name of Employer: _____

Employers UIF Reference No.

--	--	--	--	--	--	--	--

 /

ID No of contributor

--	--	--	--	--	--	--	--	--	--	--	--	--	--

(A) In terms of section 12(1)b, 19(1), 24(2) and 27(3) of the abovementioned Act,

I hereby certify that the contributor would receive less than 100% of his/her remuneration as
 from ____/____/____ (full date) due to

Illness Leave	Maternity Leave	Adoption Leave	Reduced working time
---------------	-----------------	----------------	----------------------

Gross remuneration (prior to confinement/RWT) Per Month / Per Week	Periods during which different rates of remuneration were received				Gross remuneration received whilst on leave/RWT (PM/PW)
	From		To		
	From		To		
	From		To		
	From		To		
	From		To		
	From		To		
	From		To		

(B) The contributor is expected to return to work / full time on ____/____/____.

(C) The contributor returned to work on / full time on ____/____/____.

DATE

SIGNATURE OF EMPLOYER OR AUTHORISED AGENT

Contact Details of employer: _____

BUSINESS STAMP

<div style="border: 1px solid black; width: 100px; height: 100px; margin: auto;"></div>

Date Received

Date Received

Date Received _____

Date Received:

VI-19

Employers Declaration of Employees for the month of

Information to be supplied in terms of Section 56(1&3) read with Regulation 13(1&2)

An employer must by the seventh day of each month inform the Commissioner of any changes arising during the previous month regarding the employer's contact details or employees 1580/81/82 or submit same at any branch of the UIF which is closest to the employer. The completed form can also be faxed to any of the following numbers: **Pta** (012) 337-1943/44 or 337-1580/81/82 or **Jhb** (011) 497 3293; **Dbn** (031) 366 2156; **Polokwane** (015) 290 1670; **Mmabatho** (018) 384 2658; **East Ldn** (043) 701 3263; **Biftm** (051) 447 9353; **CT** (021) 441 8024; **Wtb** (013) 656 0233; **PE** (041) 586 1541; **Gmn** (011) 873 2219; **George** (044) 873 2568; **Pmb** (033) 394 5069.

1. EMPLOYER DETAILS

[illegible]

2. EMPLOYEE DETAILS

[illegible]

I, _____, (Name of Employer), ID No _____, declare that the above information is true and correct. I understand that it is an offence to make a false statement.

EMPLOYER SIGNATURE

DESCRIPTIONS		REASON FOR TERMINATION CODES	
**	If the employer is not resident in the RSA, or is a body corporate not registered in the RSA, an authorised person must carry out the duties of the employer in terms of this Act.	2	Deceased
D*	Remuneration means actual basic salary plus payment in kind (Declare actual gross salary)	3	Retired
E*	If paid Weekly, convert wages to monthly salary (weekly wages X 52/12) Total Hours Worked i.e. Actual hours worked during the month	4	Dismissed
Q	Employers may also submit these details electronically from payrolls or on the UIF's website at www.labour.gov.za (Ufiling) Ttd. no (012) 337 1680/1 700	5	Contract Expired
****	Only Applicable for Commercial Employers. For Domestic Employers provide Surname and Initials Can only be determined by CCMA; Bargaining Council or Labour Court	6	Resigned
		7	Constructive Dismissal ****
		8	Insolvency/Liquidation
		9	Maternity/Adoption
		10	Illness /Medically boarded
		11	Retrenched/Start Reduction
		12	Transfer to another Branch
		13	Abandoned
		14	Business Closed
		15	Death of Domestic Employer
		16	Voluntary Severance Package
		17	Reduced Work Time

DEPARTMENT OF LABOUR

(CONFIRM)



Office Stamp

Date:

Dear Sir/Madam

UNEMPLOYMENT INSURANCE ACT 63 OF 2001 (AS AMENDED)
PAYMENTS TO DEPENDANTS/NOMINEE OF DECEASED CONTRIBUTORS
DECEASED NAME:

IDENTITY NUMBER:[illegible]**COMPANY NAME/REFERENCE:**

In order that the application for payment to the dependant/s of the abovenamed deceased contributor may be considered, kindly and without delay, submit the following information/documents to this office.

Details of his/her dependants (Name/Addresses/Relationship and ID no's)

Child/Children's details:

1. Nominee: As per section

N:BWhere there is more than one nominee indicate percentage allocation

Tel. No:

Contact person:

Date:

Company Stamp

Your urgent response will be appreciated.

Yours faithfully

UI 53

CLAIMS OFFICER