### **DEPARTMENT OF LABOUR**

NO. R. 1434 28 DECEMBER 2018

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

### AMENDMENT OF UNEMPLOYMENT INSURANCE ACT REGULATIONS

The Minister of Labour has, in terms of section 54 of the Unemployment Insurance Act, 2001 (Act No. 63 of 2001), and after consultation with the Unemployment Insurance Board, made the regulations in the Schedule that will come into operation on a date of publication of the notice.

M. N. OLIPHANT, MP MINISTER OF LABOUR DATE: /2//2/20/8

### **SCHEDULE**

### Definition

 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. 536 of 23 April 2004, Government Notice No. R. 823 of 10 August 2005, and Government Notice No. R. 948 of 5 October 2009.

### 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 (Act No. 102 of 1996)."

### Insertion of regulation 3 in the Regulations

3. The following regulation is hereby inserted after regulation 2 of the Regulations:

### "Reduced working time benefits in terms of 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) A 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 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 in terms of paragraph (a), complete a nomination form at the 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

Regulations 10, 11 and 12 of the Regulations are hereby repealed.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 19 to the Commissioner.
- (2) Every employer must provide 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 form UI 19.
- (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, 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 Amendment Act Regulations, 2017.

APPLICATION	UNEMPLOYMENT INSURANCE ACT 63 OF 2001 APPLICATION FOR UNEMPLOYMENT BENEFITS IN TERMS OF SECTION 17(1) – Read with Regulation 3(1)	URANCE ACT	r 63 O SECT	F 200	UI-2.1 7(1) - Read with Regulation 3(1)
13 Digit Bar-Coded Identity Document/Passport Number  First Names	Date of Birth (dd/mm/yy)	Gender	Surname	- E	Female
Postal Address		Code	-		Code /Telephone No
Residential Address			-		Cell No
		Code			
Occupation		E-Mail Address			Fax number
F					
SPECIAL SCHOOL CERT.  BELOW GRADE 8 Use the UI-2.8 form for Banking Details Details of previous amilication	GRADE 8-9 GRADE 10 - 11	GRADE 12 ABOVE GRADE 12	12 GRADI	2 12	
a) Name and ID No under which you applied:					
FURTHER REQUIREMENTS	FURTHER REQUIREMENTS FOR REDUCED WORK TIME in term of section [12(18)]	ORK TIME in term	of section		IMPORTANT: READ THIS SECTION BELOW:
1. Are you registered as a workseeker with a Labour	1. Are you currently employed		Yes	No No	I declare that I am/ was unemployed/ I'm working reduced hours In the event of my application being successful, the Claims Officer will
Centre established by the DOL	No 2. Are / Were you on Reduced Work Time:		Yes	No	authorisce 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
	3. Has your employer completed a UL2.7?		Yes	No	understand that failure to do so will constitute fraud.
2. Are you capable and available for work?					in the even of an overpayment occurring as a result of that I will refund the full amount to the Fund.
G 5					I declare that the above information is frue and correct.  SIGNATURE OF APPLICANT:
Signature of applicant:					Date:
Signature of Official				Г	OFFICE STAMP
	Claim approved from: Application refused in terms of:				
Date:/	Claims officer (Please Print):				
COMPLETE YES NO	Signature: Date:				
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APPL	UNEMPLOYMENT IN ICATION FOR ILLNESS BENEFITS IN TERMS	UI-2.2 UPEMPLOYMENT 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	umber Date of Birth (dd/mm/yy)	Gender Male Female Surname
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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:	n applied:	
ARE YOU STILL EMPLOYED <u>YES NO</u> NB: IF YOU ARE STILL EMPLOYED, FORM UI 2.7 MUST ALSO BE COMPLETED.	UST ALSO BE COMPLETED.	IEDICAL CERTIFICATE (To be completed by an authorised practi
IF YOU IIAVE RETURNED TO WORK, STATE DATE:		I.  My Registration number is I confirm that is suffering from
IMPORTANT: READ THIS SECTION BELOW:		This patient was not capable of performing work from
In the event of my application being successful, the Cundertake to inform the Claims Officer as soon as I a constitute fraud.	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 amount to the Fund.	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.	Address
I declare that the above information is true and correct.		
Where a Proxy was appointed by Doctor or Legal Representative proof will be required	gal Representative proof will be required	
SIGNATURE OF APPLICANT / PROXY	SIGNATURE OF OFFICIAL	Chaim approved from:Office Stamp
		Application refused in terns of: Claims officer (Please Print):
		Signature:
Date	COMPLETE YES NO	Date:

APPLIC	UNEMPLOYMENT INSI ATION FOR MATERNITY BENEFITS IN TERM	UNEMPLOYMENT INSURANCE ACT 63 OF 2001 APPLICATION FOR MATERNITY BENEFITS IN TERMS OF SECTION 25(1) - Read with Regulation 5(1) and 5(4)	
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ducation PECIAL SCHOOL CERT, ELOW GRADE 8	GRADE 8-9 GRADE 10-11	GRADE 12 ABOVE GRADE 12	
se the UI-2.8 form for Banking Details etails of previous application Name and 1D / Passport No under which you applied:			
RE YOU STILL EMPLOYED YES NO NO STILL EMPLOYED, FORM U42.7 MUST ALSO BE COMPLETED. YOU HAVE RETURNED TO WORK, STATE DATE:	D BE COMPLETED.	MEDICAL CERTIFICATE (to be completed by a medical practitioner or registered midwife)  1. Any registration number is I confirm	
MPORTANT: READ THIS SECTION BELOW: 1 the event of my application being successful, the Cla	MPORTANT: READ THIS SECTION BELOW:  1 the event of my application being successful, the Claims Officer will authorise the payment of benefits. I also ndertake to inform the Claims Officer as soon as I am re-employed and understand that failure to do so will	that is under my treatment and is pregnant. The expected due date of birth is OR	
onstitute fraud. 1 the event of an overpayment occurring as a result o mount to the Fund.	onstitute fraud. 1 the event of an overpayment occurring as a result of this application I undertake that I will refund the full mount to the Fund.	gave birth / stillborn	
declare that the above information is true and correct.		Address.	7
SIGNATURE OF APPLICANT	SIGNATURE OF OFFICIAL	Clains approved from:  Application refused in terms of:  Claims officer (Please Print):	1
ite	COMPLETE YES NO	Signature: Date:	

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

Gender Female		Code /Telephone No	C sil No	Cen vo	Fax Number							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			Office Stamp			
Id no of adopted child  Date of Birth (dd/mm/yy)	Surname	Code		Code	E-Mail Address		GRADE 12 ABOVE GRADE 12					nt of benefits. I also undertake to inform the Claims Officer as soon as I	will refund the full amount to the Fund.		Claim approved from:	Application refused in terms of: Claims officer (Phese Print)	Séranture	YES NO Date:
13 Digit Bar-Coded Identity Document/Passport Number Id no of a							GRADE 8-9 GRADE 10 - 11	on vr under which you applied:	IF YOU ARE STILL EMPLOYED. FORM UI-2.7 MUST ALSO BE COMPLETED	VORK. STATE DATE:	SECTION BELOW:	veing successful, the Claims Officer will authorise the paymen	the event of an overpayment occurring as a result of this application I undertake that I will refund the full amount to the Fund.	tion is true and correct.	APPLICANT SIGNATURE OF OFFICIAL			COMPLETE
13 Digit Bar-Coded Identity	First name	Postal Address	Residential Address		Occupation	Education	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  NB: IF YOU ARE STILL EN	IF YOU HAVE RETURNED TO WORK, STATE DATE.	IMPORTANT: READ THIS SECTION BELOW:	In the event of my application b	the event of an overpayment o	I declare that the above information is true and correct.	SIGNATURE OF APPLICANT			Date

				UI-2.
APPLICATION FOR DE	UNEMPLOYMEN' PENDANT'S BENEFITS BY SURVIVING SP	UNEMPLOYMENT INSURANCE ACT 63 OF 2001 BY SURVIVING SPOUSE OR LIFE PARTNER IN 1	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	er Date of Birth (dd/mm/yy)	Gender	Fornolo	
First Names	Surname	200.07	Date of Death	
Last Residential Address		Code		
Details of previous application  a) Name and ID/ passport No under which deceased applied;	11			
	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 recuired)	narriage certificate or proof of	customary marriace, or religious union is recuired)	
13 Digit Bar-Coded Identity Document /Passport Number	unber Date of Birth (dd/mm/yy)	Gender		
First Names	Surname	Male	Female	
Brakel Address			MA F	
rostal Address		Code	OC 190	
Residential Address		Code	Cell No	
Occupation	E-Ma	E-Mail Address		
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 t 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.	surviving spouses or the only surver and that information given in thimake a false statement.	iving spouse or lift is document is true	surviving spouses or the only surviving spouse or life partner of the abovementioned deceased contributor, r and that information given in this document is true and correct. make a false statement.	
Signature of applicant	Date / /			
SIGNATURE OF APPLICANT	SIGNATURE OF OFFICIAL	AL.	Chim approved from: Application refused in terms of: Claims office Stamp	
			Commence	
Date	COMPLETE	YES NO	Date:	
				gas.

UI-2.6 UNEMPLOYMENT INSURANCE ACT 63 0F 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) Office Stamp Date of Death Cell No Tel No Application refused in terms of: Claims officer (Please Print): Female Fernale Claim approved from: Nominated beneficiary Signature: Date: Code Code Code Code 2 Male Male Gender Gender YES I declare that the information is true and correct. I understand that it is an offence to make a false statement. SIGNATURE OF OFFICIAL Date of Birth (dd/mm/yw) Date of Birth (dd/mm/yy) Independent child Surname COMPLETE Guardian of a minor child a) Name and ID No/ Passport no. under which deceased applied: 13 Digit Bor-Coded Identity Document (Passport Number 13 Digit Bar-Coded Identity Document/Passport Number A. PARTICULARS OF DECEASED CONTRIBUTOR: SIGNATURE OF APPLICANT B. PARTICULARS OF APPLICANT: Details of previous application D. CHILD'S DETAILS: First Names Last Residential Address C. CHILD'S DETAILS: Residential Address Postal Address Home Address Home Address First Names First Names First Names Date

U1-2.7

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

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Name of Employer: _						_				
Employers UIF Refere	ence No.							/		
ID No of contributor									T	
I hereby certify	that the	b, 19(1), 24(2) a contributor wou (full date) o ternity Leave	ld receiv		nan 1009		nis/her re	muneration		
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ILLNESS BENEFITS IN TERMS OF SECTION 22														
ID NO/PASSPORT.														
1. Summany														
1. Surname:														
2. Previous surname: (Only if it changed since your previous application)														
3. First names;														
4. Telephone number:														
IN THE EVENT OF A CHANGE OF ADDRESS INDICATE YOUR NEW DETAILS														
5. Postal address:														
Residential address: (If different from postal address)     Postal code  7. Date returned to work: / /														
7. Date returned to work://  I declare, except as stated in item 7, that I have not worked since the date of my application for illness benefits and have not been entitled to my														
I declare, except as stated in item 7, 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.  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.  Signature of applicant /Proxy  Date  NB: IF YOUR BANKING DETAILS HAVE CHANGED, FORM UI-2.8 MUST BE COMPLETED  Where the forms are signed by a Proxy attach proof of appointment.														
NB! > THIS FORM MUST BE SUBMITTED TO YOUR NEAREST DEPARTMENT OF LABOUR OFFICE. > NO POST DATED FORMS WILL BE ACCEPTED OR PROCESSED.														
> IN THE EVENT OF YOU RESUMING EMPLOYMENT YOU ARE REQUIRED TO INFORM THE DEPARTMENT OF LABOUR OFFI IMMEDIATELY AND TO REQUEST THE NEW/CURRENT EMPLOYER TO SUBMIT A DECLARATION (UI-19).														
MEDICAL CERTIFICATE  (To be completed by an authorized practitioner in terms Section 20(1)(c) of Act 63 of 2003														
I, am a qualified														
qualifications My registration number is														
I confirm that is suffering from														
This patient was not capable of performing work from														
Address Date Terror														
Date Received														

UI-4

## **UNEMPLOYMENT INSURANCE ACT 63 OF 2001** APPLICATION FOR CONTINUATION OF PAYMENT FOR MATERNITY BENEFITS IN TERMS OF SECTION 26 ID NO/ Passport. Surname Previous surname: (Only if it changed since your previous application) First names: 4. Telephone number. IN THE EVENT OF A CHANGE OF ADDRESS INDICATE YOUR NEW DETAILS Postal address: 5. Residential address: (If different from postal address, Postal code Date returned to work: 8. DECLARATION: I declare, except as stated in item 7, 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 U1-2.7 submitted with my application 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. 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. Date Signature of applicant NB: IF YOUR BANKING DETAILS HAVE CHANGED, FORM UI-2.8 MUST BE COMPLETED THIS FORM MUST BE SUBMITTED TO YOUR NEAREST DEPARTMENT OF LABOUR OFFICE. NB! NO POST DATED FORMS WILL BE ACCEPTED OR PROCESSED. IN THE EVENT OF YOU RESUMING EMPLOYMENT YOU ARE REQUIRED TO INFORM THE DEPARTMENT OF LABOUR OFFICES IMMEDIATELY AND TO REQUEST THE NEW/CURRENT EMPLOYER TO SUBMIT A DECLARATION (UI-19).

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he expected due date of birth is	
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# UNEMPLOYMENT INSURANCE ACT 63 OF 2001 APPLICATION FOR CONTINUATION OF PAYMENT FOR ADOPTION BENEFITS IN TERMS OF REGULATION 6(3)

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# **UNEMPLOYMENT INSURANCE ACT 63 OF 2001**

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	ontact detail id at (012) 3 ers: Pta (017 (021) 441 8				1.11 Authorised person**	Reason for Termination (Use Termination Codes as supplied at the bottom of the				true and c		s per month)		
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	ation 13(1&2)  previous month reform to the Unemp also be faxed to an (043) 701 3263; B	Reference No (If re	Physical Address	Postal address Co. Reg.No (CIPRO No)	No	F Commencement date of Employment	M M Y Y			, declare that th		Code 1 Tempo 2 No imc	14 Business Closed	15 Death of 16 Voluntary
INSURANCE ACT 63 OF 2001 eclaration of Employees for the month of	in terms of Section 56(1&3) read with Regulation 13(1&2) e Commissioner with all the information for the previous mon on of service. The employer must forward this form to the Un osest to the employer. The completed form can also be faxed to 1670; Mmabatho (018) 384 2658; East Ldn (043) 701 326 ge (044) 873 2568; Pmb (033) 394 5069.	1.2 PAYE		1.6 Postal address 1.7 Co. Reg.No (C	1.10 Phone No	E* Total Com Hours Worked during	Q Q					ust carry (Ufiling)	REASON FOR TERMINATION CODES  10 Illness Medically hoarded	miness fracturents of the state
INSURANCE ACT 63 OF 2001 sclaration of Employees for the mon	f Section 56(1&3) in the interpretation of the control of the cont			ress in 1.4)		D* Total (Gross) Remuneration paid to Employee Per Month	R			ID No		an authorised person ir Aci e at <u>www.labour.sox.za</u> d Initiaks	REASON FOR TER	
	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 provide the Commissioner with all the information for the previous month regarding the employer's contact details or employees remuneration details including new appointments and termination of service. The employer must forward this form to the Unemployment Insurance Fund at (012) 337-1943/44 or 337-1580/81/82 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) 309 5142/5286;  Jhb (011) 497 3293; Dbn (031) 366 2156; Polokwane (015) 290 1670; Mmabatho (018) 384 2658; East Ldn (043) 701 3263; Biftn (051) 447 9353; CT (021) 441 8024; Wtb			Address where employees listed in Item 2 work (if different to the address in 1.4)	1.9 Fax No	C ID Number (13 Digit bar-coded RSA ID No)				(Name of Employer), ID No	oc statement.	DESCRIPTIONS  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.  Remuneration means remuneration as specified by the Unemployment Insurance Contributions Act if paid Weekly, convert remuneration in anothly salary (weekly remuneration X 52/12)  Total Hours Worked le. Actual bours worked during the month Employers may also submit these details electronically from payrolls or on the ULF's website at <a href="https://www.labour.gnx.zatufiling">www.labour.gnx.zatufiling</a> )  Tel. no fully 33.7 1660/1700  Only Applicable for Commercial Employers. For Domestie Employers provide Surname and Initials  Can only be determined by CCMA: Bargaining Council or Labour Court	Recioned	Constructive Dismissal **** Insolvency/Liquidation Maternity/Adoption
UNEMPLOYMENT Employers L	information (seventh day of each moding new appointments ne at any branch of the U (031) 366 2156; Polok ENTAIT of	ence No	siness	oyees listed in Item 2 w	AIIS					I, (Name of I	URE	DESCRIPTIO  If the employer is not resident in the RSA, or is a budy corporate not regists out the duties of the employer in terms of this Act.  Renumeration means remuneration as specified by the Unemployment Insuranc Total Meekly, convert remuneration to monothly salary (weekly renumerat) Total Hours Worked it. Actual hours worked during the month Employers may also submit these details electronically from payrolls or on 1 Tel. no (01) 33-31 (600)(1700  Tel. no (01) 33-31 (600)(1770  Can only Applicable for Commercial Employers. For Domestic Employers prov Can only be determined by CCMAs. Bargaining Council or Labour Court	9	7 7 8 8 8 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9
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### DEPARTMENT OF LABOUR

# (CONFIRM)



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Yours faithfully												

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**CLAIMS OFFICER**