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**GENERAL NOTICES • ALGEMENE KENNISGEWINGS**

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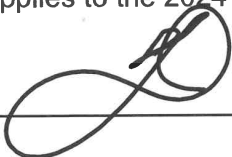
**DEPARTMENT OF EMPLOYMENT AND LABOUR****NOTICE 3060 OF 2025****COMPENSATION FOR OCCUPATIONAL INJURIES AND  
DISEASES ACT, 1993 (ACT NO 130 OF 1993)****NOTICE FOR CONFIRMATION OF EMPLOYERS REGISTRATION DETAILS  
FORMS**

I, Farzana Fakir, Acting Compensation Commissioner, hereby issue this notice in terms of section 6A of COID Act. All employers must complete and submit the Confirmation of Employer Registration Details Form when filing their 2024 Return of Earnings (ROE), to assist the Compensation Fund in cleansing and updating employer records.

This applies to all employers, including but not limited to companies, NPOs, trusts, body corporates, partnerships, joint ventures, public entities, sole proprietors, and domestic worker employers. Employers using consultants or third parties must also provide both the employer's and consultant's contact details, plus a signed consultant mandate.

Non-submission, incomplete forms, or false information may result in processing delays, incorrect assessments, penalties, or legal action.

This notice applies to the 2024 ROE cycle and remains effective until withdrawn.



FARZANA FAKIR  
ACTING COMPENSATION COMMISSIONER  
DATE

2025/03/12

## Confirmation of Employer Registration Details Form

### COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993 (Act 130 of 1993)

(To be completed in BLOCK CAPITALS using black ink only – No erasures, whiteouts, or photocopies allowed)

Please use black ink only make no erasures, whiteouts, photocopies

#### Section A: Employer Information (All Employer Types)

(please complete in Block Capitals)

##### 1. Employer Type (Select one and complete the relevant fields)

- |  |   |
|--|---|
| <input type="checkbox"/> Company (Pty Ltd, Ltd)        | <input type="checkbox"/> Trust                                      |
| <input type="checkbox"/> Individual (Sole Proprietor)  | <input type="checkbox"/> Joint Venture                              |
| <input type="checkbox"/> Partnership                   | <input type="checkbox"/> Body Corporate                             |
| <input type="checkbox"/> Non-Profit Organisation (NPO) | <input type="checkbox"/> Public Entity (Municipality, School, etc.) |
| <input type="checkbox"/> Domestic Worker Employer      |   |
| Other (Specify):                                       |   |

##### 2. Employer Identification Details (All Employer Types)

Employer Name (Legal Entity or Personal Name):

Trading Name (if applicable):

CF Registration Number:

CIPC/NPO/Trust/Sectional Title/JV Agreement Number (if applicable):

UIF Registration Number:

SARS Tax Number (where applicable):

Professional Body (if applicable):

Membership Number:

##### 3. Contact Information (All Employer Types)

Business Telephone Number:

Mobile Number:

Employer Email Address:

##### 4. Physical Address (All Employer Types)

Street Address:

City/Town:

Province:

Postal Code:

##### 5. Postal Address (if different from physical address)

• Postal Address:

• City/Town:

Province:

Postal Code:

##### 6. Representative Details (Person Completing the Form)

Name & Surname:

Designation/Capacity:

Contact Number:

Email Address:



**employment & labour**

Department:  
Employment and Labour  
REPUBLIC OF SOUTH AFRICA



## 7. Third-Party/Consultant Details (if applicable)

Consultant/Third-Party Name:

Company Name:  Contact Number:

Email Address:

Relationship to Employer:

Signed Mandate Attached: ☐ Yes ☐ No (If no, employer must submit before processing)

## Section B: Nature of Business

(please complete in Block Capitals)

Sub-Class Code:

Detailed Nature of Business:

Date First Employee Employed:  Y  Y  Y  Y  M  M  D  D Total Number of Employees (current year):

## Section C: Supporting Documents Checklist (All Employer Types)

(please complete in Block Capitals)

Document Required	Applies To	Submitted (Yes/No)	
CIPC/NPO/Trust Deed/Partnership Agreement/Joint Venture Agreement/Body Corporate Certificate	Companies, NPOs, Trusts, Partnerships, Joint Ventures, Body Corporates	<input type="checkbox"/> Yes	<input type="checkbox"/> No
ID Copies of Directors/Partners/Trustees/Members	Companies, NPOs, Trusts, Partnerships, Joint Ventures, Body Corporates	<input type="checkbox"/> Yes	<input type="checkbox"/> No
ID Copy of Employer (for Domestic Worker Employers)	Domestic Worker Employers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
ID Copy of Employee (for Domestic Worker Employers)	Domestic Worker Employers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Proof of Business Address	All Employer Types	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Photos of Business Operations (Minimum of 4)	All Employer Types except Domestic Workers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Professional Body Membership Certificate (if applicable)	Regulated Professions	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Valid Tax PIN	Companies and Trusts (where applicable)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Consultant Mandate	If Consultant Used	<input type="checkbox"/> Yes	<input type="checkbox"/> No

## Section D – Declaration

(please complete in Block Capitals)

I, the undersigned, hereby declare that:

- All information provided in this form is true, accurate, and complete.
- I understand that any misrepresentation, omission, or falsification of information may result in legal action by the Compensation Commissioner.
- I consent to the Compensation Fund processing my personal information in line with COIDA and POPIA requirements.

## Employer Representative/Delegated Official/Employer

Signature:

Name and Surname:

Date:  Y  Y  Y  Y  M  M  D  D Capacity:

## Consultant/Third Party

Signature:

Name and Surname:

Date:  Y  Y  Y  Y  M  M  D  D Capacity: