**2021**

**CF-2A FORM: COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT 130 OF 1993**

**RETURN OF EARNINGS**

**Section A – Employer’s details**

Name of Employer

CF Registration No

9

9

UIF Registration No

CIPC Registration No

SARS Tax No

Business Address

City/Town

Province

Postal Address

Code

Employer Telephone No

Mobile Telephone No

Employer’s email address

Consultant’s email address

Consultant’s Telephone No

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **SECTION B: Declaration of Earnings** | | | | | | **CF Registration number:99** | | | |
|  | |
| ***Actual Earnings:01/03/2021 - 28/02/2022*** | | | | | | ***Provisional Earnings:01/03/2022- 28/02/2023*** | | | |
| ***Month*** | *Number of* ***employees*** *and amount of earnings* ***(staff costs/salaries & wages)*** *per month paid to all employees (excluding directors of a Company or members of a close corporation) up to a* ***maximum*** *of* ***R 506 473*** *per person for the above period.* | | | *Number of* ***directors/members*** *and amount of earnings* ***(staff costs/salaries & wages)*** *per month paid to directors of a Company or members of a Close Corporation up to a* ***maximum*** *of* ***R 506 473*** *per person for the above period.* | | *Number of* ***employees*** *and amount of earnings* ***(staff costs/salaries & wages****) per month expected to be paid to all employees (excluding directors of a Company or members of a close corporation) up to a* ***maximum*** *of* ***R 529 264*** *per person for the above period.* | | *Number of* ***directors/members*** *and amount of earnings* ***(staff costs/salaries & wages)*** *per month expected to be paid to directors of a Company or members of a Close Corporation up to a* ***maximum*** *of* ***R 529 264*** *per person for the above period.* | |
| ***Number of employees*** | | ***Earnings - (Rands only)*** | ***Number*** | ***Earnings - (Rands only)*** | ***Number of employees*** | ***Earnings - (Rands only)*** | ***Number of employees*** | ***Earnings - (Rands only)*** |
| ***Mar*** |  | |  |  |  |  |  |  |  |
| ***Apr*** |  | |  |  |  |  |  |  |  |
| ***May*** |  | |  |  |  |  |  |  |  |
| ***Jun*** |  | |  |  |  |  |  |  |  |
| ***Jul*** |  | |  |  |  |  |  |  |  |
| ***Aug*** |  | |  |  |  |  |  |  |  |
| ***Sep*** |  | |  |  |  |  |  |  |  |
| ***Oct*** |  | |  |  |  |  |  |  |  |
| ***Nov*** |  | |  |  |  |  |  |  |  |
| ***Dec*** |  | |  |  |  |  |  |  |  |
| ***Jan*** |  | |  |  |  |  |  |  |  |
| ***Feb*** |  | |  |  |  |  |  |  |  |
| ***Total*** |  | |  |  |  |  |  |  |  |
|  |  | |  | ***FINAL EARNINGS PAID*** | | ***ESTIMATED EARNINGS*** | |  | |
| ***Total earnings of both employees and Directors/Members:*** | | | |  | |  | |  | |
| ***Total cash value of free food and/ or quarters. (if applicable) in Rands.*** | | | |  | |  | |  | |
|  | |
| ***GRAND TOTAL OF EARNINGS*** | | | |  | |  | |  | |
| ***State in words the grand total of earnings:*** | | | | | | ***State in words the grand total of earnings:*** | | | |
|  | | | | | |  | | | |
|  | | | | | |  | | | |
|  | | | | | |  | | | |
| **SECTION C: Declaration of Oath** | | | | | | **CF Registration number:99** | | | |
| *I confirm that the information given in this form is true, complete and accurate:*  *Any information submitted may be subjected to verification. Information submitted knowingly is false may result in a legal action by the Compensation Commissioner.*  *If an error is detected after submitting your return of earnings, you have 60 days from the date assessed to apply for the revision of assessment. The request must be forwarded to* [*cfcallcentre@labour.gov.za*](mailto:cfcallcentre@labour.gov.za) *or call 0860 105 350 for assistance.* | | | | | | | | | |
| ***Declaration by the Employer:*** | | | | | | | | | |
| **Name & Surname:** | | | | | | | | | |
| **Designation/Capacity:** | | | | | | | | | |
| **Signature:** | | | | | | | | | |
| **Date:** | | | | | | | | | |
| **Telephone No:** | | | | | | | | | |
| **e-mail address:** | | | | | | | | | |
| ***Declaration by the Consultant*** | | | | | | | | | |
| ***OR If using a service of a consultant (attach a Power of Attorney and complete)*** | | | | | | | | | |
| **Name & Surname:** | | | | | | | | | |
| **Consultant’s Company Name** | | | | | | | | | |
| **Signature:** | | | | | | | | | |
| **Date:** | | | | | | | | | |
| **Telephone No:** | | | | | | | | | |
| **e-mail address:** | | | | | | | | | |
| **Registered Professional Body & Practise No.** | | | | | | | | | |

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| ***For* Office Use Only** |