



CF-1B: COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT 130 OF 1993

APPLICATION FOR CHANGE OF NATURE OF BUSINESS

Section A – Applicant's details		
Name of Employer		
CF Registration No	99	
UIF Registration No		
CIPC Registration No		
SARS Tax No		
Business Address		
City/Town		
Province		
Code		
Employer Telephone N	\circ	
Mobile Telephone No		
Employer's email addre	255	
Consultant's email add	ress	
Consultant's Telephone		
Section B – Require	ements for the change of nature of business	

NB: In terms of section 80(3) of COIDA, employers must notify the Commissioner within 7 calendar days of any change in particulars.

Any failure to comply with this requirement shall be guilty of an offence. The change in business activities and reclassification of business entity will be effective from the date of receipt of request by the Compensation Fund.

Detailed description of the nature of business activities: (if the space is not sufficient, submit on a company's letter head and signed by the company's authorised person (with a company's stamp, if available)

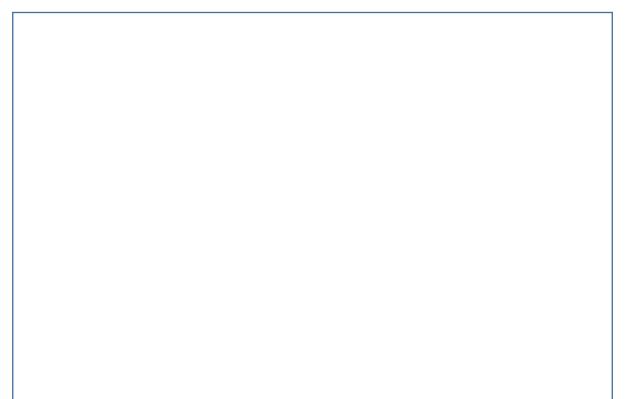






Employer website (if any)			
Is your business registered with any regulate	ory body?	YES	NO
If yes, indicate the registration number and			
the regulatory body's website			

List of at least 5 of your clients with their contact details and indicate the goods/services provided to them



List of the key activities of the business

1			
2			
3			
4			
5			

Please furnish us with at least 8 pictures of the business including the business operation site inside and out.







Section C – Provide the following documents

	Pleas	Please tick Office use on		se only
Supporting documents	Yes	No	Yes	No
1. A latest Annual Report/Annual Financial Statement				
2. A proof of business physical address				
3. Pictures of the business operations				

A failure to fully complete the Form will delay the finalisation of your request

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.

NB. If using the service of the Consultant, both the Employer and the Consultant must sign this form

Employer Representative/Delegated Official/Employer

Signature:	
Name and Surname:	
Date:	
Capacity:	

Consultant

Signature:	
Name and Surname:	
Date:	
Capacity:	

for Office Use

