## UNEMPLOYMENT INSURANCE ACT 63 OF 2001 AS AMENDED APPLICATION FOR PAYMENT OF ILLNESS BENEFITS IN TERMS OF SECTION 22

Identity Document	
1. Surname:	
2. Previous surname: (Out): if it channed show the subminion of	
2. Previous surname: (Only if it changed since the submission of your current application)	
3. First names:	
4. Contact number:	
IN THE EVENT OF A CHANGE OF ADDRESS INDICATE YOUR NEW DETAILS	
5. Postal address:	
6. Residential address: (If different from postal address)	Postal code
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 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 for payment 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 EMPLOYMENT AND 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 EMPLOYMENT AND LABOUR OFFICES IMMEDIATELY AND TO REQUEST THE NEW/CURRENT EMPLOYER TO SUBMIT A DECLARATION (UI- 19).	
MEDICAL CERTIFICATE (To be completed by a registered medical practitioner.)	
I,am a qualified _	
qualifications My registration number is	s
I confirm that is suffer	ing from
This patient was not capable of performing work from	to
Signature: Date:	Tel No.
Address	
Date Received	Medical Practice Stamp (if available)