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This notice applies to the 2024 ROE cycle and remains effective until withdrawn.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

This gazette is also available free online at **www.gpwonline.co.za**

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)

- ☐ Company (Pty Ltd, Ltd)
- ☐ Individual (Sole Proprietor)
- ☐ Partnership
- ☐ Non-Profit Organisation (NPO)
- ☐ Domestic Worker Employer
- ☐ Trust
- ☐ Joint Venture
- ☐ Body Corporate
- ☐ Public Entity (Municipality, School, etc.)

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

Compensation Fund
WORKING FOR YOU

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*	Yes No
ID Copies of Directors/Partners/Trustees/Members	*Companies, NPOs, Trusts, Partnerships, Joint Ventures, Body Corporates*	Yes No
ID Copy of Employer (for Domestic Worker Employers)	*Domestic Worker Employers*	Yes No
ID Copy of Employee (for Domestic Worker Employers)	*Domestic Worker Employers*	Yes No
Proof of Business Address	*All Employer Types*	Yes No
Photos of Business Operations (Minimum of 4)	*All Employer Types except Domestic Workers*	Yes No
Professional Body Membership Certificate (if applicable)	*Regulated Professions*	Yes No
Valid Tax PIN	*Companies and Trusts (where applicable)*	Yes No
Consultant Mandate	*If Consultant Used*	Yes 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:***

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