labour
Department:
Labour
REPUBLIC OF SOUTH AFRICA

UI-2.3

UNEMPLOYMENT INSURANCE ACT 63 OF 2001
APPLICATION FOR MATERNITY BENEFITS IN TERMS OF SECTION 25(1) - Read with Regulation 5(1) and 5(4)

UIF WORKING FOR YOU

13 Digit Bar-Coded Identity Document/Passport Number

Date of Birth (dd/mm/yy)

Gender Female *0*

First Names

Surname

Postal Address **Code**

Code /Telephone No

Residential Address **Code**

Cell No

Occupation

Occ. Code

E-Mail Address

Fax Number

Method of Payment

Use the UI-2.8 form for Banking Details

CHEQUE | *BANK TRANSFER* | *OTHER* | **PAYPOINT**

Details of previous application

a) *Name and ID No under which you applied:*

b) *Date of Application:* ___/___/____

c) Office of application:

ARE YOU STILL EMPLOYED *YES* *NO*

NB: IF YOU ARE STILL EMPLOYED, FORM UI-2.7 MUST ALSO BE COMPLETED.

DATE OF COMMENCEMENT OF MATERNITY LEAVE: ___/___/____

IF YOU HAVE RETURNED TO WORK, STATE DATE: ___/___/____

IMPORTANT: READ THIS SECTION BELOW:

If your application is successful the claims officer will authorise the payment of benefits. You must also inform the claims officer as soon as you resume employment I declare that the above information is true and correct. I understand that it is an offence to make a false statement.

SOURCES OF OTHER INCOME (mark X were applicable)

1.	Monthly Pension from State (Excluding Disability grant)	
2.	Benefit from Compensation Fund for temporary or total disablement	
3.	Benefits from an Unemployment Fund established by a bargaining or statutory council	
4.	NONE	

If applicable mark X on 1-4:

When did you begin to receive this income? _____

Do you continue to receive this income? _____

If you no longer receive this income when did it come to an end? _____

MEDICAL CERTIFICATE (to be completed by a medical practitioner or registered midwife)

I, _____ am a qualified _____.

Qualifications _____. My practice number is _____..

I confirm that _____ is under my treatment and is pregnant. The expected due date of birth is _____.

OR

I confirm that _____ gave birth on _____. \ The baby was stillborn on _____ \ the patient had a miscarriage on _____..

Signature _____ **Date** _____ **Tel No.** _____

Address _____

SIGNATURE OF APPLICANT: _____ **DATE:** _____

FOR OFFICIAL USE ONLY

DOCUMENTS/INFORMATION SUBMITTED

1.	UI-19 (If Applicable)		
2.	Certified Copy of ID		
3.	Payslips		
4.	Proof of banking details - UI-2.8		
5.	UI-2.7 (If Applicable)		
6.	SARS Number:		
7.	Other (Specify) _____		

8. Telephonic Verification
Contact Person

Designation:

Tel. No.:

Signature of Official

REMUNERATION/SALARY

Gross pay (before deductions)	*Payment Frequency (PW or PM)*

Claim approved from: _____

Application refused in terms of: _____

Claims officer (Please Print): _____

Signature: _____

Date: _____

OFFICE STAMP