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

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)	8.	Telephonic Verification
2.	Certified Copy of ID		Contact Person
3.	Payslips		
4.	Proof of banking details - UI-2.8		
5.	UI-2.7 (If Applicable)		Designation:
6.	SARS Number: _____		Tel. No.:
7.	Other (Specify) _____		

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