

**UNEMPLOYMENT INSURANCE ACT 63 OF 2001  
APPLICATION FOR CONTINUATION OF PAYMENT FOR MATERNITY BENEFITS  
IN TERMS OF REGULATION 5(3) AND 5(6)**

FORM MUST BE COMPLETED ON OR AFTER  ID NO.

1. Surname:

2. Previous surname: *(Only if it changed since your previous application)*

3. First names:

4. Identity number:  5. Telephone number:

6. Postal address:

7. Residential address: *(If different from postal address)*  Postal code

8. Date returned to work: \_\_\_\_/\_\_\_\_/\_\_\_\_

9. Kindly state whether you are in receipt of income from other sources.  
**Tick (✓) where applicable.**

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

*If any of above is applicable complete the following questions:*  
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?  
\_\_\_\_\_

**I declare, except as stated in item 8, that I have not worked since the date of my application for maternity 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.**

\_\_\_\_\_  
Signature of applicant

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

**NB: IF YOUR BANKING DETAILS HAVE CHANGED, FORM UI-2.8 MUST BE COMPLETED**

**NOTIFICATION OF BIRTH (Regulation 5(6))**

I, declare that my baby was born on \_\_\_\_\_ / the baby was stillborn on \_\_\_\_\_ / I had a miscarriage on \_\_\_\_\_

Signature of applicant \_\_\_\_\_ Date \_\_\_\_\_

**MEDICAL CERTIFICATE - Should only be completed once, after confirmation of birth by a medical practitioner/registered midwife.**

I, \_\_\_\_\_ am a qualified \_\_\_\_\_  
qualifications \_\_\_\_\_. My practice number is \_\_\_\_\_.

I confirm that \_\_\_\_\_ gave birth on \_\_\_\_\_ \ The baby was stillborn  
on \_\_\_\_\_ \ had a miscarriage on \_\_\_\_\_.

Signature \_\_\_\_\_ Date \_\_\_\_\_ Tel No. \_\_\_\_\_

Address \_\_\_\_\_