employment & labour
Department:
Employment and Labour
REPUBLIC OF SOUTH AFRICA

Compensation Fund
WORKING FOR YOU

CF-1B: COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT 130 OF 1993

APPLICATION FOR CHANGE OF NATURE OF BUSINESS

Section A – Applicant's details

Name of Employer

CF Registration No 9 9

UIF Registration No

CIPC Registration No

SARS Tax No

Business Address

City/Town

Province

Code

Employer Telephone No

Mobile Telephone No

Employer's email address

Consultant's email address

Consultant's Telephone No

Section B – Requirements for the change of nature of business

NB: In terms of section 80(3) of COIDA, employers must notify the Commissioner within 7 calendar days of any change in particulars.

Any failure to comply with this requirement shall be guilty of an offence. The change in business activities and re-classification of business entity will be effective from the date of receipt of request by the Compensation Fund.

Date of change of nature of business D D M M Y Y Y Y

Detailed description of the nature of business activities: (if the space is not sufficient, submit on a company's letter head and signed by the company's authorised person (with a company's stamp, if available)

Employer website (if any)

Is your business registered with any regulatory body? YES NO

If yes, indicate the registration number and the regulatory body's website

List of at least 5 of your clients with their contact details and indicate the goods/services provided to them

List of the key activities of the business

1

2

3

4

5

Please furnish us with at least 8 pictures of the business including the business operation site inside and out.

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Section C – Provide the following documents

Supporting documents	Please tick		Office use only	
	Yes	No	Yes	No
1. A latest Annual Report/Annual Financial Statement				
2. A proof of business physical address				
3. Pictures of the business operations				

Failure to fully complete the Form will delay the finalisation of your request

I confirm that the information given in this form is true, complete and accurate:

Any information submitted may be subjected to verification. Information submitted knowingly is false may result in a legal action by the Compensation Commissioner.

NB. If using the service of the Consultant, both the Employer and the Consultant must sign this form

Employer Representative/Delegated Official/Employer

Signature:	
Name and Surname:	
Date:	
Capacity:	

Consultant

Signature:	
Name and Surname:	
Date:	
Capacity:	

for Office Use

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