

To be furnished by all employers to: **THE COMPENSATION COMMISSIONER** ⊠ 955, Pretoria, 0001 Compensation House Cnr. Hamilton St. and Soutpansberg Road **2** 0860 105 350 e-mail: cfinf@labour.gov.za website : www.labour.gov.za fax: (012) 323 5023

	REGISTRATION OF EMPLOYER				
Mark	with X where applicable Partnership For office use only				
Sole	Proprietor (farmers included) Public/Local Authorities				
Clos	e Corporation Organisation/Association				
Com	pany Trust NO AA				
	CHECK ACTIVATE				
PART 1 DATE, TRADING NAME AND ADDRESS					
1.1	Date on which first employee was				
1.2	employed: (Item 1.1 must be completed)       YYYY       MM       DD         Trading Name and Postal Address:				
1.2					
	● IMPORTANT ● USE ONLY BLOCK				
	LETTERS TO COMPLETE THIS FORM.				
1.3	Physical address/name(s) of farm(s)				
	Postal Code				
	Magisterial district				
PAR					
2.1					
	Name(s) and Id number(s) of owner(s)/partnership of business: (Copy of Id Document must be attached))				
2.2	2.2 Registered name of Company or Close Corporation				
	Company or Close Corporation Number:				
	Copy of CK1/2 or Company Registration document (CM1 + CM29) must be attached.				
2.3	2.3 If a limited liability company or a close corporation, state names, Id numbers and addresses of directors or members (Attach a list if necessary)				
DAD					
<b>PAR</b> 3.1	T 3 PARTICULARS OF OPERATIONS Describe the nature of goods manufactured / sold or services rendered:				
0.1					
3.2	3.2 Describe the following if applicable:				
	3.2.1 Materials used in the manufacturing of goods:				
	3.2.2 Nature and extent of construction / erection undertaken:				
3.3       In the case of farming, indicate the nature thereof:       Livestock farming       Tillage       Mixed farming: % Livestock       % Tillage         2.4       Devenues and texture and texture actives active					
3.4 Do you use any tractors and/or power – driven saws     Yes     No     FOR OFFICE USE       Tel. No.:     Dialling Code:     No.:     Contact person:					
Fax No.: Dialling Code: No.: Cell.: E-mail Address:					
	ORIGINAL FORM MUST BE POSTED.				
W.As					

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993 [Section 80 – Rules, forms and particulars of the Compensation Commissioner – Annexure 7]

PART 4 RESPONSIBLE PERSON / DIRECTOR / MEMBER OR PARTNER OF BUSINESS					
4.1	Surname: Initials:				
	ID. No.:				
	Residential address: Postal Code:				
4.2					
	-	allocated by: Compensation Commissioner Unemployment Insurance	Unemployment Insurance Commissioner		
	Registrat				
4.3 If the business has changed ownership, furnish the following:					
	4.3.1 Previous trading name of business/farm				
	4.3.2       Name of previous owner         4.3.3       Present residential address of previous owner				
	Postal Code				
	4.3.4 Date of take-over				
PART 5 PARTICULARS OF EMPLOYEES					
5.1	Number of	of employees presently employed			
5.2	Estimated particulars of your employees as from the date furnished in item 1.1 (as indicated on p.1 of this form) up to the end of February the next yea				
5.2.1 Average number of employees expected to be employed during the above-mentioned period					
	RANDS ONLY				
		(For the period 1 March 2007 - 29 February 2008) 5.2.2.1 Total cash earnings of employees	00		
		5.2.2.1       Total cash earnings of employees         5.2.2.2       Total cash value of food and lodging provided free by employer	00		
			00		
		<ul><li>5.2.2.3 Cash value of other in-kind benefits</li><li>5.2.2.4 Earnings (see 5.2.2) of working Directors/members</li></ul>	00		
5.3	Total esti	mated earnings From: to			
PART 6 ADDITIONAL INFORMATION IN RESPECT OF HEAD OFFICE AND/OR FILIALS / BRANCHES					
6.1		ne trading name and postal address of the Head Office and/or filials / branches and if already registered, the reg yment Insurance Fund (UIF) and/or the Compensation Commissioner (CC).	istration number allocated by the		
6.2		IRNISH YOUR BANK DETAILS BY COMPLETING THE SECTION HEREUNDER. THE INFORMATION IS REQUIRED FOR THE PURPOSE	S OF AN ELECTRONIC TRANSFER		
	SYSTEM. DIRECT DEPOSITS PREVENT POSTAL DELAYS AND CHEQUE FRAUD. Bank: Branch Name: Branch Code:				
		Branch Name: Branch Code:			
		Account Holder:			
DECLARATION BY EMPLOYER OR AUTHORISED PERSON					
I certify that the above particulars are correct.					
NAME (PRINTED) SIGNATURE			DESIGNATION		
CONTACT PERSON: TEL NO: () DATE					