



CF 2c: COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT 130 OF 1993 APPLICATION FOR DEREGISTRATION OF EMPLOYER

Section A – Applicant's details		
Name of Employer		
CF Registration No		
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		
Date when the business closed		
Reason for deregistration: (please tick box)must be send proof o	n the below	
Liquidation/Sequestration		
Cease Trading/No employees		
Amalgamation		
Sold/Taken Over		
Deceased		
Section B – Furnish the following documents		
	Please tick Office	e use only







1. Court documents 2. Proof of CIPC deregistration 3. Proof of UIF deregistration 4. Certified copies of Directors/Owner's ID (all) Cease Trading/No employees: 1. Proof of UIF deregistration 2. Proof of CIPC deregistration 3. Certified copies of Directors/Owner's ID (all) 4. Any other proof of deregistration 3. Certified copies of Directors/Owner's ID (all) 4. Any other proof of deregistration Amalgamation: 1. Signed Sales Agreement 2. Proof of CIPC certificate 3. Proof of UIF deregistration 4. Certified copies of Directors/Owner's ID (all) Sold/Take Over: 1. Signed Agreement 2. Proof of CIPC certificate 3. Proof of UIF deregistration 4. Certified copies of Directors/Owner's ID (all) Deceased Owner: 1. Proof of Tipe deregistration 4. Certified copies of Directors/Owner's ID (all) Deceased Owner: 1. Proof of residential address 2. Proof of UIF deregistration 3. Death Certificate	Liquidation/Sequestration:	Yes	No	Yes	No
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Proof of residential address Proof of UIF deregistration	4. Certified copies of Directors/Owner's ID (all)				
2. Proof of UIF deregistration	Deceased Owner:				
	1. Proof of residential address				
3. Death Certificate	2. Proof of UIF deregistration				
	3. Death Certificate				

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.

Signature:	
Name and Surname:	
Date:	
Capacity:	

