Application for a voluntary grant towards rehabilitation measures

Sächsische Ärzteversorgung
Einrichtung der Sächsischen Landesärztekammer
Körperschaft des öffentlichen Rechts

Membership number

Sächsische Ärzteversorgung
Institution of the Sächsische Landesärztekammer
Dr.-Külz-Ring 10
01067 Dresden

Note:
For ease of reading, this form uses the masculine and/or feminine form for personal designations and personal nouns. All such terms are intended in the sense of equal treatment to apply to all genders. The shortened language form is for editorial reasons only and does not imply any judgement.

I hereby apply for a grant towards the costs of a medical rehabilitation measure pursuant to section 36 of the Statutes of the Saxon Medical Pension Scheme.

Notes: In order to decide on your application properly, we require some important information and documents from you in accordance with the Statutes of the Saxon Medical Pension Scheme. We therefore kindly ask you to answer all questions in full and to provide us with the requested documents as soon as possible. Please note that a decision on your application can only be made once all required documents have been received in full.

The mandatory information requested in this form is necessary and required solely to fulfil the statutory remit of the Saxon Medical Pension Scheme. It is collected on the basis of statutory authorisations. Your data will be processed by the Saxon Medical Pension Scheme in compliance with data protection regulations and will only be passed on to external recipients where this is necessary for the administration or processing of your application, where your consent has been obtained, or where another legal basis permits this.

Information about the processing of your personal data and your rights as a data subject is available online. Please refer to the privacy notice published on our website at www.saev.de/en/privacy-policy .

1. Personal details

Surname		First name (preferred name)
Birth surname (if different)	Gender ☐ female ☐ diverse ☐ male	Nationality ☐ German ☐ _____
Date of birth		
Street, House number		
Postcode	City	
Country	Tax Identification Number (**11-digit** tax ID)	
Phone (optional)		Email

2. Requested medical rehabilitation measure

2.1 What type of medical rehabilitation measure are you applying for?

☐ Follow-on treatment (AHB) ☐ inpatient rehabilitation ☐ outpatient rehabilitation

☐ Other:

2.2 During which period will the rehabilitation measure take place?

From _____ to _____ .

2.3 What are the (expected) total costs of the rehabilitation measure for which the grant is being applied for? If the total costs are not yet known to you prior to the rehabilitation measure taking place, it is sufficient to provide the facility's daily flat rate. Please enclose with your application a corresponding cost estimate, offer, or evidence of the facility's daily flat rate.

Total costs: _____ EUR

Daily flat rate: _____ EUR

3. Third-party contributions towards the costs of the planned rehabilitation measure

Note: For the following questions, please provide full details of the payer (including address and reference number) as well as the amount and type of contribution. If a contribution has been refused, please enclose the refusal notices/letters with your application as an attachment.

3.1 Have you submitted a claim for reimbursement to other insurers or payers (e.g. private or statutory health insurance, German pension insurance, employers' liability insurance association, accident insurance, etc.)?

☐ yes ☐ no

If yes, when and with whom?

3.2 Do you have any entitlement for the requested costs to be covered by the German pension insurance?

☐ yes ☐ no

3.3 Do you have any entitlement for the requested costs to be covered by your health insurance?

☐ yes ☐ no

3.4 Is the health condition on which the application is based the result of an accident at work/while commuting, an occupational disease, or another accident?

☐ yes ☐ no

If yes, please state the event that caused the health condition:

4. Bank details for payment of the grant

IBAN		
BIC* (*to be stated for international transfers)		
Account number* (*to be stated for transfers outside the EU)		
Bank		
Account holder	Surname	First name (preferred name)

5. Declaration by the applicant

I confirm that all information provided is true and complete. I also confirm that no other payers (e.g. employers' liability insurance association, German pension insurance, employer subsidy, statutory or private health insurance, accident insurance fund, etc.) are eligible to cover the implementation of the rehabilitation measure applied for.

I will inform you immediately of any changes to the above information in accordance with section 14 of the Statutes of the Saxon Medical Pension Scheme.

I agree that the voluntary information provided above may be processed to facilitate communication in accordance with the data protection rules currently in force.

Consent to use the voluntary information provided may be withdrawn at any time for the future, without giving reasons. The withdrawal may be submitted to the Saxon Medical Pension Scheme by post or email.

Place, date	Signature / printed name of the applicant or authorised representative (with evidence)

6. Checklist of documents to be enclosed

Please enclose the following documents with your application:

- Medical report form for the application for a voluntary grant towards rehabilitation measures (please send the questionnaire to your specialist to complete and then return it to us, signed, together with all required attachments)
- Current medical treatment reports providing evidence of the health condition stated
- If applicable, all refusal notices/letters from other payers
- If applicable, all reimbursements from other payers
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Medical report for the application for a voluntary grant towards rehabilitation measures

Sächsische Ärzteversorgung
Einrichtung der Sächsischen Landesärztekammer
Körperschaft des öffentlichen Rechts

Sächsische Ärzteversorgung Institution of the Sächsische Landesärztekammer Dr.-Külz-Ring 10 01067 Dresden	Membership number **Note:** For ease of reading, this form uses the masculine and/or feminine form for personal designations and personal nouns. All such terms are intended in the sense of equal treatment to apply to all genders. The shortened language form is for editorial reasons only and does not imply any judgement.

Notes: To improve legibility of the medical report, we kindly ask that the report be completed electronically. Any costs for this medical report are to be borne by the applicant.

1. Personal details

Surname	First name (preferred name)
Street, House number	
Postcode	City

2. Information on the necessity and prospects of success of medical rehabilitation measures

2.1 The applicant has been under my care since _____ .

2.2 I last examined the applicant on _____.

2.3 Which diagnoses relevant to the application have currently been established for the applicant? Please list all relevant functional diagnoses, including the ICD code, in order of their medical significance.

2.4 What symptoms and complaints does the applicant suffer from? Please provide details of the medical history relevant to the application and the course of the illness.

2.5 What functional limitations does the applicant currently have?

2.6 To what extent is the applicant currently limited in their ability to practise as a medical doctor or veterinary surgeon?

2.7 Which measures (e.g. outpatient or inpatient treatment, etc.) have so far been carried out to improve the applicant's state of health? Please specify the concrete measures (previous and current treatment) and where/at which facility they were carried out.

2.8 Which medical rehabilitation measures (e.g. follow-on treatment, outpatient or inpatient rehabilitation) are being proposed to restore, substantially improve or maintain the applicant's capacity to practise their profession?

2.9 Is the applicant fit enough to undergo a medical rehabilitation measure?

☐ yes ☐ no

Additional remarks:

3. **Signature**

Place, date	Doctor's signature, stamp, professional title, where applicable including specialist designation