Application for disability Pension in the event of incapacity for work

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 reasons of readability, this form uses the masculine and/or feminine form for personal designations and nouns referring to persons. The corresponding terms are to be understood as applying equally to all genders. The abbreviated language is used for editorial reasons only and does not imply any judgement.

I hereby apply for the granting of the incapacity pension in accordance with §§ 31 and 32 of the statutes of the Sächsische Ärzteversorgung

☐ **for a temporary period from** _____ **to** _____ **.**

☐ **on an indefinite basis from** _____ **.**

Notes: In order to make an informed decision on your application, we require some important information and documents from you pursuant to the statutes of the Sächsische Ärzteversorgung. We therefore ask you to answer the questions in full and to provide the requested documents as soon as possible. Your cooperation, which is expressly provided for in § 37 of the statutes of the Sächsische Ärzteversorgung, helps us to deal with your matter promptly. Please note that if you do not cooperate, we may refuse or withdraw the benefit in whole or in part.

The mandatory information requested in this form is necessary and required solely for the fulfilment of the pension scheme's remit of the Sächsische Ärzteversorgung. It is collected on the basis of statutory authorisations. Your data will be processed by the Sächsische Ärzteversorgung in compliance with data protection regulations and will only be passed on to external recipients where this is necessary for the processing of your application, where your consent has been given, or where another legal basis permits this.

We provide information about the processing of your personal data and your rights as a data subject on the internet. Please refer to the published privacy policy on our website at www.saev.de/en/privacy-policy.

1. Personal details

Surname	First name (preferred name)	
Birth name (if different)	Gender ☐ female ☐ diverse ☐ male	Nationality ☐ German ☐ _____
Date of birth **Please attach a copy of your birth certificate**		
Street, house number		
Postcode	City	
Country	Tax identification number (**11-digit** Tax ID)	
Phone (optional)	Email	

2. Reasons for the application

Note: To enable us to form as comprehensive a picture as possible of your health impairments, you have the opportunity to provide your personal assessment. Please describe your symptoms in detail, state the diagnosed health impairments (if known, please provide the ICD code) and describe how your health impairments affect your ability to practise as a doctor or veterinarian. If the space provided is not sufficient, please use an additional sheet. In addition, please enclose meaningful, current medical documents with your application (e.g. findings, discharge reports or existing expert opinions), in particular relating to diagnosed health impairments and treatment measures carried out.

2.1 Due to which health impairment do you consider yourself incapable of working?

2.2 Since when do you consider yourself incapable of working? Please provide a date and, if applicable, name the triggering event.

Date: _____

Triggering event (if applicable):

2.3 In your opinion, are you still able to carry out medical or veterinary work?

☐ no ☐ yes

If yes, which activities and to what extent (hours)?

3. Medical treatment and assessments

3.1 Who have you consulted for outpatient treatment in relation to the health impairment due to which you feel incapable of working? Please provide the doctor's name, specialty and full address.

3.2 Who have you consulted for inpatient treatment in relation to the health impairment due to which you feel incapable of working? Please provide the name of the hospital/facility, the department, and the full address.

3.3 Have medical assessments (e.g. commissioned by a health insurer, employers' liability insurance association, private insurer or another body) already taken place in relation to your health impairment?

☐ no ☐ yes

If yes, on whose behalf and by whom was the medical assessment carried out? Please provide the name of the organisation that commissioned the assessment, the doctor's name and the full address. Please attach a copy of the assessment report.

4. Claims for damages against third parties

4.1 Are there any claims for damages against third parties arising from the circumstances that triggered the incapacity for work (e.g. a road traffic accident, actions of other persons or other special circumstances)?

☐ no ☐ yes

If yes, please provide the following details:

First name and surname of the liable party:

Address of the liable party:

Insurer of the liable party:

4.2 Have claims for damages already been asserted (e.g. with private insurers)?

☐ no ☐ yes, on _____

If yes, with whom (the third party or their insurer):

5. Cessation of medical or veterinary practice

Notes: The entitlement to an incapacity pension arises in accordance with § 31 paragraph 3 sentence 1 of the statutes of the Sächsische Ärzteversorgung only once the member has demonstrably ceased all medical or veterinary professional activity. In the case of temporary incapacity for work of a self-employed member, the practice may, in accordance with § 31 paragraph 3 sentence 2 of the statutes of the Sächsische Ärzteversorgung, be continued by a representative for the duration of the pension payments, but for no longer than four years.

It is recommended that you wait for the review of the medical documents you have submitted and the results of any assessment carried out by the Sächsische Ärzteversorgung before deregistering your professional activity and closing your practice. If you wish to follow this recommendation, it is sufficient to provide us with the following information as evidence of the cessation of your professional activity only after the Sächsische Ärzteversorgung has confirmed the existence of incapacity for work.

Any resumption of medical or veterinary work during receipt of an incapacity pension must be reported to the Sächsische Ärzteversorgung without delay.

5.1 Since when have you no longer carried out any medical or veterinary work?

From _____ I have not carried out any medical or veterinary work.

☐ I closed my practice on _____ .

☐ My practice is being continued by a representative.

☐ My authorisation to practise as a statutory / contract physician ends on _____ .

☐ The declaration regarding cessation of professional activity will be submitted later.

I will inform you without delay of any changes to the above information in accordance with § 37 of the statutes of the Sächsische Ärzteversorgung.

6. Bank details for payment of benefits

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

7. Other insurance periods

Do you have insurance or residence periods in a foreign social security system within the European Economic Area (EEA) or the United Kingdom of Great Britain and Northern Ireland, or in another domestic pension institution (insurance periods in the statutory pension scheme are not taken into account)?

☐ **yes**, please complete the enclosed additional sheet (Other insurance periods) ☐ **no**

8. Biological and/or adopted children

8.1 Do you have biological and/or adopted children?

☐ **no** ☐ **yes,** please continue with 8.2

8.2 Child details

If you have statutory health insurance, to prove parenthood for the long-term care insurance contribution rate:

For children up to the age of 25: Please enclose copies of the birth certificates of all children or equivalent evidence (see annex: information sheet for children).

For children over the age of 25: Please enclose a copy of one child's birth certificate or equivalent evidence (see annex: information sheet for children).

For the granting of a child supplement:

For children up to the age of 21: Please enclose a copy/copies of the birth certificate(s) as evidence.

For children aged between 21 and 27 who are in education/training or permanently incapable of work: Please enclose a copy/copies of the birth certificate(s) as evidence and, in addition, copies of relevant evidence of education/training or incapacity for work.

Surname	Date of birth	☐ in education/training
First name (preferred name)		☐ permanently incapable of work
Surname	Date of birth	☐ in education/training
First name (preferred name)		☐ permanently incapable of work
Surname	Date of birth	☐ in education/training
First name (preferred name)		☐ permanently incapable of work
Surname	Date of birth	☐ in education/training
First name (preferred name)		☐ permanently incapable of work
Surname	Date of birth	☐ in education/training
First name (preferred name)		☐ permanently incapable of work

9. Declaration by the applicant

I confirm that all information provided is true and complete.

I will inform you without delay of any changes to the above information in accordance with § 37 of the statutes of the Sächsische Ärzteversorgung.

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

Consent to the use of the information provided voluntarily may be withdrawn at any time with future effect, without giving any reason. The withdrawal may be sent by post or email to the Sächsische Ärzteversorgung.

City, Date	**The account holder's** or authorised representative's handwritten signature (with supporting documentation)

Annex to the application for Benefits

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 Surname First name (preferred name)

Additional sheet: Other insurance periods

1. Other insurance periods

Insurance or residence periods in a foreign social security system within the European Economic Area (EEA) as well as the United Kingdom of Great Britain and Northern Ireland of the member, or—if applying for survivors' benefits—of the deceased

☐ **no,** continue with item 3 ☐ **yes**

If yes, did you—or, in the case of an application for survivors' benefits, did the deceased—have insurance periods in the statutory pension scheme (e.g. Deutsche Rentenversicherung Bund, Knappschaft)?

☐ **no,** continue with item 2 ☐ **yes**

If yes, please complete:

Pension insurance institution	Insurance number / reference number
From	To

2. Details of the social security system

Name of pension institution	Address of pension institution
Insurance number	
From	To
Name of pension institution	Address of pension institution
Insurance number	
From	To
Name of pension institution	Address of pension institution
Insurance number	
From	To
Name of pension institution	Address of pension institution
Insurance number	
From	To

3. Details of other pension schemes

Insurance or residence periods in other domestic pension institutions of the member, or—if applying for survivors' benefits—of the deceased

☐ **no** ☐ **yes,** please complete:

Pension scheme	Membership number
From	To
Pension scheme	Membership number
From	To
Pension scheme	Membership number
From	To

4. Declaration of consent

I have—or, in the case of an application for survivors' benefits, the deceased had—insurance or residence periods in a foreign social security system within the European Economic Area (EEA) or the United Kingdom of Great Britain and Northern Ireland, and I hereby give my consent, where applicable with a release from confidentiality,

- to the forwarding of the application documents submitted by me, as well as the medical documents available, to the participating/processing institution(s), and/or
- to the request for medical documents from the

participating/processing institution(s) within the European Economic Area (EEA) or the United Kingdom of Great Britain and Northern Ireland, and/or the participating/processing domestic pension institutions.

City, Date	Signature/name of the applicant or authorised representative (with supporting documentation)

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Determination of the health insurance fund responsible for the beneficiary

(Please complete and return promptly so that payment of benefits is not delayed due to unclear health insurance coverage.)

1. General information

The data is collected on the basis of § 202 of Book V of the German Social Code (SGB V) and processed in compliance with data protection regulations.

As the paying agency for pension benefits, the Sächsische Ärzteversorgung is required by law to determine the health insurance fund responsible for the beneficiary (§ 202(1) sentence 1 SGB V) so that it can verify whether contributions to the health insurance fund must be paid from the pension benefits.

This is generally the case if the beneficiary is insured with a statutory health insurance fund.

If you have questions about the obligation to pay contributions and the amount of health and long-term care insurance contributions to be paid by the Sächsische Ärzteversorgung, please always contact your health insurance fund, as it is the responsible body.

Under § 202(1) sentence 3 SGB V, the beneficiary must state their health insurance fund to the paying agency (Sächsische Ärzteversorgung) and report any change of health insurance fund **without delay**.

For persons subject to compulsory statutory insurance, the Sächsische Ärzteversorgung pays the general contribution rate and the fund-specific additional contribution rate from the benefits to the health insurance funds in accordance with §§ 241 and 242 SGB V.

Changes in the amount of the fund-specific additional contribution rate are to be taken into account in calculating the health insurance contribution from pension benefits only after two months, in accordance with § 248 SGB V.

With the Act to Support and Relieve Long-Term Care (Pflegeunterstützungs- und -entlastungsgesetz), the contribution rate to long-term care insurance is differentiated according to the number of children as of 01/07/2023. For persons without children, the contribution rate is increased by 0.60 percentage points in accordance with § 55(3) SGB XI. For beneficiaries with several children under 25, the contribution rate is reduced accordingly under § 55(3) SGB XI.

The statutes of the Sächsische Ärzteversorgung do not provide for any subsidy toward health and long-term care insurance. This applies both to pension recipients with statutory health insurance and to those with private health insurance.

2. Beneficiary / applicant

Familienname	Responsible health insurance fund
First name (preferred name)	Address of the health insurance fund
Date of birth	
Social security number (DRV Bund)	

3. **Beneficiary orphans** (up to completion of the 18th year of life; only for survivors' benefits)

Familienname	Responsible health insurance fund
First name (preferred name)	Address of the health insurance fund
Date of birth	

Social security number (DRV Bund)

Familienname	Responsible health insurance fund
First name (preferred name)	Address of the health insurance fund
Date of birth	

Social security number (DRV Bund)

Familienname	Responsible health insurance fund
First name (preferred name)	Address of the health insurance fund
Date of birth	

Social security number (DRV Bund)

Familienname	Responsible health insurance fund
First name (preferred name)	Address of the health insurance fund
Date of birth	

Social security number (DRV Bund)

If you are not insured with a statutory health insurance fund, please provide the following declaration:

☐ I am **not** insured with a statutory health insurance fund.

☐ The beneficiary orphans are **not** insured with a statutory health insurance fund.

If I am insured with a statutory health insurance fund, I agree that the Sächsische Ärzteversorgung will withhold health and long-term care insurance contributions from my pension benefits until my insurance obligation has been finally clarified. This does not apply if I enclose with my application a written confirmation from my health insurance company regarding my voluntary insurance from the start of the pension benefit. After appropriate evidence has been provided, any contributions withheld in excess will be refunded without delay.

I certify that the above information is complete and correct and I have taken note that I am obliged to inform the Sächsische Ärzteversorgung without delay of any change of health insurance fund.

City, Date	Signature/name of the applicant or authorised representative (with supporting documentation)

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Information sheet for children

1. Evidence for biological parents and adoptive parents

For biological parents and adoptive parents (first-degree relationship to the child), the following may be provided as evidence (alternatively):

- Birth certificate or international birth certificate ("multilingual extracts from civil status registers")
- Certificate of parentage/ancestry certificate (kept at the person's place of birth)
- Extract from the birth register of the registry office
- Extract from the family record book / family register
- Tax-related proof of life/civil status certificate from the residents' registration office (issued, for example, if a taxpayer wishes to have a half child allowance entered on their wage tax card for a child who is not registered at their address; they must prove a first-degree relationship to the child, e.g. by presenting a birth certificate)
- Certificate of acknowledgement of paternity and certificate establishing paternity
- Adoption certificate
- Child benefit notice from the Federal Employment Agency (BA) – Family Benefits Office (for members of the public service and recipients of pension payments: the benefits/salary statement from the office responsible for setting benefits or paying salaries of the respective public-law employer or appointing authority)
- Account statement showing payment of child benefit by the BA – Family Benefits Office (the statement should indicate the amount transferred, the child benefit number and, as a rule, the period for which the amount is intended)
- Parental allowance notice
- Certificate of receipt of maternity benefit
- Proof of taking parental leave under the Federal Parental Allowance Act (BErzGG)
- Income tax assessment notice (showing consideration of a child allowance)
- Wage tax card (entry of a child allowance)
- Child's death certificate
- Determination notice from the pension insurance institution showing child-raising and child-care/consideration periods

Note: Copies of the above documents are also accepted as proof. If there are doubts about the correctness of the copies, the originals or certified copies/certified extracts must be presented.

2. Evidence for stepparents

For stepparents (parents within the meaning of § 56(3) no. 2 in conjunction with § 56(2) no. 1 SGB I), the following may be provided as evidence (alternatively):

- Marriage certificate or proof of registration of a civil partnership and a registration certificate from the residents' registration office (or another authority responsible for civil status matters) stating that the child is or was registered as living in the stepparent's household (cf. household certificate or marital status certificate for granting child benefit—BA forms for the declaration of children's household membership and for employees whose children live in Germany)
- Determination notice from the pension insurance institution showing child-raising and child-care/consideration periods
- Income tax assessment notice (showing consideration of a child allowance)
- Wage tax card (entry of a child allowance)

Note: Copies of the above documents are also accepted as proof. If there are doubts about the correctness of the copies, the originals or certified copies/certified extracts must be presented.

3. Evidence for foster parents

For foster parents (parents within the meaning of § 56(3) no. 3 in conjunction with § 56(2) no. 2 SGB I), the following may be provided as evidence (alternatively):

- Registration certificate from the residents' registration office (or another authority responsible for civil status matters) and proof from the youth welfare office of "full-time foster care" under § 27 in conjunction with § 33 SGB VIII (e.g. a foster care agreement between the youth welfare office and foster parents, a decision on benefits granted to the legal guardians, or a certificate from the youth welfare office regarding the foster care relationship; the foster care relationship must be or have been intended for a longer period and a domestic community must exist or have existed; day-care carers are not included in the term foster parents; a foster child relationship is not assumed if a man lives with his partner and her children, or a woman lives with her partner and his children, in a shared household—consideration only if stepparent status exists)
- Determination notice from the pension insurance institution showing child-raising and child-care/consideration periods
- Income tax assessment notice (showing consideration of a child allowance)

Note: Copies of the above documents are also accepted as proof. If there are doubts about the correctness of the copies, the originals or certified copies/certified extracts must be presented.