Change Notification / Activity Statement

regarding membership

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

1. Personal details

Surname
First name (preferred name)
Street, House number
Postal code, City
Date of birth

2. Change in personal details

☐ Name change (attach proof)	new name
☐ Title (attach proof)	title

3. Details of previous employment

☐ Nothing has changed in my previous employment.		Position/activity (exact title)
☐ My previous employment ended on	Date	Position/activity (exact title)

4. Change in current (professional) situation (please tick what applies and complete)

☐ unpaid **leave of absence** granted by the employer	from	to
☐ **Illness** without continued remuneration	from	to
	☐ statutorily insured	☐ privately insured
Specify the provider (health insurance / employers' liability insurance association)	☐ Sickness benefit	☐ Injury benefit
☐ **Maternity protection** (If self-employed: submit a copy of the child's birth certificate)	from	to
☐ **Parental leave**	from	to

5. Details of new future employment

☐ Start of a **new employment**	from (contract start date)	if applicable, until

Employer / department (full address)

Note:
If you wish to be exempt from the statutory pension insurance obligation for this employment, you must submit a new application for exemption to the Deutsche Rentenversicherung. In order for the exemption to take effect from the start of your employment, the application must be submitted within 3 months of taking up this employment. You can access the application via the QR code:

☐ **in my own practice <u>for the first time</u>** self-employed	since (SHI registration)	
☐ **self-employed**	since	as / in
☐ **<u>not</u> working as a physician/veterinarian**	from	expected until
☐ Registered with the **Employment Agency**	from	expected until

☐ Unemployment benefit I (ALG I) ☐ Citizen's allowance (Bürgergeld) ☐ no benefits received ☐ Blocking period until:

☐ **Civil servant / soldier** (attach proof)	since	
☐ **Military service / exercise / reservist service**	from	to
☐ **abroad** employed / resident without employment	since	Country
☐ **Working outside the profession**	since	
☐ **Scholarship holder / observer / visiting physician** (attach proof)	since	
☐ **Nursing activity**	since	
☐ Receipt of **care support allowance**	since	

6. Declaration of truthful information and data protection statement

Phone(optional)

Email

The mandatory information provided in this form is necessary and required solely to fulfil the pension scheme's statutory mandate of Sächsische Ärzteversorgung. It is collected on the basis of legal authorisations.

Please also note the published data protection statement on our website www.saev.de.

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

Consent to the use of the voluntary information provided may be revoked at any time for the future, without stating reasons. The revocation may be submitted to Sächsische Ärzteversorgung by post or email.

Place, date	Signature / printed name