

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

<input type="checkbox"/> Name change (attach proof)	new name
<input type="checkbox"/> Title (attach proof)	title

3. Details of previous employment

<input type="checkbox"/> Nothing has changed in my previous employment.	Position/activity (exact title)	
<input type="checkbox"/> My previous employment ended on	Date	Position/activity (exact title)

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

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

5. Details of new future employment		
<input type="checkbox"/> Start of a new employment	from (contract start date)	if applicable, until
Employer / department (full address)		
<p>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:</p>		
<input type="checkbox"/> in my own practice for the first time self-employed	since (SHI registration)	
<input type="checkbox"/> self-employed	since	as / in
<input type="checkbox"/> not working as a physician/veterinarian	from	expected until
<input type="checkbox"/> Registered with the Employment Agency	from	expected until
<input type="checkbox"/> Unemployment benefit I (ALG I)	<input type="checkbox"/> Citizen's allowance (Bürgergeld)	<input type="checkbox"/> no benefits received <input type="checkbox"/> Blocking period until:
<input type="checkbox"/> Civil servant / soldier (attach proof)	since	
<input type="checkbox"/> Military service / exercise / reservist service	from	to
<input type="checkbox"/> abroad employed / resident without employment	since	Country
<input type="checkbox"/> Working outside the profession	since	
<input type="checkbox"/> Scholarship holder / observer / visiting physician (attach proof)	since	
<input type="checkbox"/> Nursing activity	since	
<input type="checkbox"/> Receipt of care support allowance	since	

6. Declaration of truthful information and data protection statement
Phone(optional)
Email
<p>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.</p> <p>Please also note the published data protection statement on our website www.saev.de.</p> <p>I agree that the voluntary information provided above may be processed to facilitate communication in accordance with the data protection regulations currently in force.</p> <p>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.</p>

Place, date	Signature / printed name
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