Transfer Application

Sächsische Ärzteversorgung
Einrichtung der Sächsischen Landesärztekammer
Körperschaft des öffentlichen Rechts

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

☐ **Physician** ☐ **Veterinarian**

Membership number

1. Personal details

Surname	First name (preferred name)	
Birth name (if different)	Sex ☐ female ☐ diverse ☐ male	Nationality ☐ German ☐ _____
Date of birth		
Phone (optional)	Email	
New address: Street, house number		
Postal code	City	resident since:
Previous address: Street, house number		
Postal code	City	resident until:

2. Information on divorce proceedings or pension rights equalisation proceedings

Are divorce proceedings or pension rights equalisation proceedings pending?

☐ yes ☐ no

3. Activity within the scope of the newly responsible pension scheme

☐ not practising as a physician/veterinarian	since	Reason (parental leave, unemployment, etc.)
☐ self-employed	since	☐ in private practice
☐ employed	since	as
Employer name		
Street, house number		
Postal code	City/Town	

4. Membership in the previously responsible pension scheme

Pension scheme:		
Membership period:	from	to
Membership number:		

5. Declaration by the applicant

I hereby apply for the contributions I paid to the pension scheme previously responsible for me (see section 4) to be transferred in my favour to the

_____ (newly responsible pension scheme)

and I declare that all information provided is true and complete, that I have not applied for an occupational disability pension with the previous pension scheme, and that I was not occupationally disabled at the time my professional activity was relocated.

I will notify the Saxon Medical Pension Scheme immediately of any changes to the above information in accordance with section 14 of its statutes.

The mandatory information requested in this form is necessary and required solely to fulfil the pension mandate 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 to process or handle your request/application, where you have given your consent, or where another legal basis permits such disclosure.

Please also note the published privacy policy on our website www.saev.de.

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

Consent to the use of the voluntary information provided may be revoked at any time with effect for the future, without stating reasons. The revocation 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 proof)