

Apothekerversorgung  
Schleswig-Holstein  
Düsternbrooker Weg 75  
24105 Kiel, Germany

### APPLICATION FOR A DISABILITY PENSION

LAST NAME	FIRST NAME	TEL.:
HOME ADDRESS:		
DATE OF BIRTH:	PLACE OF BIRTH:	
MEMBERSHIP NO.:	PENSION PAYMENT FROM (DATE): <small>(the pension is paid on the 20th of each month)</small>	
	YES NO	
DO YOU HAVE ELIGIBLE DEPENDENTS? <small>(spouse, children under the age of 27 in full-time education)</small>		
BANK ACCOUNT INFORMATION		
ACCOUNT NO.:	SORT CODE:	
IBAN:		
BIC:		
BANK:		
HEALTH INSURANCE (private): <small>If you have private health insurance, please provide a certificate from your health insurer confirming that the insurance cover provides benefits corresponding those of statutory health insurance in accordance with the German Social Security Code, Vol. 5 (SGB V).</small>		
HEALTH INSURANCE (statutory):		
HEALTH INSURANCE NO.:		
<small>If you have statutory health insurance, please also indicate whether you have children (including adults)</small>		
CHILDREN: YES NO		
PLEASE NOTE: The Apothekerversorgung (Pharmacists' Pension Fund) does not supplement contributions!		
TAX IDENTIFICATION NUMBER (11-digit):		
DATE	SIGNATURE	