APOTHEKERVERSORGUNG
SCHLESWIG-HOLSTEIN

Apothekerversorgung Schleswig-Holstein
Düsternbrooker Weg 75
24105 Kiel

Questions or concerns?
We are here to assist you.
Telefon: 0431 579 3550
Telefax 0431 579 3560
E-Mail: info@av-sh.de
Internet: www.av-sh.de

Membership Declaration Form

of the Pharmacists' Pension Fund Schleswig-Holstein (Apothekerversorgung Schleswig-Holstein)

Name, Academic Title

First Name

Name at birth

Date of birth

Place of birth

☐ male ☐ female ☐ diverse
Gender

Nationality

Phone number

Residence

Street | Number

ZIP Code | Residence

Marital status ☐ single ☐ married ☐ widowed ☐ divorced

Date of birth Spouse

Children (number | date of birth)

Tax identification number (Steuer-Identifikationsnummer)

It is mandatory to provide your 11-digit tax identification (Steuer-Identifikationsnummer), which you can find, for example, on your last income statement or income tax certificate. You can obtain further information from the Federal Central Tax Office at www.bzst.de

Social Security Number (Sozialversicherungsnummer)

Details of occupation

Licence to practise

since

Pharmacy trainee

from

Employment in Schleswig-Holstein for **no** longer than 3 months ☐ Yes ☐ No

Are there currently other employment relationships in other chamber areas? ☐ Yes ☐ No

Details of previous memberships

If you were already a member of another pension scheme or another statutory pension insurance institution in Germany or another European country (EU/EFTA/EEA) before you started working in Schleswig Holstein, please state the period of membership, the relevant country and the name of the pension scheme here.

from	to	Country/Federal state	Pension scheme/pension provider
__.__.____ –	__.__.____		
__.__.____ –	__.__.____		
__.__.____ –	__.__.____		

If you were previously a member of another pension scheme, you can apply to transfer the contributions paid to your previous pension scheme to us, as your new pension scheme, **within three months of taking up employment in this chamber**, provided you have **not been a member of your previous pension scheme for more than 60 months**.

I request that the contributions I have paid to date to Apothekerversorgung _____ be transferred to Apothekerversorgung Schleswig-Holstein.
A copy of the transfer application may be sent to my previous pension fund for the purpose of transferring contributions. ☐ Yes ☐ No

The protection of your personal data is very important to us. We treat your personal data confidentially and in accordance with the statutory data protection regulations and our privacy policy.
You can read about this on our website at: www.av-sh.de or request this in writing by calling 0431-579-3550.

It is possible to communicate with the pension fund by e-mail. Please note that this method of transmission is not completely secure and unauthorised persons could, for example, manipulate the sender or recipient address or the content of the e-mail.

I agree that the pension fund may send me information by e-mail. ☐ Yes ☐ No

E-mail address

Place, Date **Signature**