

The purpose of this form is to check whether you are insured under the Dutch Act on Exceptional Medical Expenses (AWBZ)



1 Your details

 Surname (at birth) _____

 Forenames _____

 Date of birth and sex _____ male female

 Postcode and town/city _____

 Burgerservicenummer | | | | | | | | | |

 Daytime telephone number | | | | | | | | | |

2 Postal address

Only complete this section if you wish to receive post from the SVB at a different address than your home address.

 Street and number _____

 Postcode and town/city _____

3 Domestic situation

By "partner" we mean the person with whom you share a household.

What is your current domestic situation? I am married/ am in an officially registered domestic partnership with

Name of partner _____

I am married and am living with

Name of partner _____

I live alone

Other (please specify) _____

4 Your employment

Please name the country/countries where you work.

Are you working? Yes, in paid employment in _____ since _____

Enclose documentary evidence, for instance an employer's statement or a payslip.

Yes, as a self-employed person in _____ since _____

No _____



Are you active in the military? Yes, since _____
 No

Do you work for an organisation under international law? Yes, name of organisation _____ since _____
Enclose documentary evidence, for instance an employer's statement or a payslip.
 No

5 Course of study

Are you staying in the Netherlands in order to follow a course of study? Yes, since _____
 No

In addition to your studies, do you work in the Netherlands at all? Yes, since _____
 No

6 Your healthcare insurance

Do you have healthcare insurance with a healthcare insurer in the Netherlands? Yes, name of healthcare insurer _____
 No, because _____

Only complete this section if you have a partner. Name the country/countries where your partner works.
7 Employment of your partner *By "partner" we mean the person with whom you share a household..*

Is your partner working? Yes, in paid employment in _____ since _____

Enclose documentary evidence, for instance an employer's statement or a payslip.

Yes, as a self-employed person in _____ since _____ - -

No

Does your partner work for an organisation under international law? Yes, name of organisation _____ since _____

Enclose documentary evidence, for instance an employer's statement or a payslip

No

8 Healthcare insurance of your partner

Does your partner have healthcare insurance with a healthcare insurer in the Netherlands? Yes, name of healthcare insurer _____
 No, because _____



Are you co-insured under your partner's non-Dutch health insurance policy?

Yes, since – –

Enclose a copy of your proof of registration.

No

9 Signature

Date

I declare that the information on this form is true and complete.

Send this form and any enclosures to: SVB, Insurance Office, Department BAV, Postbus 357, 1180 AJ Amstelveen, the Netherlands.

