



Baden-Württemberg

LANDESAMT FÜR BESOLDUNG UND VERSORGUNG

Erklärung und Änderungsmitteilung zum Zuschuss für den Krankenversicherungsbeitrag nach § 257 SGB V für freiwillig Versicherte ab _____ - *Declaration and Notice of Change regarding the Contribution to Health Insurance according to Section 257 of the Fifth Social Code (Fünftes Sozialgesetzbuch, SGB V) for Voluntarily Insured Members as of _____*

Please note:

The following information is necessary for the payment of your remuneration. Please see the information sheet on data protection ("Merkblatt zum Datenschutz") for information on the relevant legal provisions on the basis of which your data are collected. All questions must be answered, unless marked (optional).

1. Personal data

Please check or fill in as appropriate

| | | |
|---------------|-------------------------|---------------------------------|
| Last name | First name | Personnel number / area of work |
| Date of birth | Phone number (optional) | |

2. Insurance details

I am insured as a voluntary member with the following health insurance provider

in (city)

- I have attached a confirmation from the health insurance provider.
- The confirmation will be sent directly from the health insurance provider.

Declaration

I hereby confirm that the information provided above is both accurate and complete. I am aware that I am obliged to immediately inform the Landesamt of any changes with regard to my contribution rate or health insurance provider and that I am obliged to pay back any excess amounts received due to failure, delay or incomplete information.

I am aware that I cannot waive the contribution as long as I meet the prerequisites.

Date, Signature

**Landesamt für Besoldung und
Versorgung Baden-Württemberg
70730 Fellbach**

LBV 496 – 01/10