

Application for a document S1

Medical care for a family member

You can use this form to apply for a document S1 for a family member who lives outside the Netherlands.
When can you apply for a document S1 for a family member?

- You have health insurance under the Healthcare Insurance Act (Zvw) with a Dutch health insurer.
- Your family member lives outside the Netherlands, but in an EU Member State, an EEA country or Switzerland.

The health insurance fund (or competent body) in his or her country of residence will determine whether your family member can be co-insured under your policy and will let you know.

Send the completed application form to:
CAK, Regeling Buitenland, Antwoordnummer 91041, 2509 VC The Hague

If you complete the form by hand, please use block capitals.

Please note! The information under points 1 to 4 must be completed in full;
only complete the additional information if it applies to you.

1 Your personal details

1.1	Name	<i>First names (in full)</i>	_____
	Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	
		<i>Surname</i>	_____
		<i>Maiden name (if married)</i>	_____
1.2	Date of birth	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<i>DD / MM / YYYY</i>
1.3	BSN or Sofi number		_____

2 Your address details

2.1	Address	<i>Street and house number</i>	_____
		<i>Postcode</i>	_____
		<i>Town/city</i>	_____
		<i>Province</i>	_____
		<i>Country</i>	_____

3 Your family member's details

3.1 Name *First names (in full)* _____

Sex Male Female

Surname _____

Maiden name (if married) _____

Date of birth *DD / MM / YYYY*

BSN or Sofi number _____

3.2 Address *Street and house number* _____

Postcode _____

Town/city _____

Province _____

Country _____

3.3 S1 start date *DD / MM / YYYY*

3.4 Reason for applying for an S1

Your family member is moving to another EU/EEA country or Switzerland.

Your family member is stopping working in his or her country of residence.

Birth.

Marriage.

Other reason (please specify): _____

4 Signature

I declare that I have read all the information carefully and that I have entered the details truthfully.

4.1 Place and date _____

DD / MM / YYYY

4.2 Signature _____

Additional information

Please provide the name of your Dutch health insurer.

Name of health insurer

If you would prefer not to provide this information, that is not a problem. We will contact you if we need more information.

Can we contact you by telephone or email?

Landline telephone number

Mobile telephone number

Email address
