Your social security rights

in the Netherlands

Employment,
Social Affairs
and Inclusion

The information provided in this guide has been drafted and updated in close collaboration with the national correspondents of the Mutual Information System on Social Protection (MISSOC). More information on the MISSOC network is available at: http://ec.europa.eu/social/main.jsp?langId=en&catId=815

This guide provides a general description of the social security arrangements in the respective countries. Further information can be obtained through other MISSOC publications, all available at the abovementioned link. You may also contact the competent authorities and institutions listed in annex to this guide.

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Chapter I: Introduction, organisation and financing

Introduction

The Dutch social security system comprises schemes covering the following:

- sickness and maternity;
- occupational disability insurance; there is no separate insurance scheme in the Netherlands for accidents at work and occupational diseases;
- old-age pensions;
- survivors' benefits;
- unemployment;
- child benefits.

Who is insured?

As a rule, all employed and self-employed persons are insured. However, the self-employed are not insured against unemployment and do not receive sickness benefits or disability benefits.

How to join the social security scheme

As soon as you start working in the Netherlands as an employed person, you are automatically covered by all the insurance schemes listed above.

There is only one exception: under the Health Insurance Act, all residents of the Netherlands and non-residents who are liable to Dutch payroll tax are required to take out health insurance with a health insurer. The insurance is not established automatically simply by a person meeting the criteria, as is the case with insurance under the Exceptional Medical Expenses Act. This is because a person must choose an insurer and conclude an insurance agreement. For their part, the care insurers are under obligation to accept anyone who applies for insurance.

If you are self-employed and your enterprise is domiciled in the Netherlands or you pursue your professional occupation there, you are automatically covered by most of the national insurance schemes. You are not covered, however, by the unemployment insurance scheme.

Further steps to be taken

If you are an employee, you will have to deal with the Institute for Employee Benefit Schemes (*UWV, Uitvoeringsinstituut Werknemersverzekeringen*) if you become incapable of working or unemployed. UWV is also responsible for job-seeking activities.

Another organisation which may be important for you is the Social Insurance Bank (*Sociale Verzekeringsbank*), to which you will have to apply in order to obtain family allowances or, on reaching the legal retirement age, an old-age pension.

In the event of your death, your surviving partner and/or children will also have to deal with the Social Insurance Bank.

How are contributions paid?

If you are in employment, your employer pays the contributions due to the various social security schemes. The part of the contribution to be paid by you will be deducted from your salary. Your employer is obliged to reimburse to you the amount of the contribution, proportional to revenue, which you pay under the Health Insurance Act. If you receive benefits in cash, the institution paying them may in some cases deduct contributions from them.

If you are self-employed, you will receive a form stating the contributions you have to pay. Also stated on the form is the amount of the contribution, proportional to revenue, which you have to pay under the Health Insurance Act.

In the case of healthcare insurance, the nominal contribution is paid directly to the Health care insurance company (insurer) with which you are registered. Your employer or the benefits agency concerned can give you further information about how much you have to pay.

What should you do if you do not agree with a decision by an insurance institution?

If you do not agree with a decision by an insurance institution, you are entitled to appeal against it. You do this by lodging a complaint within a certain period with the institution concerned. It is then obliged to reconsider its decision and decide whether the complaint is justified or not. You may – again, within a certain period – lodge an appeal against the decision concerning your complaint with the administrative law section of the district court (*Arrondissementsrechtbank*) referred to in the text of the institution's decision. The date by which an appeal can be lodged is also stated in the decision.

You should submit a notice of appeal to the district court in which you state that you do not agree with the decision taken by the insurance institution and request that it be reviewed. The notice should be accompanied by a copy of the contested decision.

If the district court's ruling does not satisfy you, you can usually appeal to the Central Appeal Board (*Centrale Raad van Beroep, Vrouwe Justitiaplein 1, Postbus 16002, 3500 DA Utrecht*) within six weeks of the date on which the ruling is made known.

Organisation of social protection

Social insurance in the Netherlands is organised jointly by the Ministry of Social Affairs and Employment (*Ministerie van Sociale Zaken en Werkgelegenheid*) and the Ministry of Health, Welfare and Sport (*Ministerie van Volksgezondheid, Welzijn en Sport*). A distinction is drawn between national insurance on the one hand, which covers the whole of the population and employees' insurance, on the other, only covering employees. The national insurance schemes provide for:

- insurance for old-age,
- maintenance for survivors,
- medical care,
- insurance for exceptional medical costs, and
- family benefits.

The employees' insurance schemes provide for:

- insurance for sick pay,
- insurance for invalidity, and
- insurance for unemployment.

There is an invalidity insurance scheme for young disabled people. No special insurance for employment injuries or occupational diseases exists; these risks are covered by the other insurance schemes. In addition to this, the State runs a social assistance scheme that is managed by the municipal authorities. This scheme is characterised as a safety-net since its objective is to guarantee minimum income to people who do not or no longer have sufficient resources to cover the necessary costs of living.

With the exception of the insurance for exceptional medical costs and costs for medical care, the national insurance schemes are implemented by the Social Insurance Bank (Sociale Verzekeringsbank).

The Institute for Employee Benefit Schemes (*UWV*) is responsible for administering the employees' insurance schemes. The public employment service is also operated by the *UWV.* The Inspectorate Social Affairs and Employment *(Inspectie SZW)* is responsible for monitoring the *UWV* and *SVB*.

Health insurance (medical care) is implemented by private health insurance companies, which are supervised by the Dutch Healthcare Authority (*Nederlandse Zorgautoriteit*).

The general insurance for exceptional medical costs is implemented by private health insurance companies. Supervision is also carried out by the Dutch Healthcare Authority (*Nederlandse Zorgautoriteit*).

See also part on competent authorities.

Financing

The social security system in the Netherlands is financed through a system of both contributions (by residents as well as non-residents; employees, self-employed and employers) and taxes. Sometimes there is an additional financing through general taxes, for example with regards to the old age pension.

Chapter II: Healthcare

When are you entitled to healthcare?

Medical care is covered by two different insurance schemes which complement each other: healthcare insurance and exceptional medical expenses insurance. The latter is based on the Exceptional Medical Expenses Act (*Algemene Wet Bijzondere Ziektekosten - AWBZ*).

People compulsorily insured under this Exceptional Medical Expenses Act are those that reside legally in the Netherlands or live in another country but work in the Netherlands and pay Dutch payroll tax. They are obliged to take out health insurance under the Health Insurance Act (*Zorgverzekeringswet*).

The government has made two exceptions to the general rule:

- Members of the armed forces on active service are insured under the Exceptional Medical Expenses Act but do not have to take out insurance under the Health Insurance Act. They receive care from the military medical services.
- Another exception to the insurance obligation has been made for people with conscientious objections. Those who object to insurance on principle pay no premiums under the Exceptional Medical Expenses Act, nor are they obliged to take out insurance under the Health Insurance Act. However, they do pay the income-related contribution in the form of a substitute tax.

With health insurance cover under the Health Insurance Act, you are entitled to medical benefits. There are two main variants of health insurance policies: policies based on benefits in kind and policies based on reimbursement of medical costs. Your insurer will provide you with a certificate of registration so that you can prove you are an insured person when requesting medical care. Taking out health insurance with a health insurer guarantees that you automatically have *AWBZ* insurance cover.

What is covered?

Your care insurer can explain in detail all the benefits to which you are entitled under the Health Insurance Act and the *AWBZ*. Persons insured under the Health Insurance Act are entitled, amongst other things, to:

Medical care

Medical care encompasses the services provided by general practitioners, specialists, psychologists and gynaecologists. This does not mean that these services have to be provided by those persons. If the benefits in question do not relate to reserved services which have to be recorded and the designation of which is protected under the Healthcare Professions Act, they can also be provided by other persons. These services include laboratory tests and nursing care.

They also extend to genetic tests, non-clinical haemodialysis, services for patients with chronic intermittent respiratory problems and thrombosis prevention. Medical devices

covered include equipment needed for non-clinical haemodialysis and for the artificial respiration of patients suffering from chronic intermittent respiratory problems. Certain types of medical care which have to be provided by specialist doctors may be excluded from reimbursable benefits. It should be pointed out that the portion of the cost borne by the person insured is subject to a ceiling set under the applicable regulations.

The costs of mental healthcare (including general psychological help) are covered under the Health Insurance Act.

Pharmaceuticals

Pharmaceuticals comprise not only medicines but also certain food products intended for medical use. Authorised medicines are, in principle, categorised into groups of therapeutically equivalent substances. The reimbursement ceiling for a group of medicines is laid down on the basis of the average price for the medicines in the particular group. If someone chooses a drug whose cost exceeds this limit, he or she must pay the difference. There is no reimbursement ceiling for an authorised medicine which has no therapeutically equivalent substance. This regime is known as the 'medicines reimbursement system' (*Geneesmiddelenvergoedingensysteem* or *GVS*).

Care insurers may limit reimbursement to medicines containing certain active substances. It should be stressed that it is the insurers themselves who (subject to certain conditions) designate which medicines are reimbursed.

Transport

Subject to authorisation, sick persons can be transported by ambulance, taxi or private car, provided this is necessary for medical reasons. The doctor providing treatment issues a certificate to this effect. This entitlement also covers the cost of public transport in the most economical class if the journey is to or from an institution providing healthcare. In certain cases, the care insurer may authorise special means of transport, such as a helicopter.

Whether public transport, a taxi or a private car is used, insured persons firstly pay a certain amount themselves over a 12-month period. The costs of transport by private car are reimbursed on the basis of a fixed amount per kilometre.

Authorisation for the transport of sick persons lying down or under medical supervision is given only in four cases: patients on renal dialysis, patients receiving chemotherapy or radiotherapy, visually impaired persons who cannot travel unaccompanied, and persons confined to a wheelchair. The distance is limited to 200 km (outward journey). Patients who, having obtained prior authorisation from the care insurer to do so, receive care under the health insurance scheme at an institution or service that is further afield (either in the Netherlands or abroad) are entitled to reimbursement of the costs of transport over the greater distance.

There is a contingency clause, however, under which insured persons not coming under the above-mentioned categories may nevertheless qualify for reimbursement in certain cases. Such a case may be where an insured person has to travel to receive treatment for a chronic disease.

Dental care

For children and persons up to 18 years of age, dental care includes preventive maintenance work, fluoride applications up to twice a year from the age of six, sealing, periodontal care and surgical treatment. For adults, dentures and specialist surgical treatment are covered.

Prosthesis, spectacles, hearing-aids

These health expenses are subject to prior approval of the care insurer. There is no cost sharing except under certain conditions for orthopaedic shoes and hearing appliances.

Hospital treatment

The cost of care in hospitals other than psychiatric hospitals or the psychiatric departments of general or teaching hospitals is borne by the *AWBZ* implementing body once this care has been provided for more than one year.

How is healthcare accessed?

Your care insurer will provide you with a certificate of registration so that you can prove you are insured when requesting medical care.

You have a free choice to refer to any doctor that is qualified to practice. Specialists however can only be accessed via a general practitioner. With regard to hospital treatment, you have a free choice among hospitals or institutions approved by the Ministry of Health.

Payments will be made by the private health insurance company. For most types of care under the Act, insured persons over 18 are required to make personal contributions towards the costs. There is, however, a compensation for chronically ill patients.

To receive pharmaceutical products, insured persons must register with a chemist of their choice.

Chapter III: Sickness cash benefits

When are you entitled to sickness cash benefits?

Entitlement to sickness benefit while covered by insurance

Under the Civil Code, employers are obliged to continue paying a sick employee at least 70% of his or her wage or salary during the first two years of illness. For people who do not have an employer (any more), sickness insurance legislation provides a safety net. After the period of two years one may be eligible for a *WIA* benefit.

You are entitled to sickness benefit if your employment relationship ends on the first day of sickness or during the period for which your wage or salary must continue to be paid. Sickness benefit is then paid as from the date of termination of employment, after at least two waiting days have elapsed. There are two possible situations: a person with an employer is covered by his/her employer, who will pay the wages for up to two years. If a person is on a fixed term contract, works as a temporary worker *(uitzendkracht)* or receives an unemployment benefit and becomes ill, *UWV* plays the role of the employer and the person receives a sickness benefit.

Entitlement to sickness benefit ceases in any event on the first day of the month in which you reach the legal retirement age or when a person is no longer ill.

Entitlement to sickness benefit after the end of the insurance period

In the event of illness reported within one month of the end of the insurance period, you may still be entitled to sickness benefit under certain conditions.

What is covered?

The employee will receive (at least) 70% of his or her wage or salary during the first two years of illness. An employer will thus continue paying an employee until the 104th week of illness, but never beyond the duration of the contract of employment.

The maximum daily wage considered is € 195.96. With the minister's approval this percentage can be increased by the industrial boards in collective agreements between employers and employees. Also, if 70% of the daily wage is less than the social minimum, a supplement can be claimed under the Supplementary Benefit Act *(Toeslagenwet, TW)* (subject to means-testing for income).

How are sickness cash benefits accessed?

An employed person who is entitled to sickness benefit must, as soon as possible (by the second day of sickness at the latest), report or be reported sick to his employer once he or she has to stop work or is unable to come to work because of sickness. The employer will inform the employee of the rules for reporting sick.

The employed person must allow checks to be carried out. In principle, he or she must be at home at certain times indicated in the rules governing such checks.

An employed person who claims sickness benefit and whose inability to work is thus checked by a benefits agency, must comply with the rules of the Institute for Employee Benefit Schemes *(UWV)*.

Chapter IV: Maternity and paternity benefits

When are you entitled to maternity or paternity benefits?

See part on healthcare.

Persons insured under the Health Insurance Act are entitled, amongst other things, to maternity care. Persons insured under the *AWBZ* are entitled to, amongst other things, care for mother and child.

If you are employed in the Netherlands and are insured in your own right, you are entitled during pregnancy to maternity cash benefit (*Zwangerschapsuitkering* or *WAZO, Wet Arbeid en Zorg*).

What is covered?

Persons insured under the Health Insurance Act are entitled to care provided for mother and child over a maximum of ten days following confinement.

Persons insured under the *AWBZ* are entitled to support, advice and other forms of care during pregnancy as well as regular, systematic checks of the child's state of health during the early years of life. In principle, the AWBZ covers the cost of treatment, nursing and auxiliary care in the case of long-term illness or serious disability.

Maternity leave is granted for a period of 16 weeks. Prior to confinement, a leave between six and four weeks is compulsory; ten to twelve weeks remain for leave after confinement.

In case of premature birth, the number of days that the baby is premature will be added to the leave after confinement. If the baby comes late, the number of 'late' days will be added to the total period of leave. In this case, the leave will be longer than 16 weeks.

During pregnancy, you receive maternity benefit equal to your daily earnings. During your 16-week maternity leave, you are entitled to receive benefit equal to 100% of your salary from the institution to which your employer is affiliated. The maximum daily wage considered is € 195.96.

If, having received this benefit, you are still incapable of working as a result of your pregnancy or confinement, the same benefit (100% of your daily earnings) will continue to be paid out for up to 104 weeks. In addition, if you become sick as a result of your pregnancy before maternity leave begins, you will receive sickness benefit equivalent, again, to 100% of your daily earnings.

You are also entitled to free obstetric services and to reimbursement of post-natal care costs by the sickness fund if you are covered by the Dutch health insurance scheme (*Zorgverzekeringsqwet*). Obstetric care is normally provided by a midwife but may be provided by a general practitioner or specialist, if necessary in a clinic or hospital when no midwife is available or when medically indicated.

How are maternity and paternity benefits accessed?

To receive maternity benefit, you must present beforehand a certificate confirming your pregnancy (*Zwangerschapsverklaring*) to your employer. He/she will have the costs of maternity leave reimbursed by UWV. If you are self-employed, you can address to UWV to receive maternity benefits.

For more information about free obstetric services and reimbursement of post-natal care costs, please address to your insurance carrier.

If you wish to use the services of a maternity care centre (*Kraamcentrum*) you should contact the community care association (*Kruisvereniging*) not later than five months before the expected date of delivery.

Chapter V: Invalidity benefits

When are you entitled to invalidity benefits?

Employees

The *Work and Income according to Labour Capacity Act* (*Wet werk en inkomen naar arbeidsvermogen, WIA*) covers all employees who are completely or partially incapable of working.

You are considered completely or partially incapable of working when, as a result of sickness or infirmity, you cannot earn what healthy workers with similar training and equivalent skills normally earn at the location where you work or previously worked, or in the vicinity. No distinction is made as to the cause of incapacity (invalidity or employment injury). You need to be at least 35% unfit to obtain any benefits.

For the partially disabled, the emphasis is not on income protection but on the possibilities of rehabilitation. The Return to Work Scheme for the Partially Disabled (*Regeling Werkhervatting Gedeeltelijk Arbeidsgehandicapten, WGA*) encourages both the employee and the employer to endeavour to rehabilitate the employee. The Income Provision Scheme for People Fully Occupationally Disabled (*Regeling inkomensvoorziening volledig en duurzaam arbeidsongeschikten, IVA*) provides for income in case of full and permanent occupational disability, with no prospect or only a small chance of recovery. The IVA and WGA are part of the WIA.

Self-employed

Self-employed people who became incapable of work are not covered by these provisions and have to take out their own insurance against the risk of occupational disability.

What is covered?

The *Work and Income according to Labour Capacity Act* (*Wet werk en inkomen naar arbeidsvermogen, WIA*) consists of two parts:

Return to Work Scheme for the Partially Disabled

The Return to Work Scheme for the Partially Disabled (*Regeling Werkhervatting Gedeeltelijk Arbeidsgehandicapten, WGA*) provides a wage-related benefit that is paid for a duration varying from three to 38 months. The amount of the benefit depends on the degree of disablement, the employee's last wage and the wage earned when being partially disabled. If you do not work, you receive 75% of the last wage during the first two months and 70% of the last wage afterwards. If you are a partially disabled person and you work, you get 75% of the difference between the last wage and the income earned from work on top of your wage during the first two months.

A wage supplement benefit / follow-up benefit might be paid until the legal retirement age is reached. If you earn at least 50% of your remaining earning capacity, your wage will be supplemented by 70% of the difference between the last wage and the remaining earning capacity. If you do not work after expiry of the wage-related benefit, or earn less than 50% of the remaining earning capacity, you will receive a benefit based on a percentage of the statutory minimum wage.

Income Provision Scheme for People Fully Occupationally Disabled

Under the Income Provision Scheme for People Fully Occupationally Disabled (*Regeling inkomensvoorziening volledig en duurzaam arbeidsongeschikten, IVA*), you receive 75% of your last wage.

How are invalidity benefits accessed?

UWV must decide whether, and to what extent, you are incapable of working. To this end, after a maximum of 20 months from the start of your incapacity for work, they will inform you how to apply for a benefit. You must submit your request after 21 months at the latest.

Chapter VI: Old-age pensions and benefits

When are you entitled to old-age benefits?

People living or working in the Netherlands are insured under the General Old-Age Pensions Act (*Algemene Ouderdomswet, AOW*). As a rule, all men and women are entitled to an old-age pension when they reach the legal retirement age of 65 years and one month. Under certain conditions, voluntary insurance may be taken out under the *AOW* when you are abroad.

Supplementary pension schemes

If you work in the Netherlands, you may also be covered by a supplementary pension scheme. In many sectors, there is a compulsory occupational pension scheme. Such schemes exist, in particular, for the metallurgical industry, the construction sector, painters, agriculture, the printing industry, catering, road haulage, the merchant navy, sea fishing, the textile industry and the healthcare sector. It is also possible that your employer has a supplementary pension scheme covering the company only, or that he has concluded an agreement with a life assurance company.

What is covered?

The amount of each individual pension is fixed, but it is adjusted in line with wage increases twice a year. The pension is paid monthly. A yearly holiday allowance is paid in May. The fixed pension (*AOW*) is reduced by 2% for each year during which you were not insured. This means you acquire 2% of the full pension for each full year you have lived or worked in the Netherlands.

How are old-age benefits accessed?

Old-age pensions

Some months before reaching the legal retirement age, you will receive, if you are then living in the Netherlands, a special old-age pension claim form that you should send to the Social Insurance Bank (*Sociale Verzekeringsbank*).

The Dutch old-age pension commences on the first day of the month in which you reach the legal retirement age. If you submit your claim more than one year after that date, this may be to your financial disadvantage.

In the case of a voluntary pension, the Social Insurance Bank can give you all the necessary information. If you apply for voluntary insurance, your application must be submitted in time, i.e. within one year of having gone to live abroad, or within one year of having become established in the Netherlands or of having begun to work there. However, if your spouse or partner is living in your country of origin, he or she is not insured.

Supplementary pension schemes

Information on entitlements can be obtained from your employer.

These supplementary schemes are supervised by the *Nederlandsche Bank*.

All claims for payments from supplementary pension schemes must be submitted to the occupational pension fund in question or to the life assurance company operating the scheme. Any disputes arising from the application of a supplementary pension scheme should be brought before a civil court.

Chapter VII: Survivors' benefits

When are you entitled to survivors' benefits?

As long as you are living or working in the Netherlands, you are covered by the Dutch survivors' insurance scheme. If you no longer live or work in the Netherlands, you can be insured for this on a voluntary basis.

This insurance, which is regulated by the General Surviving Relatives Act (*Algemene Nabestaanden Wet, ANW*), provides for various benefits such as a survivor's pension, a half-orphan's and an orphan's pension, as well as an assistance allowance.

The surviving partner of a deceased insured person is entitled to a survivor's pension if he or she, at the time of the former's death, has an unmarried child under 18 years of age or is expecting a child, is incapable of working (not able to earn 45% of a normal wage in suitable employment), or was born before 1 January 1950. Deemed to be a surviving partner's children under the age of 18 are all his or her natural children and adoptive children, i.e. another person's children cared for and brought up as their own. Payment of the survivor's pension ends when the surviving partner no longer has an unmarried child or is no longer incapable of working.

At all events, the entitlement to a pension ceases on the first day of the month when the surviving partner reaches the legal retirement age. He or she then usually becomes entitled to an old-age pension. Entitlement to a survivor's pension also ends in the event of remarriage, registration of a partnership or cohabitation.

A parent or carer who looks after an unmarried half-orphan aged under 18 in their own home is entitled to receive a half-orphan's pension. A half-orphan is a child who has lost one of his or her parents.

Payment of a half-orphan's pension ends when the youngest child reaches the age of 18 or joins another household or if the parent or carer begins to receive a single-parent pension based on an old age pension. It also ends if the child is adopted by the (new) spouse of the surviving parent.

Normally, an orphan's pension is payable only where both parents have died. Orphans aged between 16 and 21 who are in full-time education or who for more than 19 hours a week look after a household containing at least one other orphan have the same entitlement, as do orphans aged 16 or 17 who are disabled. These benefits are directly linked to the minimum wage and vary according to the orphan's age. There are three age brackets: children aged under 10, children aged between 10 and 16, and children aged between 16 and 21.

What is covered?

The survivor's pension is subject to a ceiling of 70% of the minimum wage and depends on the survivor's income.

The half-orphan's pension is equal to 20% of the minimum wage and does not depend on income. A surviving partner with a child aged under 18 can therefore receive benefits of up to 90% of the minimum wage.

An orphan's pension is directly linked to the minimum wage and varies according to the orphan's age. There are three age brackets: children aged under 10, children aged between 10 and 16, and children aged between 16 and 21. The orphan's pension is not affected by other sources of income.

The amount of benefit is adjusted twice a year in line with minimum wage increases. Payments are made once a month. A holiday allowance is paid in May of each year.

In the case of death after expiration of the insurance period, the amount of the pension depends on international agreements and on the insurance periods which the deceased had accrued in the Netherlands.

Death grant

If a worker dies, his or her survivors are granted a cash benefit starting from the day the death occurs. After that day, wage payment stops. This benefit is equivalent to 100% of the monthly wage at the moment the death occurs. If the deceased was in receipt of a social benefit (*WW-, Ziektewet-, WAO, WIA, WAZ, IOW, TW or Wajong uitkering*), a death grant will also be paid. This benefit is also equivalent to one monthly benefit payment.

How are survivors' benefits accessed?

If you wish to take out voluntary insurance, you must apply within one year after leaving the Netherlands. Further information can be obtained from the Social Insurance Bank (*Sociale Verzekeringsbank*).

If an insured person dies, survivors resident in the Netherlands must submit an application for a surviving partner's and/or (half-)orphan's pension as soon as possible to the Social Insurance Bank. If an application is submitted more than a year after the insured person's death, this may result in a financial disadvantage.

Receiving a survivor's pension does not rule out qualifying for family allowances. Further information can be obtained from the Social Insurance Bank.

In the case of death after expiration of the insurance period, survivors must submit their application to the pension insurance institution of their country of residence, which will forward it to the Social Insurance Bank. If a claim is submitted more than a year after the death of the insured person, this may result in a financial disadvantage. The Social Insurance Bank will examine whether the conditions for the award of a pension have been fulfilled and will at the same time establish whether you are entitled to family allowances.

Chapter VIII: Benefits in respect of accidents at work and occupational diseases

When are you entitled to benefits in respect of accidents at work and occupational diseases?

There is no separate insurance scheme in the Netherlands for accidents at work and occupational diseases. If you are incapable of working as a result of an accident at work or an occupational disease, the rules on sickness apply for the first two years. Thereafter you may be eligible for an invalidity benefit in cash. You are also entitled to benefits in kind under your sickness insurance.

What is covered?

See part on sickness cash benefits and part on invalidity.

How are benefits in respect of accidents at work and occupational diseases accessed?

See part on sickness cash benefits and part on invalidity.

Chapter IX: Family benefits

When are you entitled to family benefits?

If you live or work in the Netherlands, you are normally entitled to child benefit from the first child onwards. The entitlement covers your own children, stepchildren and adoptive children, provided that they are aged under 16 and are your dependants as defined by Dutch legislation. In the case of children between 16 and 18, additional requirements must be met: the child concerned must either be studying, disabled or unemployed. Conditions regarding maintenance apply for children not living with their parents, i.e. the amount of family benefit may vary depending on the level of maintenance given by the parents. The income of the child may not exceed certain thresholds for children not living with their parents and children living at home aged 16 and 17 years.

To be entitled to child benefit, the claimant must be insured on the first day of the quarter in which the claim is submitted. The qualifying conditions for child benefit must also be satisfied by that date.

Besides the above mentioned child benefit there is an act on child-related allowance. The amount of this allowance depends on the income of the parents, the number of children and the age of the children.

What is covered?

The amount paid in child benefit depends on the size of the family and on the ages of the children on the first day of each quarter (the reference date).

How are family benefits accessed?

In order to obtain child benefit, you should submit a claim form, duly completed and signed, to the office *(Vestigingskantoor*) of the Social Insurance Bank (*Sociale Verzekeringsbank - SVB*) responsible for the district where you live. Claim forms can be obtained from the Social Insurance Bank. If the child is born in the Netherlands, the SVB will send you an application form within a few weeks. After the initial application, only those changes which may affect entitlement to child benefit should be communicated to the local office of the SVB. Child benefit is paid at the end of each quarter. Where children are members of the household of a married couple, the claim can be made by either spouse. Where parents are divorced or separated, the claim must be made by the parent where the child lives.

Chapter X: Unemployment

When are you entitled to unemployment benefits?

If you become unemployed in the Netherlands, you are entitled to unemployment benefit under the Unemployment Benefits Act (*Werkloosheidswet* or *WW*). In order to qualify for *WW*, you must fulfil certain conditions, notably:

- you must have lost at least five working hours (and corresponding wage) as an employee per week (employees with a job of less than 10 hours per week must have lost half of these hours);
- you must be available for work on the Dutch labour market;
- you need to have received a wage in at least 26 weeks out of the 36 weeks before your first day of unemployment (weeks' condition).

If you meet these conditions, you are entitled to *WW*, unless:

- you are entitled to a benefit for sickness of full disablement;
- you reached the legal retirement age;
- you live or reside outside the Netherlands;
- you are imprisoned;
- you are in a few other situations.

If you do not satisfy the conditions for unemployment benefit, or your entitlement to this benefit has expired, you may, in certain circumstances, be eligible for a social assistance benefit paid by the municipality where you live. The amount of this benefit depends on your family circumstances and on your means and those of your partner (where applicable).

If you are entitled to WW, you must fulfil certain obligations, for instance:

- you must register in time with the Institute for Employee Benefit Schemes *(UWV)*;
- you must sufficiently seek and accept suitable work;
- you must inform the UWV about activities like soliciting and work.

Not fulfilling these obligations leads to termination or a sanction on the benefit.

What is covered?

You receive 75% of the last daily wage (which is set at a maximum) during the first two months, and 70% thereafter.

The duration of benefits is limited. A person who only meets the weeks' condition receives benefits for a maximum duration of three months. A person who also meets the years' condition receives benefits for as many months as the number of months in employment, with a maximum of 38 months. You meet the years' condition if you have received a wage over at least 208 hours in at least four years of working out of the last five years preceding the year in which you became unemployed (note that the previous 52-days condition remains relevant for determining benefit entitlement and duration when years prior to 2013 are considered).

In certain cases, if your benefit is lower than the social minimum *(sociaal minimum)*, you are entitled to claim a supplementary payment under the Supplementary Benefits Act (*Toeslagenwet*). At all events, the benefit will cease on the day you reach the legal retirement age; as a rule, you are then entitled to an old-age pension.

How are unemployment benefits accessed?

In order to obtain unemployment benefit, you must submit a claim to the Institute for Employee Benefit Schemes (*UWV*) where you also have to register as a job seeker.

Chapter XI: Minimum resources

When are you entitled to benefits regarding minimum resources?

Supplementary Benefits Act *(TW)*

The Supplementary Benefits Act guarantees a minimum income for certain benefits' recipients whose level of income is below the social minimum. It provides for a supplementary benefit amounting to the difference between actual income and the social minimum.

This benefit may be paid in addition to sickness, unemployment or occupational disability benefit, pregnancy/maternity allowance or an adoption/guardianship grant.

You are entitled to supplementary benefit if:

- you are married (or cohabiting) and your (household) income is less than the minimum wage, or;
- there is just yourself and a child aged under 18 and household income is less than 90% of the minimum wage, or;
- you live on your own and your income is less than 70% of the minimum wage.

Act on Incapacity Benefits for Disabled Young People *(Wajong)*

This Act provides for support in finding and keeping paid employment for disabled young people and students who have become disabled at an early age. Additionally, young disabled people can apply for income support to supplement their earnings from employment.

You are entitled to this support and/or benefits under the Act if on the day of your seventeenth birthday you are not capable of earning more than 75% of the wage that a healthy person with the same education and work experience earns (*maatman*). You can also be entitled to this support and/or benefits if you are less than 30 years old, and are not capable of earning more than 75% of the wage of a healthy person with the same education and work experience (*maatman*) during the time as a student, and this will, at the end of your studies, prevent you from fully pursuing a professional activity. You must have been a student for at least six months during the year prior to becoming disabled.

You cease to be eligible for *Wajong* support/benefit when you reach the legal retirement age, or if you are able to earn more than 75% of the wage of the *maatman*.

You are entitled to a *Wajong* benefit if you have been recognised as not being able to earn more than 75% of the wage of the *maatman* for at least 52 consecutive weeks. In other words, there is a waiting period of one year. This takes into account periods of sickness of four consecutive weeks.

At the end of the waiting period, you still must not be able to earn more than 75% of the wage of the *maatman*. Even if this is not the case, you will continue to be eligible

for the benefit if during four weeks counting from the end of the waiting period you cannot earn more than 75% of the wage of the *maatman*.

Social assistance

As a safety net facility, the Work and Social Assistance Act (*Wet Werk en Bijstand - WWB*) grants a minimum income to anyone legally resident in the Netherlands who has insufficient means to support him- or herself. The assistance benefit bridges the period until you find a job. You have to do anything in your power to support yourself again and you are obliged to agree to work that is generally accepted. If you are unsuccessful in getting work, your local municipality, at which you have applied for social benefit and/or a reintegration company can support you in finding work or an education. An individual living alone with housing costs is in principal entitled to a social assistance benefit of 70% of the minimum wage.

For more detailed information on the WWB, please refer to the MISSOC Tables.

What is covered?

Supplementary Benefits Act (*TW*)

The *TW* will come into play to supplement your wage or salary in every employee insurance scheme if the benefit falls below the social minimum (70% of minimum wage) and where your employer continues to pay you in a second year of sickness, but only 70% of your wage or salary, which could mean that your income falls below the social minimum.

Act on Incapacity Benefits for Disabled Young People (*Wajong*)

The amount of the benefit provided depends on your age and the wage you earn. The income support is designed so that young disabled people will generate as much of their income as possible themselves, and the general approach is to make going to work an attractive and worthwhile proposition. The *Wajong* benefit will change as the situation changes. If there is any change to someone's health, job or salary, the benefit may be adjusted. This is why the Institute for Employee Benefit Schemes *(UWV)* will continue to assess the situation.

A *Wajong* benefit is payable for as long as the inability to work lasts and ends when the recipient reaches the legal retirement age. The *UWV* may require you to undergo a reassessment of your incapacity.

How are minimum resources benefits accessed?

Supplementary Benefits Act (*TW*)

The benefit is paid by the Institute for Employee Benefit Schemes *(UWV)*. Once your eligibility for this benefit has been recognised, you have six weeks to submit your claim. Applications for a supplement to any benefit scheme have to be made to the UWV Work Company *(UWV Werkbedrijf)*.

Act on Incapacity Benefits for Disabled Young People (*Wajong*)

If you have become (partially) disabled before your seventeenth birthday, you can apply for *Wajong* with the *UWV* four months before your eighteenth birthday.

If you have become (partially) disabled during your studies and you have not reached the age of 30, you can apply for *Wajong* within eight months after becoming disabled.

Chapter XII: Long-term care

When are you entitled to long-term care?

The Exceptional Medical Expenses Act *(Algemene wet bijzondere ziektekosten, AWBZ)*, Law of 14 December 1967 covers the risks of care for long-term hospitalised persons, elderly people, disabled persons and mentally disabled persons with chronic problems.

All residents and non-residents who work in the Netherlands and consequently pay tax on wages, are insured for long-term care.

Medical care is covered by two different insurance schemes which complement each other: healthcare insurance and exceptional medical expenses insurance. The latter is based on the Exceptional Medical Expenses Act (*Algemene Wet Bijzondere Ziektekosten – AWBZ*). Everyone living or working in the Netherlands is insured under the *AWBZ*. In principle, the people compulsorily insured under this Exceptional Medical Expenses Act are obliged to take out health insurance. The government has made two exceptions to the general rule: for members of the armed forces on active service and for people with conscientious objections.

What is covered?

The care is defined in the form of five broadly-defined functions: (personal care (e.g. providing assistance with showering, dressing, shaving, going to the toilet, eating and drinking), nursing (e.g. dressing wounds, administering medication and injections), supportive guidance (e.g. helping to organise the day or learn to look after one's household), treatment (e.g. specific treatment by a geriatric specialist, a doctor for the developmentally disabled or by a behavioural scientist) and accommodation (e.g. sheltered housing and inpatient care when care in the home environment is not suitable due to excessive need of care).

Care is provided in the form of 'products'. Home care, admission to a nursing home, admission to an institution for the developmentally or physically disabled are all examples of products offered under the *AWBZ*. A product consists of a single function or of a combination of functions.

Within the framework of an experiment with regard to cash benefits, the insured person can opt not to obtain care provision in kind, but to receive a personal care budget *(persoonsgebonden budget, PGB)* to enable him/her to purchase care independently. This budget is only available for people with an indication for long stay (accommodation) or an indication for personal care and nursing. The amount of the PGB is dependent on the required care. People who already receive a PGB without having an indication for long stay (accommodation) retain their budget until 1 January 2014.

A yearly financial compensation of € 200 is granted to informal caregivers who provide long-term care at home to a person with an indication for long-term care.

The care is given as a benefit in kind. The benefits in kind covered are:

Home care

This is care provided at home by an institution to insured persons with a somatic, psychogeriatric or psychiatric condition or impediment, or a physical or mental disability. Activities in the field of personal care are supported or taken over, with the aim of compensating for the (temporary) inability of the insured person to live independently.

Home care includes the loan of nursing equipment for a maximum period of 26 weeks.

Semi-residential care

This is care provided in an institution for insured persons with a somatic, psychogeriatric or psychiatric condition or impediment, or a physical or mental disability. The care is aimed at promoting or preserving independent living and serves to prevent institutionalisation or neglect of the insured person.

Residential care

This is care in an institution that is necessary due to the need for a protected living environment, therapeutic environment or permanent supervision of an insured person with a somatic, psychogeriatric or psychiatric condition or impediment, or a physical or mental disability.

Other benefits

In addition to care functions as mentioned above, there is also entitlement under the AWBZ to, for example, patient transport, nursing supplies, care and support related to sign language, rehabilitation care, prenatal care, research into certain congenital metabolic disorders, and vaccinations included as part of a vaccination programme.

How is long-term care accessed?

The Care Needs Assessment Centre *(Centrum Indicatiestelling Zorg, CIZ)* is responsible for determining impartially, objectively and thoroughly whether care is required and, if so, what type of care and how much care is needed.

The *CIZ* assesses the need for care according to the International Classification of Functioning, Disability and Health (*ICF*) of the World Health Organisation. The assessment made by the *CIZ* is valid for a certain period with a maximum of five years. After this period, a new needs assessment is required.

Care is mainly provided by institutions. In order to be entitled to provide care under the *AWBZ*, an institution must have received approval and concluded an agreement with a body that implements the provisions of this Act.

Insured persons can also choose to use their personal care budget *(persoonsgebonden budget, PGB)* to receive assistance from informal caregivers (such as a neighbour or a friend) or professional providers (such as specialised agencies).

Your insurer will provide you with a certificate of registration so that you can prove you are an insured person when requesting medical care. People who have taken out health care insurance under the Health Insurance Act are registered automatically with the health care insurer for *AWBZ* insurance.

Annex: Useful addresses and websites

For social security issues concerning more than one EU country, you may search for a contact institution in Europe on the Institutions' directory maintained by the European Commission and available at: http://ec.europa.eu/social-security-directory

If you would like to know more about social security in the Netherlands, consult *Stand van zaken van de sociale zekerheid: overzicht 1 juli 2013* (Social security in the Netherlands as at 1 July 2013) at:
http://www.rijksoverheid.nl/documenten-en-publicaties/brochures/2013/06/28/stand-van-zaken-sociale-zekerheid-juli-2013.html

If you would like to know more about healthcare in the Netherlands, consult *Gezondheid en Zorg* at:
http://www.rijksoverheid.nl/themas/gezondheid-en-zorg

Information on legislation in English:
http://www.government.nl/issues/pensions-and-benefits

Information on cross-border social security

Healthcare Insurance Board
College voor zorgverzekeringen (CVZ)
Postbus 320
1110 AH Diemen
Tel.: (31-10) 428 9551
http://www.buitenland.cvz.nl

Social Insurance Bank
Sociale Verzekeringsbank (SVB)
Postbus 357
1180 AJ Amstelveen

International Secondments Department
Internationale Detachering (ID)
Tel.: (31-20) 656 52 77

Voluntary Insurance
Vrijwillige Verzekeringen AOW / Anw
Tel. 020 656 52 25
Vestiging Roermond Postbus 1244
6040 KE Roermond
Tel.: (31-475) 36 80 40
http://www.svb.nl

German Affairs Department
Bureau voor Duitse Zaken
Takenhofplein 4
6538 SZ Nijmegen
Tel.: (31-24) 343 19 00

http://www.svb.nl/bdz
bdz@svb.nl

Belgian Affairs Department
Bureau voor Belgische Zaken
Rat Verleghstraat 2
4815 NZ Breda
Tel.: (31-76) 54 85 840
http://www.svb.nl/bbz
bbz@svb.nl

Institute for Employee Benefit Schemes
Uitvoeringsinstituut Werknemersverzekeringen (UWV)
Postbus 58285 1040 HG Amsterdam
Tel.: (31-88) 898 2001
http://www.uwv.nl

Healthcare Insurance Benefits outside the Netherlands (Agis)
Zorgverzekering buitenland (Agis)
Postbus 19 3800 HA Amersfoort
Tel.: (31-900) 8685
http://www.agisweb.nl

Healthcare Insurance Benefits outside the Netherlands (CZ Sittard)
Zorgverzekering buitenland (CZ Sittard)
Postbus 55
6130 MA Sittard
http://www.cz.nl

Information on cross-border taxation

Advisory centre on working and starting a business across borders - Germany, Belgium, Netherlands
Steunpunt Grensoverschrijdend Werken en Ondernemen (GWO) Duitsland, België Nederland
Terra Nigrastraat 10
6216 BL Maastricht
Tel.: 0800 024 12 12 (from the Netherlands)
0800 902 20 (from Belgium)
0800 101 13 52 (from Germany)
http://www.belastingdienst.nl

Tax and Customs Administration
Belastingdienst
Limburg/Department of International Issues
(Limburg/kantoor Buitenland)
Postbus 2865
6401 DJ Heerlen
Tel.: (31-55) 53 85 385
http://www.belastingdienst.nl
http://www.minfin.nl/nl/onderwerpen,belastingen/belastingen_internationaal