Member's name	
Health insurance number	Member's date of birth

Main insured person's general information

I previously had the following health insurance:

☐ I was covered through my own membership

☐ I was covered through family insurance

☐ Non-statutory insurance

Name of health insurance company or general insurance company (please provide the full name):

Marital status

☐ Married since |_|_|_|_|_|_|_|_|

☐ Living apart since |_|_|_|_|_|_|_|_|

☐ Divorced since |_|_|_|_|_|_|_|_|

☐ Widowed since |_|_|_|_|_|_|_|_|

☐ In a registered civil partnership since |_|_|_|_|_|_|_|_|

☐ single

Reason for inclusion in the family insurance cover

☐ I'm starting my membership

☐ Birth of a child

☐ A relative's previous membership has ended

☐ Immigration from abroad on |_|_|_|_|_|_|_|_|

☐ Marriage

☐ Other:

Important information regarding your details

We always need the information regarding your spouse's / life partner's health insurance if this family insurance is going to cover your children and your spouse / life partner is related to the children. If your spouse / life partner does not have statutory health insurance, their income must be stated and verified with proof of income. Extra charges that are paid in relation to marital status should not be taken into account when providing the information on income. If your spouse / life partner is a member of a statutory health insurance company, no income information is required. Please note that taking out family insurance with different health insurance companies at the same time is not permitted. For this reason, please make sure that your information confirms you do not have double family insurance.

Information about your family members (please fill in the fields that apply to you)

	Spouse/ life partner	**Child**	**Child**	**Child**
Should family insurance be taken out?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Start of family insurance	|_|_|_|_|_|_|_|_|	|_|_|_|_|_|_|_|	|_|_|_|_|_|_|_|	|_|_|_|_|_|_|_|
Surname*				
* If you and your family members do not have the same surname, we require a copy of the birth or marriage certificate. If you cannot provide these documents, you can provide one-off proof of the family relationship using other suitable documents, (such as a child allowance notice).				
First name				
Date of birth	|_|_|_|_|_|_|_|_|	|_|_|_|_|_|_|_|	|_|_|_|_|_|_|_|	|_|_|_|_|_|_|_|
Health insurance number				
Pension insurance number				
Place of birth				
Country of birth				
Nationality				
The information in the following section is only required if a pension insurance number has not been assigned yet.				
Birth name				
Multiple	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

HEK

Member's name	
Health insurance number	Member's date of birth

	Spouse / life partner	**Child**	**Child**	**Child**
Surname				
First name				
Different address to that of the member if applicable				
Gender (m = male, f = female, v = various, u = unknown)	☐ m ☐ f ☐ v ☐ u	☐ m ☐ f ☐ v ☐ u	☐ m ☐ f ☐ v ☐ u	☐ m ☐ f ☐ v ☐ u
Relationship to the member	--- Not applicable ---	☐ Biological child ☐ Stepchild ☐ Foster child ☐ Grandchild	☐ Biological child ☐ Stepchild ☐ Foster child ☐ Grandchild	☐ Biological child ☐ Stepchild ☐ Foster child ☐ Grandchild
Are you married to the child's parent?	--- Not applicable ---	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Previous insurance cover has ended Health insurance company's name (Please enter the full name of the health insurance company or general insurance company.)	The previous insurance cover ended on |_|_|_|_|_|_|_|_| and was provided by _____	The previous insurance cover ended on |_|_|_|_|_|_|_|_| and was provided by _____	The previous insurance cover ended on |_|_|_|_|_|_|_|_| and was provided by _____	The previous insurance cover ended on |_|_|_|_|_|_|_|_| and was provided by _____
The previous insurance cover continues to be provided by (Please enter the full name of the health insurance company or the insurance company.)		--- Not applicable ---	--- Not applicable ---	--- Not applicable ---
Type of previous or existing insurance	☐ Membership ☐ Family insurance ☐ Non-statutory	☐ Membership ☐ Family insurance ☐ Non-statutory	☐ Membership ☐ Family insurance ☐ Non-statutory	☐ Membership ☐ Family insurance ☐ Non-statutory
If family insurance was the most recent type of insurance: Surname and first name of the person who held that family insurance policy	Surname First name	Surname First name	Surname First name	Surname First name

Other information about your family members

Attending school or studying (For children aged 23 or above, current school or provide certificate of study.)	--- Not applicable ---	From |_|_|_|_|_|_|_|_| until |_|_|_|_|_|_|_|_|	From |_|_|_|_|_|_|_|_| until |_|_|_|_|_|_|_|_|	From |_|_|_|_|_|_|_|_| until |_|_|_|_|_|_|_|_|
Military service or legally regulated voluntary service (Please provide certificate of length of service.)	--- Not applicable ---	From |_|_|_|_|_|_|_|_| until |_|_|_|_|_|_|_|_|	From |_|_|_|_|_|_|_|_| until |_|_|_|_|_|_|_|_|	From |_|_|_|_|_|_|_|_| until |_|_|_|_|_|_|_|_|
Is a change in circumstances that will lead to the end of family insurance foreseeable? This could be a family member finishing school or starting employment, for example.	☐ Yes, from |_|_|_|_|_|_|_|_| What is the change?	☐ Yes, from |_|_|_|_|_|_|_|_| What is the change?	☐ Yes, from |_|_|_|_|_|_|_|_| What is the change?	☐ Yes, from |_|_|_|_|_|_|_|_| What is the change?

HEK

Member's name	
Health insurance number	Member's date of birth

	Spouse / life partner	**Child**	**Child**	**Child**
Surname				
First name				
Self-employment (Please provide a copy of the current income tax assessment.)	☐ Yes Monthly profit from self-employment _____ __	☐ Yes Monthly profit from self-employment _____ __	☐ Yes Monthly profit from self-employment _____ __	☐ Yes Monthly profit from self-employment _____ __
Marginal employment	☐ Yes Monthly gross pay _____ __	☐ Yes Monthly gross pay _____ __	☐ Yes Monthly gross pay _____ __	☐ Yes Monthly gross pay _____ __
More than marginal employment (Please provide relevant proof.)	☐ Yes Monthly gross pay _____ __	☐ Yes Monthly gross pay _____ __	☐ Yes Monthly gross pay _____ __	☐ Yes Monthly gross pay _____ __
Statutory pension, pension payments, company pension and other pensions (Please provide relevant proof.)	☐ Yes Monthly amount paid _____ __	☐ Yes Monthly amount paid _____ __	☐ Yes Monthly amount paid _____ __	☐ Yes Monthly amount paid _____ __
Other regular income governed by income tax law (For example, income from capital assets or rental and leasing or other income, such as severance pay in the event of loss of employment. Please provide us with relevant proof for each type of income.)	☐ Yes Type of income _____ Monthly Income _____ __	☐ Yes Type of income _____ Monthly Income _____ __	☐ Yes Type of income _____ Monthly Income _____ __	☐ Yes Type of income _____ Monthly Income _____ __
Benefits according to Book II or III of the German Social Code (Please provide a copy of the benefit notice.)	☐ Yes Since _____	☐ Yes Since _____	☐ Yes Since _____	☐ Yes Since _____

My contact details (providing this information is not mandatory)

Private phone number	Mobile phone number
Email address	

I confirm that these details are correct. I will inform you of any changes immediately. This applies in particular if the income of the relatives I have mentioned above changes, (for example, in the event of a new income tax assessment for self-employment) or if they become members of a (another) health insurance company.

Place and date

Member's signature

Family members' signatures if applicable

By signing this document, I declare that I have received the consent of the family members concerned to submit the required details.

In the case of family members living separately, the family member's signature is sufficient.

Data protection notice (Artikel 13 der Verordnung (EU) 2016/679): In order for us to be able to fulfil our duties lawfully, your cooperation in accordance with §§ 10 Abs. 6, 289 Sozialgesetzbuch (SGB) V is required. The data is collected to determine the relationship between the individuals insured (§§ 10, 284 SGB V, § 7 Zweites Gesetz über die Krankenversicherung der Landwirte (KVLG) 1989, § 25 SGB XI).