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| **Questionnaire for inclusion in the family insurance policy** |

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| **1. Member`s general data** |

****Up until now I was/I am

🞏 insured independently

🞏 insured under a family insurance policy Name of health insurance fund

🞏 not insured by a statutory health fund

Family status: 🞏 Unmarried 🞏 Married 🞏 Separated 🞏 Divorced 🞏 Widowed

🞏 Registered civil partnership in compliance with the Civil Partnership Act – LPartG

(in this case the data must be entered under „Spouse“)

Reason for inclusion in the family insurance policy:

🞏 Start of my membership 🞏 Birth of the Child (add a copy of the birth certificate) 🞏 Marriage

🞏 Termination of the relative`s prior own membership

🞏 Other:

**Start of the family insurance:**

I am available for further inquiries at this telephone-no.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ during the daytime (voluntary information).

My email adress is: (voluntary information).

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| **2. Information about family members** |

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| The following data are in principle only required for those relatives who are to be co-insured by us. By way of derogation from this we require individual information about your spouse/civil partner even if the family insurance is intended exclusively for your children. In this case, besides the general data, we require the information about your spouse’s/civil partner’s insurance and – if the spouse/civil partner does not have statutory insurance and is related to the children – it is imperative to provide evidence of income plus allowances which are paid out of consideration for the family status. The information about those aforementioned allowances must be disregarded.  **Please pay attention that it is illegal to take out co-insurance with different health funds. Please therefore make sure that double co-insurance is excluded.** |

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|  | **Spouse** | **Child** | **Child** | **Child** |
| Name\* |  |  |  |  |
| \* Please enclose a marriage certificate or proof of descent if your spouse/civil partner or your children bear a different name and you have not already  presented these documents. | | | | |
| First name |  |  |  |  |
| Gender (m = male, f = female) | 🞏 (m) 🞏 (f) | 🞏 (m) 🞏 (f) | 🞏 (m) 🞏 (f) | 🞏 (m) 🞏 (f) |
| Date of birth |  |  |  |  |
| Adress if it differs from that of the member |  |  |  |  |
| Relationship between member and child  (\* The term „biological child“ must also be used for adopted children.) |  | 🞏 Biological child\* 🞏 Stepchild 🞏 Grandchild  🞏 Foster child | 🞏 Biological child\* 🞏 Stepchild 🞏 Grandchild  🞏 Foster child | 🞏 Biological child\* 🞏 Stepchild 🞏 Grandchild  🞏 Foster child |
| Is the spouse related to the child?  (Please only cross if this is not the case) |  | 🞏 (No) | 🞏 (No) | 🞏 (No) |

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| **3. Information concerning last insurance policy to date or the still-existing insurance of the family members** |

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|  | **Spouse** | **Child** | **Child** | **Child** |
| The insurance   * ended on: * was with: (name of health insurance fund) | .......................  .......................... | .......................  .......................... | .......................  .......................... | .....................  .......................... |
| Type of insurance to date: | 🞏 Membership 🞏 co-insurance 🞏 not statutory | 🞏 Membership 🞏 co-insurance 🞏 not statutory | 🞏 Membership 🞏 co-insurance 🞏 not statutory | 🞏 Membership 🞏 co-insurance 🞏 not statutory |
| Insofar as a family insurance already existed, name and first name of the person whose membership is the basis for the co-insurance. | ......................  ......................  (name, first name) | ......................  ...................... (name, first name) | .......................  ...................... (name, first name) | ......................  ...................... (name, first name) |
| The previous insurance continuous with: (Name of health insurance fund / health insurance) |  | \_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ |

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| **4. Other information about family members** |

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|  | **Spouse** | **Child** | **Child** | **Child** |
| ****self-employed  (If Yes, please answer further questions:)  - main source of income  **-** I declare that I have workers employed more than minor.  - Number of hours worked per week | 🞏 Yes 🞏 No  🞏 Yes 🞏 No  🞏 Yes 🞏 No  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞏 Yes 🞏 No  🞏 Yes 🞏 No  🞏 Yes 🞏 No  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞏 Yes 🞏 No  🞏 Yes 🞏 No  🞏 Yes 🞏 No  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞏 Yes 🞏 No  🞏 Yes 🞏 No  🞏 Yes 🞏 No  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Profit from self-employed professional activities (monthly)  Please enclose a copy of the current notice of income tax assessment | EUR | EUR | EUR | EUR |
| Gross pay from minor employment (per month) | EUR | EUR | EUR | EUR |
| pension, pensions and related benefits, occupational pension, foreign pension, other pensions (monthly amount paid) | EUR | EUR | EUR | EUR |
| monthly earnings as defined in the income tax law (e.g. gross pay from a more than marginal employment, income from rentals and royalties, income from capital assets) | ..................EUR................. (Type of income) | ..................EUR................. (Type of income) | ..................EUR................. (Type of income) | .................EUR................. (Type of income) |
| School education/Studies (For children above the age of 22, please enclose confirmation of enrolment) |  | from...................  to .................... | from...................  to .................... | from...................  to .................... |
| Military service or statutory volunteer work (Please enclose confirmation of period of service) |  | from...................  to .................... | from...................  to .................... | from...................  to .................... |

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| **5. Information on the allocation of a health insurance number for co-insured dependents** |

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|  | **Spouse** | **Child** | **Child** | **Child** |
| Own pension insurance fund number |  |  |  |  |
| The following data are only required if a pension insurance fund no has not been allocated. | | | | |
| Name at birth: |  |  |  |  |
| Place of birth: |  |  |  |  |
| Country of birth: |  |  |  |  |
| BKK_DBNationality: |  |  |  |  |

I confirm that the information given is correct. I will inform you immediately if any changes are made. This applies in particular if the income of my aforementioned relatives changes (e.g. a new notice of income tax assessment for a self-employed occupation) or if they become members a (different) statutory health insurance fund. By my signature I declare that the family members have given approval for me to submit the necessary data.

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| *Place, date* |  | *Member`s signature* |  | *\*If required, signature of the family members* |

*\*If the family members live separately, the family member`s signature will suffice.*