_____ _____

(First name and surname of the member) *(Health insurance number)*

Betriebskrankenkasse Deutsche Bank AG

Questionnaire for admission to the family insurance scheme

1. General information about the member

- I am

☐ within the framework of own membership

☐ within the framework of family insurance > insured by: _____

Name of the health insurance company

☐ not covered by statutory health insurance

- Marital status: ☐ single ☐ married ☐ separated ☐ divorced ☐ widow

☐ Registered civil partnership under the Civil Partnership Act - LPartG
(in this case, the information is to be provided under the heading "Spouse")

- Reason for inclusion in the family insurance scheme:

☐ Start of my membership ☐ Birth of the child (please enclose a copy of the birth certificate) ☐ Marriage

☐ Termination of the relative's own previous membership

☐ Other _____

- **Start of family insurance:** _____

- If you have any queries, you can contact me during the day at telephone no.: _____ (voluntary entry)
- My e-mail address is: _____
(voluntary entry)

2. Details of family members

The following data are generally only required for those relatives who are to be insured with us as family members.
In deviation from this, we also require individual details of your spouse/life partner if we are only to provide family insurance for your children. In this case, in addition to the general information, information on the insurance of the spouse/life partner and – if the spouse/life partner is not insured by law and is related to the children – on his or her income is necessary; in this case, it is mandatory to prove the income by means of proof of income and to disregard supplements paid with regard to the marital status in the information on income.
Please note that it is not legally permissible to have family insurance with different health insurance companies at the same time. Therefore, please ensure with your information that double family insurance is excluded.

3. General details of the family members

	Spouse	Child	Child	Child
Surname*				
* In the case of different surnames: Do we already have the Birth or marriage certificate? If not, please attach.				
First name				
Gender (m = male, f = female, X= diverse)	☐ (m) ☐ (f)	☐ (m) ☐ (f) ☐ (x)	☐ (m) ☐ (f) ☐ (x)	☐ (m) ☐ (f) ☐ (x)
Date of birth				
Address differing from that of the member, if applicable				
Relationship of the member to the child (* The term "natural child" is also to be used in the case of adoption.)		☐ Natural child* ☐ Step child ☐ Grandchild ☐ Foster child	☐ Natural child* ☐ Step child ☐ Grandchild ☐ Foster child	☐ Natural child* ☐ Step child ☐ Grandchild ☐ Foster child
Is the spouse related to the child? (Please tick only if there is no family relationship)		☐ (No)	☐ (No)	☐ (No)

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Betriebskrankenkasse Deutsche Bank AG

(First name and surname of the member) _____ (Health insurance number) _____

4. Details of the last previous or continuing insurance of the family members

	Spouse	Child	Child	Child
The previous health insurance • ended on: • existed with: (Name of the health insurance company)	....	....	....	....
Type of the previous health insurance	☐ Membership ☐ Family insurance ☐ not statutory	☐ Membership ☐ Family insurance ☐ not statutory	☐ Membership ☐ Family insurance ☐ not statutory	☐ Membership ☐ Family insurance ☐ not statutory
If family insurance was last in force, surname name and first name of the person from whose membership the family insurance was derived.	.... (Surname, first name)	.... (Surname, first name	.... (Surname, First name	.... (Surname, First name
The previous insurance **continues** with: (Name of the health insurance company / health insurance)				

5. Other details of the family members

	Spouse	Child	Child	Child
▸ **Self-employed activity exists** (If so, please answer further questions:) - Main source of income - I declare that I have employed workers more than marginally. - 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) .....
Earnings from self-employment (monthly) Please enclose a copy of the current income tax assessment. If you have received a start-up grant, a copy of this notification.	EUR	EUR	EUR	EUR
Gross remuneration from marginal employment (monthly)	EUR	EUR	EUR	EUR
Statutory pension, pension benefits, occupational pension, foreign pension, other pensions (monthly payment amount)	EUR	EUR	EUR	EUR
Other regular monthly income within the meaning of income tax law (e.g. gross remuneration from more than marginal employment, income from renting and leasing, income from capital assets), other income, e.g. severance pay	EUR	EUR	EUR	EUR
School attendance/Studies (Please enclose school or study certificate for children aged 23 and over.)		from ..... to	from ..... to	from ..... to .....
Military/civilian service or statutory service Voluntary service (Please enclose certificate of service)		from ..... to	from ..... to	from ..... to .....

6. Other information on the allocation of a health insurance number for family-insured relatives

	Spouse	Child	Child	Child
Own pension insurance number:				
The following information is only required if a pension insurance number has not yet been assigned.				
Name at birth:				
Place of birth:				
Country of birth:				
Nationality:				

I confirm that the information provided is correct. I will inform you immediately about any changes. This applies in particular if the income of my above-mentioned relatives changes (e.g. new income tax assessment in the case of self-employment) or if they become a member of a (different) health insurance company. By signing this form, I declare that I have obtained the consent of the family members to provide the required data.

_____ _____ _____

Place, date *Member signature* ** if required Signatures of family members*

**In the case of separated family members, the signature of the family member is sufficient.*

Data protection notification: In order for us to be able to fulfil our tasks lawfully, your cooperation is required in accordance with §§ 10 para. 6, 289 Social Security Code (SGB) V.
The data must be collected to establish the insurance relationship (§§ 10, 284 Social Security Code (SGB) V, § 7 Farmers' Health Insurance Act (KVLG) 1989, § 25 Social Security Code (SGB) XI).
The contact details (email and telephone number) are voluntary and will only be used for queries regarding your insurance relationship. For more information about how we process your personal data and your rights under the EU General Data Protection Regulation, please visit our website at www.bkkdb.de/Datenschutzhinweise.

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