Questionnaire Membership Application Family Insurance

Fragebogen für die Aufnahme in die Familienversicherung

Member's First Name Vorname des Mitglieds

Member's Last Name Name des Mitglieds

HI Number KV-Nummer

1. General Member Information Allgemeine Angaben des Mitglieds

I was previously Ich war bisher

- ☐ Within the scope of my own membership im Rahmen einer eigenen Mitgliedschaft
- ☐ in a family insurance plan im Rahmen einer Familienversicherung

insured with versichert bei

Name of the Health Insurance Plan
Name der Krankenkasse

- ☐ Not a member of any statutory health insurance plan nicht gesetzlich krankenversichert

Family status Familienstand

- ☐ Single ledig
- ☐ Married verheiratet
- ☐ Separated getrennt lebend
- ☐ Divorced geschieden
- ☐ Widowed verwitwet
- ☐ Registered Life Partnership in accordance with the German Life Partners' Act – LPartG (in this case, please make sure you provide the information requested in Section "Spouses") Eingetragene Lebenspartnerschaft nach dem Lebenspartnerschaftsgesetz – LPartG (In diesem Fall sind die Angaben unter der Rubrik „Ehepartner" zu machen.)

Occasion for Application for Membership in the Family Plan Anlass für die Aufnahme in die Familienversicherung

- ☐ Start of my membership Beginn meiner Mitgliedschaft
- ☐ Termination of the family member's prior own membership Beendigung der vorherigen eigenen Mitgliedschaft des Angehörigen
- ☐ Marriage (please enclose marriage certificate) Heirat (Bitte Heiratsurkunde beifügen.)
- ☐ Birth of a child (please enclose birth certificate) Geburt des Kindes (Bitte Geburtsurkunde beifügen.)
- ☐ Other Sonstiges

Activation date family insurance plan Beginn der Familienversicherung

I can be reached at the following phone number during the daytime*
Bei Rückfragen bin ich tagsüber unter folgender Telefon-Nr. zu erreichen*

(optional information)
(freiwillige Angabe)

My e-mail address is* Meine E-Mail-Adresse lautet*

(optional information) (freiwillige Angabe)

2. Information About Family Members Angaben zu Familienangehörigen

Principally, the following information is only required for family members that you are applying for family insurance coverage for. However, we do need detailed information on your spouse/life partner also if you only intend to have your children covered under the family plan. In this case, besides the general data, the insurance information of your spouse/life partner and – if your spouse/life partner is not covered by statutory health insurance and related to the children – related to his/her income will be required; the verification of the income through the submission of income statements is mandatory and any supplements that are being paid on the basis of the family status do not have to be taken into account as far as the income information is concerned.

Nachfolgende Daten sind grundsätzlich nur für solche Angehörigen erforderlich, die bei uns familienversichert werden sollen. Abweichend hiervon benötigen wir einzelne Angaben zu Ihrem Ehepartner/Lebenspartner auch dann, wenn bei uns ausschließlich die Familienversicherung für Ihre Kinder durchgeführt werden soll. In diesem Fall sind neben den allgemeinen Angaben die Informationen zur Versicherung des Ehepartners/Lebenspartners und – sofern der Ehepartner/Lebenspartner nicht gesetzlich versichert und mit den Kindern verwandt ist – zu seinem Einkommen notwendig; hierbei sind die Einnahmen zwingend durch Einkommensnachweise zu belegen und Zuschläge, die mit Rücksicht auf den Familienstand gezahlt werden, bei den Angaben zu den Einkünften unberücksichtigt zu lassen.

Please remember that it is illegal to file for simultaneous family insurance coverage with different health insurance plans. Consequently, please make absolutely certain that the information you provide will make it possible to rule out that duplicate family insurance coverage is obtained.

Bitte beachten Sie, dass eine gleichzeitige Durchführung der Familienversicherung bei unterschiedlichen Krankenkassen rechtlich unzulässig ist. Stellen Sie deshalb bitte mit Ihren Angaben sicher, dass eine doppelte Familienversicherung ausgeschlossen ist.

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3. General Information about family members Allgemeine Angaben zu Familienangehörigen

	Spouse (Ehepartner)	**Child 1** (Kind 1)	**Child 2** (Kind 2)	**Child 3** (Kind 3)
Name[1] Name[1]				
First name Vorname				
Date of birth Geburtsdatum				
Gender Geschlecht (m = male männlich, f = female weiblich, x = undetermined unbestimmt)	☐ m ☐ f ☐ x	☐ m ☐ f ☐ x	☐ m ☐ f ☐ x	☐ m ☐ f ☐ x
If different from member's address, enter family member's address Ggf. vom Mitglied abweichende Anschrift				
Relationship of the member and the child. Please attach a birth certificate for the child to be insured under this plan. Verwandtschaftsverhältnis des Mitglieds zum Kind. Bitte fügen Sie eine Geburtsurkunde/einen Abstammungsnachweis für das zu versichernde Kind bei.	———	☐ Biological child[2] leibliches Kind ☐ Step child Stiefkind ☐ Grandchild Enkel ☐ Foster child Pflegekind	☐ Biological child[2] leibliches Kind ☐ Step child Stiefkind ☐ Grandchild Enkel ☐ Foster child Pflegekind	☐ Biological child[2] leibliches Kind ☐ Step child Stiefkind ☐ Grandchild Enkel ☐ Foster child Pflegekind
Is your spouse related to the child? (please check this section only if your spouse is not related to the child) Ist der Ehegatte mit dem Kind verwandt? (Bitte nur beim fehlenden Verwandtschaftsverhältnis ankreuzen)	———	☐ No Nein	☐ No Nein	☐ No Nein

[1] Please attach a marriage certificate or birth certificate if your spouse/life partner or children have different last names than you and if you have not already submitted these documents in the past. Fügen Sie bitte eine Heiratsurkunde bzw. einen Abstammungsnachweis bei, wenn Ihr Ehepartner/Lebenspartner bzw. Ihre Kinder einen anderen Namen haben und Sie diese Unterlagen nicht schon vorgelegt haben.

[2] Use the term "biological child" also for any adopted children. Die Bezeichnung „leibliches Kind" ist auch bei Adoption zu verwenden.

4. Information on Most Recent Insurance Coverage or Existing Insurance Coverage of Family Members

Angaben zur letzten bisherigen oder zur weiter bestehenden Versicherung der Familienangehörigen

	Spouse (Ehepartner)	**Child 1** (Kind 1)	**Child 2** (Kind 2)	**Child 3** (Kind 3)
Insurance coverage held to date Die bisherige Versicherung ▪ Ended on: endete am ▪ Was provided by: (name of the health insurance plan) bestand bei: (Name der Krankenkasse)				
Type of insurance coverage held to date: Art der bisherigen Versicherung	☐ Membership family Familienversicherung ☐ insurance plan Mitgliedschaft ☐ Voluntary nicht gesetzlich	☐ Membership family Familienversicherung ☐ insurance plan Mitgliedschaft ☐ Voluntary nicht gesetzlich	☐ Membership family Familienversicherung ☐ insurance plan Mitgliedschaft ☐ Voluntary nicht gesetzlich	☐ Membership family Familienversicherung ☐ insurance plan Mitgliedschaft ☐ Voluntary nicht gesetzlich
I was without health insurance in the last 18 months in Germany. Ich war in den letzten 18 Monaten nicht in Deutschland krankenversichert.	☐ Yes Ja ☐ No Nein	☐ Yes Ja ☐ No Nein	☐ Yes Ja ☐ No Nein	☐ Yes Ja ☐ No Nein
If the most recent insurance coverage was a family plan, enter the name and first name of the individual from whose membership the family plan originated Sofern zuletzt eine Familienversicherung bestand, Name und Vorname der Person, aus deren Mitgliedschaft die Familienversicherung abgeleitet wurde	First name Vorname Last name Name	First name Vorname Last name Name	First name Vorname Last name Name	First name Vorname Last name Name
The existing insurance plan will remain active with: (name of the health insurance plan) Die bisherige Versicherung besteht weiter bei: (Name der Krankenkasse/Krankenversicherung)		———	———	———

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5. Additional Information Concerning Family Members Sonstige Angaben zu Familienangehörigen

	Spouse (Ehepartner)	**Child 1** (Kind 1)	**Child 2** (Kind 2)	**Child 3** (Kind 3)
5.1 Does this person receive Unemployment Benefits II? Wird Arbeitslosengeld II bezogen?	☐ Yes Ja	☐ Yes Ja	☐ Yes Ja	☐ Yes Ja
5.2 School attendance/studies (enclose enrollment certificate for students older than 23) Schulbesuch/Studium (Bitte bei Kindern ab 23 Jahren Schul- oder Studienbescheinigung beifügen.)	_____	from vom _____ to bis _____	from vom _____ to bis _____	from vom _____ to bis _____
5.3 Military service or legally regulated voluntary service (please enclose service time certificate) Wehrdienst oder gesetzlich geregelter Freiwilligendienst (Bitte Dienstzeitbescheinigung beifügen.)	_____	from vom _____ to bis _____	from vom _____ to bis _____	from vom _____ to bis _____
5.4 Self-employed Selbstständige Tätigkeit liegt vor Profit from self-employment (monthly) – please attach a copy of the current income tax return Gewinn aus selbstständiger Tätigkeit (monatlich). Bitte Kopie des aktuellen Einkommensteuerbescheides beifügen.	☐ Yes Ja _____ Euro	☐ Yes Ja _____ Euro	☐ Yes Ja _____ Euro	☐ Yes Ja _____ Euro
5.5 Gross wages from low income job (monthly); please attach respective documentation Bruttoarbeitsentgelt aus geringfügiger Beschäftigung (monatlich)	_____ Euro	_____ Euro	_____ Euro	_____ Euro
5.6 Statutory regular retirement benefits, pensions, corporate pensions, foreign retirement benefits, other retirement benefits (monthly payment amount); please attach documentation Gesetzliche Rente, Versorgungsbezüge, Betriebsrente, ausländische Rente, sonstige Renten (monatlicher Zahlbetrag). Bitte entsprechende Nachweise beifügen.	_____ Euro	_____ Euro	_____ Euro	_____ Euro
5.7 Other periodic monthly income as defined by the German income tax act (e.g. gross wages from more than low paying jobs, income from rentals and lease holds, income from capital assets, incomes from agriculture and forestry). Please include corresponding verification Sonstige regelmäßige monatliche Einkünfte im Sinne des Einkommensteuerrechts (z. B. Bruttoarbeitsentgelt aus mehr als geringfügiger Beschäftigung, Einkünfte aus Vermietung und Verpachtung, Einkünfte aus Kapitalvermögen). Bitte entsprechende Nachweise beifügen.	_____ Euro _____ (type of income) (Art der Einkünfte)	_____ Euro _____ (type of income) (Art der Einkünfte)	_____ Euro _____ (type of income) (Art der Einkünfte)	_____ Euro _____ (type of income) (Art der Einkünfte)

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6. Information Required for Assignment of a Health Insurance Identification Number for Family Members Covered by the Family Plan

Angaben zur Vergabe einer Krankenversichertennummer für familienversicherte Angehörige

	Spouse (Ehepartner)	**Child 1** (Kind 1)	**Child 2** (Kind 2)	**Child 3** (Kind 3)
Own retirement insurance number (RV No) Eigene Rentenversicherungsnummer (RV-Nr.)				
The information below is required only if a retirement insurance number has not been assigned yet. Die folgenden Angaben werden nur dann benötigt, wenn noch keine Rentenversicherungsnummer vergeben wurde.				
Name given at birth Geburtsname				
Place of birth Geburtsort				
Country of birth Geburtsland				
Nationality Staatsangehörigkeit				

I herewith confirm that the information provided is correct. I will immediately notify you if any of the information provided should change. This will apply in particular if my above-mentioned family members' income should change (e.g. new income tax return if self-employed) or if they become members of a (different) health insurance plan.

Ich bestätige die Richtigkeit der Angaben. Über Änderungen werde ich Sie umgehend informieren. Das gilt insbesondere, wenn sich das Einkommen meiner o.a. Angehörigen verändert (z.B. neuer Einkommensteuerbescheid bei selbstständiger Tätigkeit) oder diese Mitglied einer (anderen) Krankenkasse werden.

☐ I agree to my application data being used by IKK classic to inform me of current offers in the areas of health and insurance on the phone, by fax, SMS, or email. I can revoke my consent at any time with effect for the future by contacting IKK classic.

Ich bin damit einverstanden, dass meine Antragsdaten von der IKK classic genutzt werden, um mich telefonisch, per Fax, SMS oder E-Mail über aktuelle Angebote aus dem Gesundheits- und Versicherungsbereich zu informieren. Dieses Einverständnis kann ich jederzeit für die Zukunft bei der IKK classic widerrufen.

Place Ort	Date Datum	Member's signature Unterschrift des Mitglieds	If applicable, family member's signature Ggf. Unterschrift der Familienangehörigen

By signing this document I declare to have obtained my family members' consent to provide the required data.

Mit der Unterschrift erkläre ich, die Zustimmung der Familienangehörigen zur Abgabe der erforderlichen Daten erhalten zu haben.

If family members live in separate households, the signature of the family member shall suffice.

Bei getrennt lebenden Familienangehörigen reicht die Unterschrift des Familienangehörigen aus.

Data protection notice: Collecting your data serves the purpose of assessing your insurance relationship and is based on § 10 and § 284 of SGB V in conjunction with § 94 of SGB XI. The obligation to cooperate comes from §§ 60 et seq. of SGB I. You are not required to provide any data marked with an *. This is collected exclusively for the purposes of answering questions relating to your insurance relationship. You can object to IKK classic using this data at any time in the future. Your data will not be disclosed to third parties. More information regarding data protection can be found at www.ikk-classic.de/datenschutz

Datenschutzhinweis: Die Erhebung Ihrer Daten dient der Beurteilung des Versicherungsverhältnisses und beruht auf § 10, § 284 SGB V i. V. m. § 94 SGB XI. Die Verpflichtung zur Mitwirkung ergibt sich aus §§ 60 ff. SGB I. Die Angabe der mit * gekennzeichneten Daten ist freiwillig und dient ausschließlich für Rückfragen zu Ihrem Versicherungsverhältnis, der Nutzung dieser Daten können Sie jederzeit für die Zukunft bei der IKK classic widersprechen. Eine Weitergabe der freiwilligen Daten an Dritte erfolgt nicht. Weitere Informationen dazu finden Sie unter www.ikk-classic.de/datenschutz

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Family Insurance

Information for the completion of the Questionnaire for Family Insurance Membership Applicants

Date: May 2019

Please keep in mind that it is absolutely prohibited to obtain simultaneously family insurance coverage from multiple health insurance plans.

1. General information about the member:

The following information must be entered into this section of the questionnaire: current family status, the reason for and the start of family insurance coverage.

2. Information about family members

Special requirement if children are added as new members

Please enclose a birth certificate for each child to be insured.

Disabled children

Children who due to a disability are not able to earn an income of their own, will continued to be covered under the family plan beyond age 23 or 25 under certain circumstances and there will be no premiums due for their coverage. Please attach a physician's certificate for the purpose of documentation.

Special requirements for information about spouses

Information about spouses must also be provided if your spouse will not be covered under your family plan. In these cases we absolutely have to know the name of your spouse's health insurance plan (example: insured with: name of the other health insurance plan or private insur-ance coverage).

If your spouse has coverage through a statutory health insurance plan, we do not need his income information. If your spouse has private insurance coverage, we need information on your and his/her income. Proof of income must be provided in the form of copies of respective records (self-employed individuals = last valid income tax return, employees = last valid income tax return or payroll statement or a current unemployment benefits statement issued by the Federal Department of Labor). However, if your spouse is not related to any of the children covered under your family plan, you do not have to provide any information about him/her. In these cases, please indicate that he/she is not related to any of your children.

3. General information about family members

Field: Relationship between member and child

Simply enter the pertinent information about the relationship between you and the child/children listed, e.g. biological child, stepchild. If stepchildren or grandchildren are supposed to be covered under your family plan, we will have to conduct additional investigations. The related questionnaire will be sent to you as soon as we have received your completed family insurance questionnaire.

Field: Is your spouse related to the child?

If your spouse is related to the respective child, please do not enter anything into this field. You will have to complete this field only if the child is not related to your spouse.

4. Information on most recent or existing insurance coverage of family members

If your spouse has or had coverage under a different health insurance plan or if your children were covered under a different health insurance plan, you will have to complete these fields to rue out accidental duplicate coverage.

5. Other information about family members

5.1 Unemployment Benefits II

If your family members are recipients of Unemployment Benefits II, please place a cross mark into the box and enclose the latest notice from the Job Center.

5.2 School attendance/studies

If any of your insured children is 23 years of age or older, we need an up-to-date school or student certificate. This certificate is usually issued by the administrative assistance of the school. Students of colleges or universities receive student certificates at the beginning of each semester, so simply send a copy to us every time you receive one.

5.3 Military or substitute civil service

If your child has served in the military or in civil service, please enter the time period in this field and attach a copy of the service certificate (unless you have already submitted one with previous questionnaires). Family insurance coverage will be available only if certain income limits are not ex-ceeded. Please enter the incomes of your family members into the designated fields.

5.4 Self-employment

If your child/children or spouse are self-employed, please place a cross into the box. Please also provide the income information and attach the latest income tax return. If further issues have to be clarified, we will contact you.

5.5 Low-income (mini) jobs

A low-income job is a so-called mini job. If you are not certain whether one of your family members does actually have a mini job, please ask the employer or attach a copy of the payroll statement. Please remember that you absolutely must not enter self- employment under this section. Information about self-employment must be entered into section 5.4.

5.6 Pensions

In this section, please provide information on your family plan insured children's or spouse's income from pension plans (e.g. survivor's pensions, basic cost of living pension). If they have any such income, we also must receive a copy of e.g. the pension benefits notice. The information and documentation is also a mandatory requirement if pensions are paid by foreign pension insurance plans.

5.7 Other regular income as defined under the German Income Tax Law

If any of your children or yours spouse covered under the family insurance plan do have any other income (e.g. wages or income from mini jobs, income from rentals/lease holds, capital gains), please enter the income amounts into the respective fields. Also attach copies of the latest income tax return or of payroll statements. Please strike through this field if your family members do not have any regular income.

6. Assignment of a retirement insurance identification number

Please enter the retirement insurance identification numbers of your family members here. If any family member should not have been assigned such a number yet or if you do not have it, please fill in all the other information.

Please do not forget to confirm by the correctness of the information provided by signing the form.

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