

BKK DR. OETKER DEPENDENTS' CO-INSURANCE (FAMILY INSURANCE)

1. Member's General Data – For explanation of the numbers in brackets, please refer to the notes: "Help With Filling Out the Form"

Last name, first name	Health insurance number or date of birth
I am/was <input type="checkbox"/> insured under my own name <input type="checkbox"/> insured as co-dependent under family insurance	Name of health insurance fund / insurance scheme
<input type="checkbox"/> not insured under any state health insurance scheme	Daytime telephone number

2. Member's Marital Status

Single Married Widowed Separated Divorced since: _____

Registered "lifetime partnership" under the German Lifetime Partnership Act (LpartG) (such a partner's details are to be entered in the column "Spouse" below)

My spouse is himself/herself Not insured Insured with (1)... Name of health insurance fund _____

This family insurance should My spouse My children beginning on: _____ Date _____ also cover, as co-insured dependents

3. Family Members (2)

	Spouse (3)	Child (4)	Child (4)	Child (4)
Surname				
First name				
Date of birth				
Address, if different from that of member				
Relationship to member (5)				
Family member's own insurance with a different health insurance fund (1)	from: _____ to: _____ which fund? <input type="checkbox"/> private <input type="checkbox"/> statutory	from: _____ to: _____ which fund? <input type="checkbox"/> private <input type="checkbox"/> statutory	from: _____ to: _____ which fund? <input type="checkbox"/> private <input type="checkbox"/> statutory	from: _____ to: _____ which fund? <input type="checkbox"/> private <input type="checkbox"/> statutory
In employment	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
In minor part-time employment	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Self-employed	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Unemployed	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Monthly gross income (6)	€ _____	€ _____	€ _____	€ _____
Type of revenues (7)				
Schooling/ university studies (8)		from: _____ to: _____	from: _____ to: _____	from: _____ to: _____
Military service/ community service in lieu of military service (9)		from: _____ to: _____	from: _____ to: _____	from: _____ to: _____
Name of the health insurance fund with which the family insurance has, up to now, been held				
Pension insurance number				
The following information is only required if you have not yet been issued with a National insurance number (Rentenversicherungsnummer).				
Name at birth				
Place/country of birth				
Nationality				

I hereby confirm and certify the accuracy of all the information given above. Should any changes occur, I will inform you of them without delay, and most particularly and especially if there shall occur any changes in the income of any of the family members named above, or if any of them should become members of a health insurance fund (other than this one).

Date	Location
Signature of member	(where required) signature of family member
With this signature I also declare that I have received the consent of the family members concerned to provide the data which shall be necessary for this application. In the case of family members living apart, the signature of the family member shall be enough.	

Note on Data Protection:

§ 67 a Paragraph 3 of the Social Security Statute Book, Book Ten (SGB X): In order that we may complete our duties in a manner accordant with the law, your cooperation is required under §289 of Book Five of the Social Security Statute Book (SGB V). Data must be gathered so as to properly establish the terms of the insurance contract (§10, 284, SGB V, §7 KVLG 1989). The personal data you provide are protected by the laws on data protection.

■ HELP WITH FILLING OUT THE FORM

Help with filling out the form: “BKK Dr. Oetker Dependents’ Co-Insurance (Family Insurance)”

For a swift processing of your application it is essential that you provide the documentary evidence relevant in your case!

1. If you are already insured under a private health insurance scheme, please attach a copy of your tax assessment notice, as well as, where relevant, a statement of your earnings.
2. Please enter the requested details for your spouse even in the case where the dependents’ co-insurance that you wish to take out with us is one that will only cover your children as co-dependents. This shall not apply if the spouse in question is not related to the children. Information about your spouse’s income is not required if said spouse is him/herself a member of a state health insurance scheme.
3. If your spouse’s surname is different from yours, please attach a copy of your marriage certificate.
4. If your child’s or children’s name(s) are different from yours, please attach a copy of the relevant birth certificate(s) or, where applicable, official acknowledgement(s) of paternity.
5. For example: son, daughter, step- or foster-child, grandchild.
6. Please enter only the income(s) of family members.
7. For example: wages or salaries; pensions drawn from the state pension insurance scheme; other pensions or annuities; retirement pensions; income from renting or leasing of property; income from capital. Please attach relevant documentary proof in each case.
8. In the case of children aged 23 and above, please attach documentation certifying attendance of school or university, or participation in a course of training/apprenticeship.
9. Please attach copy of certificate attesting to completed service.

