# Form for including your relatives in family insurance

**(Please only mark with a cross as applicable, do not strike through!)**

## Details of main insured family member on whom the family insurance is based

Surname, forename of the main insured member | Date of birth | Health insurance number

**I am/I have been**

☐ insured as part of my own membership with _____ Name of health insurance provider

☐ insured as part of a family policy with _____ Name of health insurance provider

☐ not covered by statutory health insurance

## Marital status of main insured member

☐ Married since | ☐ Divorced since __ __.__ __.__ __ __ __

☐ Single ☐ separated ☐ widowed ☐ in a civil partnership in accordance with the German Civil Partnerships Act
**(in this case, details should be given in the 'Spouse' column)**

## Main insured member's spouse is insured

☐ with Audi BKK ☐ with another statutory health insurance provider ☐ privately

Insurance provider:

## Grounds for inclusion in family insurance

☐ Beginning of my membership ☐ Birth of child (Enclose copy of birth certificate) ☐ Marriage (Enclose copy of marriage certificate)

☐ End of previous own membership/relative's insurance cover

☐ Other: _____

**Start of family insurance**

IIf you have any questions, I can be reached during the day by telephone on _____

or by mail _____ (optional).

## Details of the main insured member's family members

The following details are only required for relatives who are intended for inclusion in our family insurance. However, we also require some of your spouse's/civil partner's details even if our family insurance cover is only intended for your children and your spouse/civil partner is related to these children. In that case, as well as the general details, we require information on your spouse's/civil partner's insurance cover and – if they do not have statutory insurance cover – additional information on their income; in that case, their income must be documented with evidence of earnings; additional amounts which are paid in light of family status should not be taken into account in the income details. **Please note that taking out family insurance with different providers at the same time is not permitted by law. You must therefore ensure with your details that there is no doubling up of family insurance**.

| **General details** | **Spouse** | **Child** | **Child** | **Child** |
|---|---|---|---|---|
| **Surname*** | | | | |
| *If the names of the member and their relatives are not identical, the relations between them must be proven by means of suitable documents (e. g. marriage certificate, civil partnership certificate, birth certificate) or – if it is not possible to present such documents – by means of other suitable documents (e. g. notification of child benefit). | | | | |
| **Forename** | | | | |
| **Gender** (m=male, w=female, x=intersex, o=other) | ☐ m ☐ f ☐ x ☐ o | ☐ m ☐ f ☐ x ☐ o | ☐ m ☐ f ☐ x ☐ o | ☐ m ☐ f ☐ x ☐ o |
| **Date of birth** | | | | |
| Address, if different from that of the member | | | | |
| **Relationship of the member stated at the beginning to the child** (*The term 'biological child' must also be used in the case of adoption.) | | ☐ Biological child* ☐ Stepchild ☐ Grandchild ☐ Foster child | ☐ Biological child* ☐ Stepchild ☐ Grandchild ☐ Foster child | ☐ Biological child* ☐ Stepchild ☐ Grandchild ☐ Foster child |
| Is your spouse related to the child? | | ☐ no | ☐ no | ☐ no |

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| Details of family members' most recent or existing insurance cover | | | | |
|---|---|---|---|---|
| **Member HI no.** | **Spouse** | **Child** | **Child** | **Child** |
| The previous insurance does not end, but continues with? | ..... (Name of health insurance provider) | ..... (Name of health insurance provider) | ..... (Name of health insurance provider) | ..... (Name of health insurance provider) |
| The previous insurance ends on which date? | _____ | _____ | _____ | _____ |
| was with which health insurer? | ..... (Name of health insurance provider) | ..... (Name of health insurance provider) | ..... (Name of health insurance provider) | ..... (Name of health insurance provider) |
| Previous insurance type | ☐ Membership ☐ Family insurance policy ☐ Not statutory | ☐ Membership ☐ Family insurance policy ☐ Not statutory | ☐ Membership ☐ Family insurance policy ☐ Not statutory | ☐ Membership ☐ Family insurance policy ☐ Not statutory |
| For family insurance, details of the person on whose membership the family insurance is based | ..... (Surname) ..... (Forename) | ..... (Surname) ..... (Forename) | ..... (Surname) ..... (Forename) | ..... (Surname) ..... (Forename) |

| Other details | Spouse | Child | Child | Child |
|---|---|---|---|---|
| **Self-employment applies** | ☐ yes | ☐ yes | ☐ yes | ☐ yes |
| **Earnings from self-employment (monthly)** Please enclose a copy of the latest income tax assessment. | ..... EUR | ..... EUR | ..... EUR | ..... EUR |
| **Minor/casual employment** Gross pay (monthly) | ..... EUR | ..... EUR | ..... EUR | ..... EUR |
| **Statutory pension, pension payments, company pension, foreign pension, other pensions, maintenance payments** (monthly payment amount) Enclose evidence | ..... EUR | ..... EUR | ..... EUR | ..... EUR |
| **Other regular monthly income as defined by the Income Tax Act or from abroad** (e. g. gross pay, income from renting and leasing, income from capital assets) **Other income** (e. g. severance payment for loss of job) Enclose evidence | ..... EUR ..... (Type of income) | ..... EUR ..... (Type of income) | ..... EUR ..... (Type of income) | ..... EUR ..... (Type of income) |
| **School/other educational institution** (For children aged 23 years and over, please include certificate of school attendance/student enrolment) | | from ..... to ..... | from ..... to ..... | from ..... to ..... |
| **Military service or statutory voluntary service** (Please enclose certificate of service) | | from ..... to ..... | from ..... to ..... | from ..... to ..... |

| Details of health insurance number allocation for relatives covered by family insurance | | | | |
|---|---|---|---|---|
| | **Spouse** | **Child** | **Child** | **Child** |
| Pension contributions number | | | | |
| The following details are only required if a pension contributions number has not yet been allocated. | | | | |
| Birth name | | | | |
| Place of birth | | | | |
| Country of birth | | | | |
| Nationality | | | | |

I confirm that the details are correct. I shall inform you immediately of any changes. This applies in particular if my above relatives' income changes (e. g. new income tax assess-ment for self-employment) or they become a member of a (diff erent) health insurance provider.

Place, date

Signature of main insured member

Family members' signature (if applicable)

By signing this form, I declare that I have obtained the consent of the family members to provide the required data.

For family members who live apart, the signature of the family member is sufficient.

Data protection notice (Article 13 of Regulation [EU] 2016/679, Article 5 [1] GDPR): In order for us to be able to assess the family insurance, your cooperation is required in accordance with Articles 10 section 6 and 289 SGB V. The data must be collected to establish the insurance relationship (Articles 10, 284 SGB V, Article 7 of the Farmers' Health Insurance Act [KVLG] 1989, Article 25 SGB XI) Contact details provided voluntarily shall be used exclusively for queries in order to fulfil our statutory duties. By signing this form, you consent to this processing. For more information on data protection, please visit **www.audibkk.de/datenschutz**