Form for including your relatives in family insurance

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

① General 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

② Start of family insurance

③ 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)**

④ Main insured member's spouse is insured

☐ Audi BKK ☐ another statutory health insurer ☐ no statutory insurance **(e.g. private, civil servant)**

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: _____

If you have any questions, I can be reached during the day by telephone on _____ or by email (optional).

⑤ 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 details of your spouse/civil partner under the Civil Partnerships Act 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/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.

General details of family members	**Spouse/civil partner** under Civil Partnerships Act	**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, f = female, x = indeterminate, d = gender diverse)	☐ m ☐ f ☐ x ☐ d	☐ m ☐ f ☐ x ☐ d	☐ m ☐ f ☐ x ☐ d	☐ m ☐ f ☐ x ☐ d
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 the spouse/civil partner (under the Civil Partnerships Act) related to the child?		☐ no	☐ no	☐ no
⑥ **School/other educational institution** (For children aged 23 years and over, please include certificate of school attendance/student enrolment)		☐ yes to	☐ yes to	☐ yes to .....
⑦ **Voluntary military service or statutory voluntary service** (Please enclose certificate of service)		☐ yes from..... to	☐ yes from ..... to	☐ yes from ..... to .....

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⑧ Details of family members' previous insurance cover

Member HI no.	Spouse/civil partner under Civil Partnerships Act	Child	Child	Child
The previous insurance is not ending and still exists 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)

⑨ Details of family members' income

	Spouse/civil partner under Civil Partnerships Act	Child	Child	Child
Self-employment applies	☐ yes	☐ yes	☐ yes	☐ yes
Profit from self-employment (monthly) Please enclose a copy of the latest income tax assessment.	..... EUR	..... EUR	..... EUR	..... EUR
Minor/casual employment applies	☐ yes	☐ yes	☐ yes	☐ yes
Statutory pension, pension payments, company pension, foreign pension, other pensions (monthly payment amount) Enclose evidence	..... EUR	..... EUR	..... EUR	..... EUR
Other regular income as defined by the Income Tax Act or from abroad (e.g. gross pay from employment more than minor/casual, income from renting and leasing, income from capital assets) **Other income** (e.g. severance payment for loss of job, or maintenance payments) Enclose evidence	..... EUR ..... (Type of income)	..... EUR ..... (Type of income)	..... EUR ..... (Type of income)	..... EUR ..... (Type of income)

Details of health insurance number allocation for relatives covered by family insurance

	Spouse/civil partner under Civil Partnerships Act	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 assessment if self-employed) or – for children with family insurance – the other parent stops being a statutory health insurance member. If the parents get married, this must be reported if the other parent does not have statutory health insurance.

⑩ _____ _____ _____

Place, date | Signature of main insured member | Family members' signature (if applicable)

By signing this form I declare that I have received my family members' consent to provide the required details.

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 any queries required to fulfil our legal obligations. By signing this form, you consent to processing. For more information on the topic of data protection, please visit **www.audibkk.de/datenschutz**