Surname, first name of the member

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Health insurance No.

Family Insurance Form

General information concerning the member

- I was previously
  - ☐ insured personally with _____ Name of the health insurance company
  - ☐ insured as a family member with _____ Name of the health insurance company
  - ☐ not statutory health insured
- Marital status ☐ single ☐ married since ☐ separated since ☐ divorced since ☐ widowed since
  - ☐ Registered civil partnership in accordance with the German Civil Partnership Act - *LPartG* (in this case, please provide the information requested under "spouse") since
- Reason for insurance as a family member
  - ☐ Start of my membership ☐ Birth of a child ☐ Marriage
  - ☐ Termination of the previous personal insurance of a family member ☐ Other _____
- Start of the family insurance: _____
- Daytime telephone number should there be any questions _____ (voluntary information)
- My email address is: _____ (voluntary information)

Information concerning family members

The following data is basically only required for family members that are to be family insured by us. As a deviation from this, we also require some data concerning your spouse/life partner if only your children are to be family insured by us. In this case, not only the general information but also that concerning the insurance of the spouse/life partner and – if the spouse/life partner should not be statutory insured and be related to the children – on his/her income; it is imperative that the proof of income is provided and that allowances that are paid in connection with the marital status are not taken into account when providing income information.

Please note that family insurance with different health insurance companies at the same time is not legally permissible. Please therefore ensure that a double family insurance is excluded when providing information.

General information concerning the family members				
	Spouse	**Child**	**Child**	**Child**
Name*				
* If your spouse/life partner or your children should have another name, please enclose a marriage certificate or proof of parentage if they should not already be in our possession.				
First name				
Sex (m=male, f=female, d=diverse, i=indefinite)	☐ m ☐ f ☐ d	☐ m ☐ w ☐ i	☐ m ☐ w ☐ i	☐ m ☐ w ☐ i
Date of birth				
Address should it differ from that of the member				
Kinship between the member and the child (* The term "biological child" is also to be used for adopted children.)	_____	☐ biological child* ☐ stepchild ☐ grandchild ☐ foster child	☐ biological child* ☐ stepchild ☐ grandchild ☐ foster child	☐ biological child* ☐ stepchild ☐ grandchild ☐ foster child
Is the spouse related to the child? (Please only place a cross should there not be a kinship)	_____	☐ (No)	☐ (No)	☐ (No)

Surname, first name of the member

Health insurance No.

Information concerning the last, previous or still existing insurance of the family members

	Spouse	Child	Child	Child
Surname				
First name				
The previous insurance ○ terminated on: ○ was with:				
Type of previous insurance:	☐ Membership ☐ Family insurance ☐ not statutory	☐ Membership ☐ Family insurance ☐ not statutory	☐ Membership ☐ Family insurance ☐ not statutory	☐ Membership ☐ Family insuance ☐ not statutory
Should a family insurance have previously existed: surname and first name of the person from whose membership the family insurance was derived				
The previous insurance still exists with: (Health insurance company/health insurance)				

Other information concerning family members

	Spouse	Child	Child	Child
Self-employed	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Profit from self-employment (monthly). Please enclose a copy of the latest income tax assessment notice.				
Gross remuneration for a minor occupation (monthly)				
Receiving unemployment benefit II?	☐ Yes	☐ Yes	☐ Yes	☐ Yes
State pension, pensions and related benefits, company pension, foreign pension, other pension (monthly payment). **Please enclose proofs of income!**				
Other regular monthly income in the meaning of the German Income Tax Act (e.g. gross salary from an occupation which is not minor, income from letting and leasing, income from capital assets) **Please enclose proofs of income!**	(Type of income)	(Type of income)	(Type of income)	(Type of income)
School education/studies (Please enclose a school or study certificate for children aged 23 or older), Type of school (e.g. secondary school/class (voluntary information)	_____	from to	from to	from to
Military or alternative civilian service (please enclose a certificate of service should you not have already done so)	_____	from to	from to	from to

Information required for issuing a health insurance number for family insured family members

	Spouse	Child	Child	Child
Own pensions insurance number (*RV* No.)				
The following information is only required if a pensions insurance number has not been issued yet.				
Name at birth				
Place of birth				
Country of birth				
Nationality				

I hereby confirm that the information is correct. I shall immediately inform you of any changes. This is especially the case should the income of my above family members change (e.g. new incom e tax assessment notice when self-employed) or should they join a (different) health insurance company.

Place, date | **Member's signature** | **Family member's signature if appropriate**

With my signature, I declare that the family members have agreed to me providing the required information

The signature of the family member suffices if they should be separated.

Hinweis zum Datenschutz: Damit wir die Familienversicherung beurteilen können, ist Ihr Mitwirken nach §§ 10 Abs. 6, 289 SGB V erforderlich. Die Daten sind für die Feststellung des Versicherungsverhältnisses (§§ 10, 284 SGB V, § 7 KVLG 1989, § 31 a SGB X, § 25 SGB XI) zu erheben. Nach § 60 SGB I kann fehlende Mitwirkung zum Verlust des Versicherungsschutzes Ihrer Angehörigen führen. Für die Prüfung der Familienversicherung nicht erforderliche Daten können auf den Nachweisen geschwärzt werden. Freiwillige Angaben zu Kontaktdaten werden ausschließlich für Rückfragen zu Ihrem Versicherungsverhältnis verwendet. Allgemeine Informationen zur Datenverarbeitung und zu Ihren Rechten finden Sie unter www.aok.de/bayern/datenschutzrechte. Bei Fragen wenden Sie sich an die AOK Bayern - Die Gesundheitskasse, Carl-Wery-Str. 28, 81739 München, oder unseren Datenschutzbeauftragten unter datenschutz@by.aok.de.

Bearbeitungsvermerk der AOK Bayern

Beratung am | **durch Name, Vorname, Unterschrift** | **Direktions- und Beraternummer**