



## Have you received a questionnaire from us for inclusion in the family insurance scheme?

On the following pages, you will find a **translation guide**. Please answer the questions on the **form in German language** that you received by ground mail, and return it to us signed. This is **important** for the insurance cover of your family members. Thank you very much.

### **Background information:**

AOK Lower Saxony is the health insurance company for the whole family. The particularly good thing: We insure family members free of charge under certain conditions. We are legally obliged to regularly ask our insured persons for up-to-date information on their family members. We need your details even if nothing has changed in your family or if you do not want to insure any family members.

Our reference:

## Questionnaire for admission to family insurance

The information is required as of ...

### General information of the member

- ▶ I have been insured so far
  - with an own membership
  - as co-insured family member
  - I was not covered by statutory health insurance
- ▶ Marital status:
  - single  married since XXXXXXXX (then please fill in the section "Spouse")
  - Living separately  Divorced since XXXXXXXX  Widowed
  - Registered civil partnership under the Civil Partnership Act since XXXXXXXX  
(then please fill in the section "Spouse")
- ▶ Start of family insurance XXXXXXXXXXXXXXXXXXXX, because of:
  - Start of my membership  Birth of child  Marriage
  - Termination of the relative's own previous membership  Other: XXXXXXXXXXXXXXXXXXXX
- ▶ If you have any queries, I can be reached during the day on the telephone no. XXXXXXXX (voluntary information).
- ▶ My email address is XX (optional).

### Details of family members

The following data are generally only required for those relatives who are to be insured with us as family members. In derogation from this, we also require individual details of your spouse/life partner if we are only to provide family insurance for your children and your spouse/life partner is akin to these children. In this case, in addition to the general information, the information on the insurance of the spouse/life partner and - if the spouse/life partner is not insured by law – additionally, information on his/her income is required; in this case, it is mandatory to substantiate the income by means of proof of income and to disregard supplements paid due to the marital status in the information on income.

**Please note that a simultaneous implementation of family insurance with different health insurance companies is legally impermissible. Therefore, please ensure with your information that a double family insurance is excluded.**

General information on family members				
	Spouse	Child	Child	Child
Health insurance number	XXXXXX	XXXXXX	XXXXXX	XXXXXX
Name*	XXXXXX	XXXXXX	XXXXXX	XXXXXX
* If the insured person and the family member do not have the same surname, the civil status must be proven once only by suitable documents (e.g. marriage certificate, civil partnership certificate, birth certificate) or - if it is not possible to present them - by other suitable documents (e.g. notice of child benefit).				
First name	XXXXXX	XXXXXX	XXXXXX	XXXXXX
Gender (m = male, w = female, x = indeterminate, d = diverse)	XXXXXX	XXXXXX	XXXXXX	XXXXXX
Date of birth	XXXXXX	XXXXXX	XXXXXX	XXXXXX
Address differing from that of the member, if applicable	XXXXXX	XXXXXX	XXXXXX	XXXXXX
Relationship of the insured person to the child (* The designation "natural child" is also used for adoption).	<u>XXX</u>	natural child* Stepchild Grandson Foster child	natural child* Stepchild Grandson Foster child	natural child* Stepchild Grandson Foster child
Is the spouse akin to the child? (Please only tick if there is no relationship)	<u>XXX</u>	<input type="checkbox"/> (no)	<input type="checkbox"/> (no)	<input type="checkbox"/> (no)

Details of the last previous or continuing insurance of family members.				
	Spouse	Child	Child	Child
The previous insurance o ended on: o consisted in: (Name and registered office of the health insurance company)	XXXXXXXX XXXXXXXX XXXXXXXX	XXXXXXXX XXXXXXXX XXXXXXXX	XXXXXXXX XXXXXXXX XXXXXXXX	XXXXXXXX XXXXXXXX XXXXXXXX
Type of previous insurance:	<input type="checkbox"/> Membership <input type="checkbox"/> Family-insured <input type="checkbox"/> not statutory	<input type="checkbox"/> Membership <input type="checkbox"/> Family-insured <input type="checkbox"/> not statutory	<input type="checkbox"/> Membership <input type="checkbox"/> Family-insured <input type="checkbox"/> not statutory	<input type="checkbox"/> Membership <input type="checkbox"/> Family-insured <input type="checkbox"/> not statutory
If family insurance was last in force, the first name and surname of the person from whom whose membership the family insurance was derived	XXXXXXXX (first name) XXXXXXXX (last name)	XXXXXXXX (first name) XXXXXXXX (last name)	XXXXXXXX (first name) XXXXXXXX (last name)	XXXXXXXX (first name) XXXXXXXX (last name)
The previous insurance continues with: (Name and registered office of the health insurance fund/health insurance company)	XXX	XXX	XXX	XXX

Other information on family members				
	Spouse	Child	Child	Child
Self-employed activity exists	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Profit from self-employment (monthly)(Please attach a copy of the current income tax assessment notice)	XXXX.EUR	XXXX.EUR	XXXX.EUR	XXXX.EUR
Gross pay from marginal employment (monthly)	XXXX.EUR	XXXX.EUR	XXXX.EUR	XXXX.EUR
Statutory pension, foreign pension, pension benefits, occupational pension, other pensions (monthly payment amount)	XXXX.EUR	XXXX.EUR	XXXX.EUR	XXXX.EUR
Other regular monthly income within the meaning of income tax law (e. g. gross pay from more than marginal employment, income from <b>rental and leasing</b> , income from <b>capital assets</b> ), other income (e.g. <b>severance pay</b> for loss of job)	XXXX.EUR XXXXXXXX (Type of income)	XXXX.EUR XXXXXXXX (Type of income)	XXXX.EUR XXXXXXXX (Type of income)	XXXX.EUR XXXXXXXX (Type of income)
School attendance/studies (Please enclose school or study certificate for children aged 23 and over)	XXX	from XXXXX to XXXXX	from XXXXX to XXXXX	from XXXXX to XXXXX
Name and place of school/university	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
Military service or statutory voluntary service (Please attach certificate if not already done)	XXX	from XXXXX to XXXXX	from XXXXX to XXXXX	from XXXXX to XXXXX

Further information on family members				
	Spouse	Child	Child	Child
Own pension insurance number (RV-Nr.)	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX
Birth name	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX
Place of birth - <b>Mandatory</b>	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX
Country of birth - <b>Mandatory information</b>	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX
Nationality	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX

I confirm that the information provided is correct. I will inform you immediately of any changes. This applies in particular if the income of my family members listed above changes (e.g. new income tax assessment notice in the case of self-employment) or if they become a member of a (different) health insurance company.

XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXX

Place, date

Signature of insured person

XXXXXXXXXXXXXXXXXXXX

or, if applicable, signature of the family members

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

In the case of separated family members, the signature of the family member is sufficient.

The data is collected and processed for the fulfilment of our tasks pursuant to § 284 para. 1 sentence 1 no. 1 SGB V for the purpose of an examination of family insurance pursuant to § 10 SGB V and § 25 SGB XI. Your cooperation is required according to § 60 SGB I and 99 SGB X. Lack of cooperation can lead to disadvantages in the implementation of family insurance. Recipients of your data may be third parties within the scope of legal obligations and notification powers or service providers commissioned by us. General information on data processing and your rights can be found at [www.aok.de/nds/datenschutzrechte](http://www.aok.de/nds/datenschutzrechte). If you have any questions, please contact your contact person named above or our data protection officer.