Have you received a questionnaire from us to clarify your health insurance?

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 your further insurance cover. Thank you very much.

Background information:
If we receive a deregistration for social security for any member, we are legally obliged to clarify the further insurance coverage. New insurance cover can arise, for example, through a new employment subject to compulsory insurance, through the receipt of unemployment benefit or via the free family insurance.

If we do not receive a new registration and no other health insurance company informs us about a membership, the legislator provides for a so-called follow-up insurance for a gapless insurance cover. This insurance is subject to contributions. The amount of the contributions depends on the individual income.

Those who have no or little income only pay the statutory minimum contribution to health and long-term care insurance. If we do not receive the questionnaire back, we will have to charge the maximum premium in the follow-up insurance.

Your health insurance cover after the ...

Please tell us how you are insured immediately after ....

Please tick the appropriate box and complete the questionnaire.

My telephone number is XXXXXXXXXXXXXX, I can be reached by telephone from XXXX to XXXX
Email address XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

1. ☐ **Employee** employed by company XXXXXXXXXXXXXXXXXXXXX since XXXXXXXXXXXXXXXX
   Street XXXXXXXXXXXXXXXXXXXXXXX Postcode/City XXXXXXXXXXXXXXXXXXXXX
   ☐ My earnings are **above ...** euros ☐ My earnings are **below ...** euros
   insured with health insurance company XXXXXXXXXXXXXXXX (**please enclose membership certificate**)
2. ☐ I am **not in gainful employment**.
3. ☐ **Recipient of benefits from the employment agency/job centre**
   Type of benefit ☐ Unemployment benefit I ☐ Unemployment benefit II/citizens' allowance
   (please enclose the respective **notification**)
   requested on XXXXXXXXXXXXXXXXXX payment from XXXXXXXXX to XXXXXXXXXX
   A blocking period was imposed from XXXXXXXXX to XXXXXXXXXX.
   insured with health insurance company XXXXXXXXXXXXXXXX (**please enclose membership certificate**)
4. ☐ **Family insurance**
   Family insured with health insurance company XXXXXXXXXXXX (**please enclose membership certificate**)
   ☐ as spouse/registered civil partner
   Name/first name spouse/life partner XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
   ☐ as a child
   Parents' name/first name XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
   Application for family insurance with the above-mentioned health insurance company
   ☐ was submitted on XXXXXX or ☐ is expected to be submitted on XXXXXXXXXXXX.
5. ☐ **Pensioner** / pension applicant
   Pension application submitted on XXXXXXXXXXXXXXX Pension received since XXXXXXXXXXXXX
   Application for continuation of pension submitted on XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
   insured with health insurance company XXXXXXXXXXXXXXXX (**please enclose membership certificate**)
   Objection/appeal against pension rejection filed on XXXXXXXXXXXXXXXX
6. **Other**
   ☐ XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
   (e.g. studies, internship, federal voluntary service, self-employment, certificate E 104 of the foreign health insurance company)
   insured with (health insurance company) XXXXXXXXXXXXXXXX (**please enclose membership certificate**)
   ☐ In case of return abroad Name of former German health insurance XXXXXXXXXXXXXXXXXXXXXXX
   ☐ Benefits according to the **Asylum Seekers' Benefits Act** (**please enclose notification**)
   requested on XXXXXXXXXXXXXXXXXX related from XXXXXXXXX to XXXXXXXXXXX
   ☐ Civil servant/professional soldier (**please enclose proof/notification**)
   ☐ Social assistance/assistance with living costs (**please enclose proof/notification**)
   ☐ Privately insured with XXXXXXXXXXXXXXXXXXXXXXXXX (**please enclose membership certificate**)
   ☐ Name of health insurance company **before** private insurance XXXXXXXXXXXXXXXXXXXXXXXXXX
7. ☐ I am **not otherwise covered** in case of illness.
8. ☐ I declare my resignation as of ..., as I am **covered differently in case of illness** and confirm this with the **attached proof (membership certificate of your health insurance company)**.

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Place, date and signature