AOK NordWest
Die Gesundheitskasse.

Name: _____ Healthcare insurance no.: _____

Date of birth: _____ Address: _____

Questionnaire for the acceptance into the family insurance

Click here to clear all form content

1. General information of the member

Until now, I was ☐ as member ☐ as family member insured at _____
☐ No statutory health insurance Name of the health insurer

Marital status: ☐ single ☐ married ☐ living apart ☐ divorced ☐ widowed
☐ registered partnership according to the German Act on Registered Life Partnerships (In this case, please fill in the data under "spouse")
☐ I have no spouse and/or children (no further information required, only signature)
☐ My relatives (see below) have their own insurance, a family insurance is not required.

Reason for the acceptance into the family insurance:

☐ Start of my membership ☐ Birth of the child ☐ Marriage
☐ Termination of the former own membership of the relative ☐ Other: _____

Start of the family insurance: _____

In case of questions, you can contact me at the following phone number and email address (optional):

Telephone: _____ Mobile: _____ Email _____

2. Information on family members

The following data are generally only required for those relatives who are to be insured with us as family members. In deviation from this, we also require individual information on your spouse/life partner under subsections 2.1 to 2.3 if family insurance is to be carried out with us exclusively for your children and your spouse/life partner is related 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 has no statutory health insurance – 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 with regard to the marital status in the information on income.

Please note that it is not legally permissible to have family insurance with different health insurers at the same time. Therefore, please ensure with your information that double family insurance is excluded.

2.1 General information

	Spouse	**Child**	**Child**	**Child**
Name**				
** In the case of different surnames of the member and the family member, the civil status must be proven once by suitable documents (e.g. marriage certificate, civil partnership certificate, birth certificate) or – if their presentation is not possible – by other suitable documents (e.g. notice of child benefit).				
First name				
Date of birth				
Gender	☐ male ☐ female ☐ unspecified ☐ divers	☐ male ☐ female ☐ unspecified ☐ divers	☐ male ☐ female ☐ unspecified ☐ divers	☐ male ☐ female ☐ unspecified ☐ divers
Different address to the member, if applicable				
Relation to the member The term "natural child" shall also be used in case of adoption.	_____	☐ natural child ☐ stepchild ☐ grandchild ☐ foster child	☐ natural child ☐ stepchild ☐ grandchild ☐ foster child	☐ natural child ☐ stepchild ☐ grandchild ☐ foster child
Is the spouse related to the child? Please only tick if the spouse is not related to the child.	_____	☐ no	☐ no	☐ no

2.2 Details of the last previous or continuing insurance of the family members

The previous insurance ● ended on: ● existed with: (Name of the health insurer)				
Kind of previous insurance:	☐ Membership ☐ Family insurance ☐ No statutory health insurance	☐ Membership ☐ Family insurance ☐ No statutory health insurance	☐ Membership ☐ Family insurance ☐ No statutory health insurance	☐ Membership ☐ Family insurance ☐ No statutory health insurance
If family insurance was last in force, name and first name of the person from whose membership the family insurance was derived.	_____ Name _____ First name	_____ Name _____ First name	_____ Name _____ First name	_____ Name _____ First name
The previous insurance continues to exist with: (Name of the health insurer)		_____	_____	_____

Page 2 _____
Name

2.3 Other information on family members

	Spouse	Child	Child	Child
Self-employment exists	☐ yes, since	☐ yes, since	☐ yes, since	☐ yes, since
Profit from self-employed activity (monthly) Please enclose a copy of the current income tax assessment.	EUR	EUR	EUR	EUR
Gross remuneration from marginal employment (monthly)	EUR	EUR	EUR	EUR
Statutory pension, pension benefits, occupational pension, foreign pension, other pensions (monthly payment amount)	since EUR	since EUR	since EUR	since EUR
Other regular monthly income within the meaning of income tax law (e.g. gross pay from more than marginal employment, income from renting and leasing, income from capital assets)	since EUR	since EUR	since EUR	since EUR
Other income (e.g. severance pay for the loss of the job)	(Type of income)	(Type of income)	(Type of income)	(Type of income)
School attendance/studies aged 18 and older For children aged 23 and older, please enclose a current school or study certificate.	_____	from till	from till	from till
Type of school (e.g. German Hauptschule, Realschule, Gymnasium)				
Military service or statutorily regulated voluntary service Please enclose certificate of service.	_____	from till	from till	from till

2.4 Information on the allocation of a health insurance number for family-insured relatives

National insurance number				
Place of birth				
Country of birth				
Birth name				
Nationality				

3. Signature(s)

I confirm that the information provided is correct. I will inform you immediately about any changes. This applies in particular if the income of my above-mentioned relatives changes (e.g. new income tax assessment in the case of self-employment) or if they become a member of a (different) statutory or private health insurer.

Date _____ Signatures of the family members, if applicable _____
In the case of separated family members, the signatures of the family members are sufficient.

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

Data protection notice
The data is collected and processed for the fulfilment of our tasks in accordance with § 284 Para. 1 Sentence 1 No. 1 SGB V (German Social Security Code) and § 289 SGB V for health insurance tasks and § 94 Para. 1 No. 1 SGB XI for long-term care insurance tasks for the purpose of determining the health and long-term care insurance relationship in accordance with § 10 SGB V and § 25 SGB XI. Your participation is required according to § 206 SGB V and § 50 para. 3 SGB XI (German Social Security Code). In the absence of cooperation, family insurance cannot be implemented. Recipients of your data may be third parties or service providers commissioned by us within the scope of legal obligations and notification powers. General information on data processing and your rights can be found at aok.de/nw/datenschutzrechte. AOK NordWest – Die Gesundheitskasse., Kopenhagener Str. 1, 44269 Dortmund, Germany, is responsible. You can reach the Data Protection staff unit at the same address.