DAK,

Postal address

Tele contact

Internet

Our reference
IK
Date

Family insurance: Your application forms

Dear [. . .],

Thank you for placing your trust in us. We would be happy to also co-insure your children or your partner under our family insurance scheme. This offer is free of charge (non-contributory) and includes the full range of services provided by DAK-Gesundheit.

How to apply for family insurance

If you wish to make use of this offer, simply complete the attached application forms and return them to us. If we have any questions, we will contact you. Otherwise, you will immediately receive the health insurance cards for your children or your partner by post.

Save yourself work

As a public health insurance company we are obliged to check regularly whether the conditions relating to family insurance continue to be met. For this reason, in addition to submitting your new application, could you also complete a questionnaire for each of your family members who is already family-insured with DAK-Gesundheit. This will save you from having to provide such details later.

Should you have any questions or require assistance in completing the application forms, do not hesitate to contact us by phone. Our advisors will be happy to help you.

Kind regards,

935-101/englisch/03.14

Worth knowing

By opting for family insurance with DAK-Gesundheit, you can be sure you've made the right choice. For example, do you know about our paediatric medical hotline?
Paediatricians and health experts can be reached **24 hours a day 365 days a year** on **040 325325800** at the cost of a local call.

DAK Gesundheit

Non-contributory family insurance for your child/children

- **Instructions for completing application forms:** Please complete the form as follows:
  Section A: This section must be fully completed for children who you want to include as new in our family health insurance or for children who should remain insured.
  Section B: This section must be fully completed if you are married but your spouse is not family-insured via your policy.
  Section C: Your signature. Must always be completed.

- **After completing the application form(s):** Have you remembered to include all the necessary documents?
  Here is a checklist. ☑
  Besides submitting the signed form you may need to provide the following:
  ☐ Certificate(s) of birth, if the family name is different
  ☐ Income statements for A22 and/or B7–B9
  ☐ Current certificate of school attendance for students above the age of 23 years
  ☐ Certificate of enrolment at an educational institution if completing study abroad
  ☐ Certified copy of completion of service for periods of national service/alternative civilian service/voluntary service

Non-contributory family insurance for your spouses

- **Instructions for completing application forms:** Please complete the form as follows:
  Section A: This section must be fully completed if you want to include your spouse as new in our family health insurance or you want your spouse to remain insured.
  Section B: Your signature. Must always be completed.

- **After completing the application form(s):** Have you remembered to include all the necessary documents?
  Here is a checklist. ☑
  Besides submitting the signed form you may need to provide the following:
  ☐ Certificate of marriage, if the family name is different
  ☐ For civil servants: Certificate from the employer concerning excluded entitlement to aids
  ☐ Income statement for A29

Member	Health insurance number	AO

DAK Gesundheit

Non-contributory family insurance for my child/children

For non-contributory family insurance we need some information relating to your child/children and possibly also to your spouse.

Therefore, our first question: Are you married? ☐ Yes ☐ No

Under the German Life Partnership Act (LPartG), life partners are accorded the same legal status as spouses. We only use the term "spouse" for the sake of simplicity. If you are in a same sex registered civil partnership as defined by the LPartG, please indicate that you are married.

Please note that the simultaneous implementation of family insurance schemes with different health insurance companies is legally prohibited. Therefore, please make sure that a double family insurance is excluded.

A	**Information about your child/children** who you want to include as new in our family health insurance or who should remain insured		
	General information	**Child**	**Child**
1	First name		
2	Alternative family name *(Please enclose a certificate of birth)*		
3	Date of birth		
4	Gender	☐ Female ☐ Male	☐ Female ☐ Male
5	The child is my… **The term "Biological child" should also be used in case of adoption.*	☐ Biological child* ☐ Grandchild ☐ Stepchild ☐ Foster child	☐ Biological child* ☐ Grandchild ☐ Stepchild ☐ Foster child
6	*If foster child: It lives with me in the same household*	☐ Yes ☐ No	☐ Yes ☐ No
7	Address — Street		
	Postcode/City		
	Country		
8	Pension insurance no.		
	Only complete lines 9–12 if the child does not yet have its own pension insurance number.		
9	*We need this information for allocating a personal life-long health insurance number.* — Birth name		
10	Place of birth		
11	Country of birth		
12	Nationality		
13	The child should be family-insured under my insurance on a non-contributory basis as of		
	Information about previous insurance		
14	How was the child previously covered by health insurance?	☐ No insurance ☐ Family-insured ☐ Private ☐ Own insurance	☐ No insurance ☐ Family-insured ☐ Private ☐ Own insurance
15	Till when? — Date		
16	State which health insurance company/private insurance? — Name		
	Address		
17	Who was the main person insured? — Name		
	Date of birth		
	Information about occupation		
18	Current work performed	☐ Self-employed ☐ Attending school ☐ In vocational training ☐ Studying	☐ Self-employed ☐ Attending school ☐ In vocational training ☐ Studying
19	expected until — Date		
	Important: *If your child is attending school and is above the age of 23 years, enclose a current certificate of school attendance. If your child is studying abroad, enclose a certificate of enrolment at an educational institution.*		
20	Study at university/college of higher education — Name		
21	National service/alternative civilian service/voluntary service completed — from – to	**Important:** *Enclose a certified copy of completion of service* –	–

Information about your child/children continued on the back page

Please turn over ▶ ▶ ▶

935-101/englisch/03.14

DAK Gesundheit

	Information on the income of your child/children		
22	Self-employment *(Please enclose a copy of the current income tax assessment.)*	From _____ to _____ Monthly gross income (profit) €	From _____ to _____ Monthly gross income (profit) €
23	Income from minor employment (mini-job)	From _____ to _____ Monthly gross income €	From _____ to _____ Monthly gross income (profit) €
24	Receipt of unemployment benefit II	From _____ to _____	From _____ to _____
25	Statutory pension, pensions and related benefits, company pension, foreign pension, other pensions	From _____ to _____ Monthly payment amount € / Type of income	From _____ to _____ Monthly payment amount € / Type of income
26	**Other** regular monthly sources of **income** as defined by income tax law *(For example, gross wage income from more than minor employment, income from letting and leasing, income from capital assets)*	From _____ to _____ Monthly gross income € / Single payment/ special payment € Type of income	From _____ to _____ Monthly gross income € / Single payment/ special payment € Type of income
27	If entitlement to benefit exists under a pension law *(BVG, SVG, OEG or similar)*	☐ Yes	☐ Yes

B	Information relating to your spouse	*Must be completed if you are* ***married, but only your child/children*** *should be* **family-insured with DAK-Gesundheit.**
1	First name/Date of birth	/
2	Alternative family name	
3	My spouse is related to the child or children	☐ Yes ☐ No *If "no", no further details about your spouse are necessary*
4	My spouse is a member of a public health insurance company	☐ Yes ☐ No *If "yes", no further details about your spouse are necessary, except for line 5*
5	namely name	
6	My spouse has separate income *If "yes", please also provide details about your income (line 9)*	☐ no *(For example, remuneration including benefits in kind, income from self-employment, statutory and other pensions, foreign pension, pensions and related benefits, income from letting, leasing and capital assets, severance pay, single payments/special payments such as Christmas bonus and holiday pay).*
7		Monthly gross income € / Single payment € / Special payment €
8		Type of income
9	**I** have the following income	*Income as defined by income tax law (see above)* Monthly gross income € / Single payment € / Special payment € *Please specify as we are not necessarily aware of all sources of income.*
	Re lines 7–9	***Please enclose an income statement*** *(for example, current income tax assessment, current salary declaration),* ***also for family allowances*** *(for example, married/child allowances).*

C	Signature	*In cases where family members are living separately, the signature of the eligible family member(s) is sufficient.*

With my signature I confirm that the eligible family members consent to the provision of their data and the accuracy of the information. **I will inform you immediately of any changes to the information provided.** This applies in particular if there is a change in the income levels of the eligible family members or family-insured relatives themselves become a member of DAK-Gesundheit or another health insurance company.

Date/Signature of member	Date/Signature of family member(s)	For questions I can be contacted during the day *(This information is voluntary)* Dialling code: Telephone number:

Data protection notice Paragraph 67 a Article 3 SGB X. *To enable us to fulfil our duties lawfully, your participation is required pursuant to Paragraph 289 of the German Social Code Book V (SGB V). The data are to be collected for the purpose of determining the insurance relationship (Paragraphs 10, 284 SGB V).*

Member	Health insurance number	AO

DAK Gesundheit

Non-contributory family insurance for my spouse

For non-contributory family insurance we need some information relating to your spouse.

Please note that the simultaneous implementation of family insurance schemes with different health insurance companies is legally prohibited. Therefore, please make sure that a double family insurance is excluded.

A	**General information**		Under the German Life Partnership Act, life partners are accorded the same legal status as spouses. We only use the term "spouse" in this context for the sake of simplicity.
1	First name		
2	Alternative family name *(Please enclose a certificate of marriage)*		
3	Date of birth		
4	Address	Street	
		Postcode/City	
		Country	
5	Pension insurance no.		
	Only complete lines 6–9 if your spouse does not yet have their own pension insurance number.		
6	*We need this information for allocating a personal life-long health insurance number.*	Birth name	
7		Place of birth	
8		Country of birth	
9		Nationality	
10	My spouse should be family-insured under my insurance on a non-contributory basis as of		
	Information about previous insurance		
11	How was your spouse previously covered by health insurance?		☐ No insurance ☐ Family-insured ☐ Private ☐ Own insurance
12	Till when?	Date	
13	State which health insurance company/ private insurance?	Name	
		Address	
14	Who was the main person insured?	Name	
		Date of birth	
15	Was your spouse exempted from mandatory health insurance?		☐ Yes
16	When?	Date	
17	State which health insurance company?	Name	
		Address	
	Information about occupation		
18	My spouse is on maternity leave		☐ Yes
19	My spouse is on parental leave		☐ Yes
20	expected until	Date	
21	My spouse is currently studying		☐ Yes
22	expected until	Date	
23	at the following university/college of higher education	Name	
24	My spouse is a civil servant		☐ Yes
25	If „yes", there is an entitlement to aids or an entitlement to sickness insurance by application of state aid rules		☐ Yes ☐ No *Please enclose a certificate from the employer*
26	My spouse is self-employed		☐ Yes
27	…with the following time required		_____ hours per week
28	and has employees		☐ No ☐ Yes

Please turn over ▶ ▶ ▶

	Information on the income		
29	Self-employment *(Please enclose a copy of the current income tax assessment.)*	From _____ To _____	Monthly gross income (profit) €
30	Income from minor employment (mini-job)	From _____ To _____	Monthly gross income (profit) €
31	Receipt of unemployment benefit II	From _____ To _____	
32 33	Statutory pension, pensions and related benefits, company pension, foreign pension, other pensions	From _____ To _____ Type of income	Monthly payment amount €
34 35	**Other** regular monthly sources of **income** as defined by income tax law *(For example, gross wage income from more than minor employment, income from letting and leasing, income from capital assets)*	From _____ To _____ Single payment € Type of income	Monthly gross income € Special payment €
36	My spouse has entitlement to benefits under a pension law *(BVG, SVG, OEG or similar)*	☐ Yes	

B	**Signature**	*If living separately, the signature of the spouse is sufficient.*

With my signature I confirm that my spouse consents to the provision of their data and the accuracy of the information.
I will inform you immediately of any changes to the information provided. This applies in particular if there is a change in my spouse's income levels or my spouse becomes a member of DAK-Gesundheit or another health insurance company.

Date/Signature of member	Date/Signature of family member(s)	For questions I can be contacted during the day *(This information is voluntary)* Dialling code: Telephone number:

Data protection notice Paragraph 67 a Article 3 SGB X. *To enable us to fulfil our duties lawfully, your participation is required pursuant to Paragraph 289 of the German Social Code Book V (SGB V). The data are to be collected for the purpose of determining the insurance relationship (Paragraphs 10, 284 SGB V).*

Please return to:

DAK-Gesundheit Postzentrum