

**Return to:  
BKK MTU**

**Hochstraße 40  
88045 Friedrichshafen**

KV-Nr.: / / 2014 / Application

**Questionnaire for admission into the family insurance**

**General information of the member**

- marital status:     single             married             seperated             divorced             widowed  
                                   Registered life partnership under the life-partnership law (in this case fill out information under "spouse")
- Occasion for the admission into the family insurance:
- beginning of my membership     birth of the child                             marriage  
                                   previous membership of my spouse has ended                             others: \_\_\_\_\_
- Beginning of the family insurance: \_\_\_\_\_
- For further questions you can reach me during the day under Tel.: \_\_\_\_\_ (optional)
- My E-mail address: \_\_\_\_\_ (optional).

**Specifications of family members**

The following data are generally required only for those family members who are to be insured with us. Deviating from this, we will also need some information from your spouse, even if the family insurance will be carried out only for your children. If your spouse is not insured by law we need in addition to the general information also information about your spouses income. please provide a relevant proof of income.

**Please note that a simultaneous family insurance with different health insurance companies is legally prohibited. Therefore, please make sure that there is no double family insurance. .**

**General information of the family members**

my spouse is self-insured <input type="checkbox"/> no <input type="checkbox"/> yes with _____ <b>(if privately insured, please enclose a proof of income)</b> name and location of the health insurance company				
	<b>Spouse</b>	<b>Child</b>	<b>Child</b>	<b>Child</b>
Name*				
*Please enclose a marriage- or birth certificate if your spouse or your children have different names, If we don't have these documents yet.				
First Name				
Sex (m=male, w=female)	<input type="checkbox"/> (m) <input type="checkbox"/> (f)	<input type="checkbox"/> (m) <input type="checkbox"/> (f)	<input type="checkbox"/> (m) <input type="checkbox"/> (f)	<input type="checkbox"/> (m) <input type="checkbox"/> (f)
Date of birth				
Address				
Relationship of the member to the child (the term "own child" is to be used even with adoption)	_____	<input type="checkbox"/> own child* <input type="checkbox"/> stepchild <input type="checkbox"/> grandchild <input type="checkbox"/> foster-child	<input type="checkbox"/> own child* <input type="checkbox"/> stepchild <input type="checkbox"/> grandchild <input type="checkbox"/> foster-child	<input type="checkbox"/> own child* <input type="checkbox"/> stepchild <input type="checkbox"/> grandchild <input type="checkbox"/> foster-child
Is the spouse related to the child? (check only if there is no relationship)	_____	<input type="checkbox"/> (no)	<input type="checkbox"/> (no)	<input type="checkbox"/> (no)

Information on previous or current existing insurance of family members				
	Spouse	Child	Child	Child
Previous insurance • ended on: • name of insurance company	..... ..... .....	..... ..... .....	..... ..... .....	..... ..... .....
Type of coverage:	<input type="checkbox"/> membership <input type="checkbox"/> family insurance <input type="checkbox"/> privately	<input type="checkbox"/> membership <input type="checkbox"/> family insurance <input type="checkbox"/> privately	<input type="checkbox"/> membership <input type="checkbox"/> family insurance <input type="checkbox"/> privately	<input type="checkbox"/> membership <input type="checkbox"/> family insurance <input type="checkbox"/> privately
In case of a previous family coverage, please name the person whose membership was derived from the family insurance	..... (First name) ..... (Name)	..... (First name) ..... (Name)	..... (First name) ..... (Name)	..... (First name) ..... (Name)
The still existing insurance company: (name and location)		_____	_____	_____
Other information about family members				
	Spouse	Child	Child	Child
Self-employed	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Earnings from self-employment (monthly) Please provide a copy of the current income tax assessment.	€	€	€	€
Monthly gross-earnings from marginal employment (Mini-Job)	€	€	€	€
Do you receive unemployment benefits II (ALG II)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
State pension, pensions, company pension, foreign pension, other pensions (monthly amount)	€	€	€	€
Other regular monthly income under the Income Tax law (eg, gross pay of more than marginal employment, income from rental and leasing, investment income)	.....€ ..... (type of income)	.....€ ..... (type of income)	.....€ ..... (type of income)	.....€ ..... (type of income)
School or study (please enclose a proof of enrollment for children of the age from 23 years)	_____	from..... until.....	from..... until.....	from..... until.....
Prescribed military or civilian service (Please attach certificate of service)	_____	from..... until.....	from..... until.....	from..... until.....
Information from family members for assigning an insurance number				
	Spouse	Child	Child	Child
pension insurance number				
The following data will only be needed if a pension number has not been assigned yet				
Maiden name				
Place of birth				
Country of birth				
Nationality				

I confirm the accuracy of the information. In case of changes I will inform you immediately, especially if the income of my family above changes (eg new income tax return for self-employment income) or they become members of other Health insurance.

Place, date

Signature of member

Signature of family members

With my signature I declare, that I received the consent of family members to make the required disclosures

Data protection (§ 67a para 3 SGB X): In order to assess the family's insurance, your assistance pursuant to §§ 10, para 6, 289 SGB V is required. The data for the determination of the insurance contract (§§ 10, 284 SGB V, § 7 KVLG 1989, § 25 SGB XI) to be raised. Optional information of contact data will be used exclusively for further inquiries of your insurance policy.