BKK Pfalz
Die freundliche Familienkasse

Application form for being co-insured – start of family insurance: _____ (date)

Last name of member: _____ **First name:** _____ **Date of birth:** _____

Member's general data

I am / I was
☐ self insured with the statutory health insurance
☐ co-insured
☐ not insured with a statutory health insurance company
at _____ Name of health insurance

Marital status of the member: ☐ Single ☐ Married ☐ Seperated ☐ Divorced ☐ Widowed ☐ Registered life partnership under the life-partnership law – LPartG (in this case please fill in information under „spouse")

My spouse
☐ is is co-insured with me
☐ is not health insured
☐ is a member of the following statutory health insurance:
☐ is health insured with a private health insurance company:
_____ Name of health insurance/private health insurance

Reason for inclusion in co-insurance:
☐ Beginning of my membership ☐ Birth of a child ☐ Marriage
☐ Termination of the dependent's previous own membership ☐ Other: _____

Phone number in case of queries: _____ (voluntary information).

Information about family members

The following data is generally only required for those relatives who are to be co-insured with us. **Deviating from this, we also need individual information about your spouse/life partner if only the co-insurance for your children is to be carried out with us.** In this case, additional to the general information, information of the insurance of the spouse/partner and – if the spouse/partner is not statutory health insured and is related to the children – about his income are required; here, the income has to be documented with proof of income and supplements for marital status cannot be counted to the information of income.

Please note that being a member in different health insurances at the same time, ist not possible. Therefore, please make sure with your information given, that double family insurance is excluded.

General information of the family members

	Spouse/partner	Child	Child	Child
Last name*				
* If the last name is different, please enclose a certificate of marriage or proof of parentage if you have not already done so.				
First name				
Gender (m = male, f = female, n = non-binary)	☐ (m) ☐ (f) ☐ (n)	☐ (m) ☐ (f) ☐ (n)	☐ (m) ☐ (f) ☐ (n)	☐ (m) ☐ (f) ☐ (n)
Date of birth				
Alternative address (only if it differs from the member's address)				
Relationship of member to child	_____	☐ Natural child ☐ Adopted child ☐ Stepchild ☐ Grandchild ☐ Foster child	☐ Natural child ☐ Adopted child ☐ Stepchild ☐ Grandchild ☐ Foster child	☐ Natural child ☐ Adopted child ☐ Stepchild ☐ Grandchild ☐ Foster child
Is the spouse/life partner related to the child?	_____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Information on the insurance of family members

	Spouse/partner	Child	Child	Child
The previous insurance ☐ expired: ☐ was with (name of the statutory/private health insurance company):				
Type of previous insurance:	☐ Membership ☐ Co-insurance ☐ Private health insurance ☐ None	☐ Membership ☐ Co-insurance ☐ Private health insurance ☐ None	☐ Membership ☐ Co-insurance ☐ Private health insurance ☐ None	☐ Membership ☐ Co-insurance ☐ Private health insurance ☐ None
In case of a previous co-coverage, please name the name of the member who the co-insurance was with:	First name Last name	First name Last name	First name Last name	First name Last name
The previous insurance continues with: (name of the health insurance company)				

Further information about family members

	Spouse/partner	Child	Child	Child
Is anybody self-employed?	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Income from self-employment (monthly)	EUR	EUR	EUR	EUR
Gross wages from minor employment (mini job)	EUR	EUR	EUR	EUR
Do you receive unemployment benefits (ALG II)?	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Statutory pension, pension benefits, company pension, foreign pension, other pensions (monthly payment)	EUR	EUR	EUR	EUR
Other regular monthly income within the meaning of income tax law (e.g. Gross wages from more than minor employment, income from rent and lease or from capital assets)	EUR Type of income	EUR Type of income	EUR Type of income	EUR Type of income
School/study (Please enclose a current school or study certificate for children older than 23 years)		from to	from to	from to
Military, civil or voluntary service (Please enclose a certificate)		from to	from to	from to

Information the assignment of a health insurance number for relatives with co-insurance

	Spouse/partner	Child	Child	Child
Own pension insurance number				
The following information is only required if no pension insurance number has yet been assigned.				
Name of birth				
Place of birth				
Country of birth				
Nationality				

I confirm the accuracy of this. I will inform you immediately about changes. This applies in particular if the income of my relatives changed (e.g. new income tax assessment for self-employment) or they become members of (another) health insurance company.

Place and date

Signature of the member

Signature of co-insured member

With my signature, I declare that the above named family members agree with submitting the required data.

In the case of co-insured members living separately, the signature of the co-insured member is sufficient.

Data protection notice: The data is collected on the basis of legal provisions and is necessary for the performance of the tasks of the BKK Pfalz. Further information on data protection and data processing in accordance with Article 13 DSGVO is available at: www.bkkpfalz.de/datenschutz-und-informationsfreiheit.