

MEMBERSHIP APPLICATION

Yes, I would like to become a member of the Merck company health insurance fund on ____ . ____ . ____ .

PERSONAL DETAILS

Surname		First name	
Address		Postcode/Town/city	
Social insurance number	Date of birth	City of birth	
Marital status	Gender <input type="checkbox"/> female <input type="checkbox"/> male	Name at birth	
Tax identification number*	Health insurance number	Nationality	

INFORMATION ABOUT INSURANCE RELATIONSHIP

<input type="checkbox"/> Employer (name, address)	<input type="checkbox"/> Employment agency (name, address)
<input type="checkbox"/> Employee	<input type="checkbox"/> Trainee
<input type="checkbox"/> Unemployment benefit recipient	

OTHER INFORMATION

<input type="checkbox"/> Previous health insurance fund (name, address)	Previous form of insurance <input type="checkbox"/> family-insured with _____ <input type="checkbox"/> self-insured End of insurance _____
---	---

FAMILY INSURANCE

I would like to co-insure relatives. Please send me an application form.

Date, place	Signature	Telephone number so we can contact you if we have any questions
-------------	-----------	---

* I do not know my tax identification number. Please request this for me from the Central Allowance Authority for Pension Assets (ZfA). I consent the use of my tax number for the purposes of fulfilling legal responsibilities.

The information is required for the statutory fulfilment of the responsibilities of the health insurance fund; it is collected due to the provisions of the Social Security Code and is stored on data carriers. Your details are treated confidentially and are subject to data protection.