Return to:
Betriebskrankenkasse Merck

Frankfurter Str. 133
64293 Darmstadt

KV-Nr.: / / 2014 / Application

Questionaire 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.
P**lease 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 ☐ no ☐ yes with _____
(if privatly insured, please enclose a proof of income)) name and location of the health insurance company

	Spouse	**Child**	**Child**	**Child**
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)	☐ (m) ☐ (f)	☐ (m) ☐ (f)	☐ (m) ☐ (f)	☐ (m) ☐ (f)
Date of birth				
Address				
Relationship of the member to the child (the term "own child" is to be used even with adoption)	_____	☐ own child* ☐ stepchild ☐ grandchild ☐ foster-child	☐ own child* ☐ stepchild ☐ grandchild ☐ foster-child	☐ own child* ☐ stepchild ☐ grandchild ☐ foster-child
Is the spouse related to the child? (check only if there is no relationship)	_____	☐ (no)	☐ (no)	☐ (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:	☐ membership ☐ family insurance ☐ privately	☐ membership ☐ family insurance ☐ privately	☐ membership ☐ family insurance ☐ privately	☐ membership ☐ family insurance ☐ privately
In case of a prevoius 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	☐ Yes	☐ Yes	☐ Yes	☐ 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)	☐ Yes	☐ Yes	☐ Yes	☐ 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 childen 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 | Signatur 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 contactdata will be used exclusively for further inquiries of your insurance policy.