

Application for Family Insurance 2011

1. Member information

Last name | First name: _____

Date of birth: _____

Address: _____

ZIP/postcode | City: | | | | |

Member no.: _____

Phone: _____

E-mail: _____

Marital status: _____

Information

Under certain conditions, the member's **statutory health and long-term care insurance** covers **spouses** and domestic partners (in registered domestic partnerships) as well as **the member's children and the children of co-insured children** at no extra charge.

Children are defined here as:

- All children as defined by the German Civil Code (marital, extramarital, adopted)
- Stepchildren or children of the domestic partner and grandchildren whose primary support (more than 50%) is provided by the member
- Foster children who share a household with the parents in a parent-child relationship
- Adopted foster children if the parental consent required for acceptance has been granted

Conditions for family insurance:

- Regular residency within Germany
- No distinct overriding coverage (e.g., separate insurance policy)
- No exemption from insurance or from the obligation for insurance (except for minor employment as defined by the Social Security Code SGB IV, section 8)
- No full-time self-employment
- Total income no more than €365 per month or €400 per month for low-paid work (2011 figures)

Co-insured children:

- Children are insured until their 18th birthday.
- Children are insured until their 23rd birthday if not employed.
- Children are insured until their 25th birthday if they are in school or vocational training or participating in a voluntary year of social or ecological service as defined by law; if the child's school or vocational training is interrupted or delayed due to mandatory military/civilian service, the insurance continues beyond the 25th birthday for the duration of the interruption or delay.
- Children are insured for life if they are incapable of caring for themselves as a result of physical, mental or emotional disability; this requires that the disability was present at a time when the child was covered under the family policy.

If the conditions for family insurance are met under more than one health insurance policy, the member selects the insurer that should carry the family policy. The parents' income is irrelevant here.

Attention private insurance policyholders: Non-contributory family insurance ends under certain conditions.

If one parent is not insured in the statutory health insurance system (is privately insured, for example), non-contributory family insurance coverage may be excluded.

This applies when the spouse related to the child is not in the statutory insurance system and:

- his/her total regular monthly income exceeds €4,125 (2011 figure), and
- his/her total income regularly exceeds that of the member insured in the statutory health insurance system.

The income threshold drops from €4,125 to €3,712.50 if the spouse related to the child is employed and was already privately insured on December 31, 2002.

Family insurance coverage is excluded for the mandatory pregnancy leave defined by law and the parental leave period if no statutory health insurance coverage existed before such a period (as in the case of privately insured civil servants or government employees).

Continue on reverse ⇨

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2. Spouse

(Please complete this information even if the application for family insurance is only for the children. If your spouse has a different last name, please attach a copy of the marriage certificate. Complete the address information only if the spouse's address is different than the member's.)

Last name | First name: _____
 Date of birth: _____
 Address: _____
 ZIP/postcode | City: | | | | | | | | | |
 Phone: _____
 E-mail: _____
 Has statutory health insurance:

 Insured privately as
 Self-employed Civil servant Employee
 as of _____ (please attach proof of income)

Already has family insurance through me
 To be covered under my family insurance. Start: _____
 Prior insurer: _____
 Employed Self-employed
 Regular gross monthly income: € _____
 Social security number: _____
 Or if not yet assigned:
 Name at birth: _____
 Place of birth: _____
 Nationality: _____

3. Children

(Please attach copies of birth certificates. For children 14 and older, attach proof of school/college admission; attach proof for those performing mandatory military or civilian service.)

Last name | First name: _____
 Date of birth: _____
 Address: _____
 ZIP/postcode | City: | | | | | | | | | |
 Social security number: _____
 If no social security number has been assigned yet:
 Name at birth: _____
 City/country of birth: _____
 Nationality: _____

Male Female
 Biological child Stepchild Foster child
 Adopted child Grandchild
 To be covered under my family insurance. Start: _____
 Prior insurer: _____
 Employed Self-employed
 Regular gross monthly income: € _____
 School/college: from _____ to: _____
 Military/civilian service: from _____ to: _____

Last name | First name: _____
 Date of birth: _____
 Address: _____
 ZIP/postcode | City: | | | | | | | | | |
 Social security number: _____
 If no social security number has been assigned yet:
 Name at birth: _____
 City/country of birth: _____
 Nationality: _____

Male Female
 Biological child Stepchild Foster child
 Adopted child Grandchild
 To be covered under my family insurance. Start: _____
 Prior insurer: _____
 Employed Self-employed
 Regular gross monthly income: € _____
 School/college: from _____ to: _____
 Military/civilian service: from _____ to: _____

Last name | First name: _____
 Date of birth: _____
 Address: _____
 ZIP/postcode | City: | | | | | | | | | |
 Social security number: _____
 If no social security number has been assigned yet:
 Name at birth: _____
 City/country of birth: _____
 Nationality: _____

Male Female
 Biological child Stepchild Foster child
 Adopted child Grandchild
 To be covered under my family insurance. Start: _____
 Prior insurer: _____
 Employed Self-employed
 Regular gross monthly income: € _____
 School/college: from _____ to: _____
 Military/civilian service: from _____ to: _____

I understand the conditions governing family insurance coverage. I will immediately notify you of future changes to the above information, especially changes to the gross income of my family members or if my family members obtain coverage under (other) health insurance policies.

Place, date | Signature of member | Signature of spouse | Signature of children age 15 and up

Data privacy notice (per section 67a, subsection 3 SGB X): Your cooperation per section 289 SGB V is required in order for us to fulfill our legal responsibilities. This data must be collected to establish insurance coverage (sections 10, 284 SGB V, section 7 KVLG 1989).