Yes, I choose BARMER, beginning

I am providing the following information for my membership:

BARMER

Personal information

Last name, first name

Title

Gender: f, m, o, u

f = female
m = male
o = other
u = undefined

Street address

Telephone number [1]

Date of birth (dd/mm/yyyy)

Postal code

Town/city

E-mail address [1]

Mobile number [1]

Pension insurance number

Name at birth [2]

Nationality [2]

Place of birth and country of birth

Information on group of persons

I am ☐ an apprentice ☐ an employee ☐ partner/director

starting from/since

with employer/company, address

Because of my earnings, I am

☐ obliged to take out health insurance

☐ exempt from health insurance

☐ I am related to my employer by blood, marriage, etc.

☐ I am a student — starting from/since — until (expected) — Please enclose certificate of enrolment!

☐ I am (e.g. self-employed, school student, not working) — starting from/since [3]

☐ I am unemployed starting from/since — and receive/expect to receive starting from/since — unemployment benefit/unemployment benefit II [4]

☐ I receive a statutory pension starting from/since — or have applied for a pension on — (also applies to foreign pensions [4])

☐ I have income similar to a pension (company pension, annuity, etc.) or have received a one-off lump-sum payment in the last ten years [4]

☐ I am an agricultural entrepreneur or a family member working for an agricultural entrepreneur

Information on previous insurance

☐ I was last insured, from — to — by — Health insurance company

☐ myself

☐ as a family member through — Last name, first name — Date of birth — Policyholder number

☐ I have since — not had statutory insurance — Reason (e.g. privately insured, abroad):

Reason for changing health insurance company

☐ Change in the insurance relationship (e.g. change of employer)

☐ Expiry of the commitment

☐ Increase in the supplementary contribution by the previous health insurer

General information

☐ I have children (also applies to stepchildren, adopted children or foster children; information is required to determine the long-term care insurance contribution).

☐ I know other people who might be interested in a BARMER membership.

☐ I prefer communication in English.

Signature

✗ Date, signature

Membership of the health insurance fund also generally establishes membership of the long-term care insurance fund, unless an exemption from this exists.

[1] Optional information.
[2] Only required if no pension insurance number is provided.
[3] Declaration of income on separate form.
[4] Please enclose proof.

For information: Your data are processed for the purpose of clarifying the insurance contract in accordance with Sections 5 et seq. SGB Title V, and for collection of premiums in accordance with Sections 226 et seqq. SGB Title V and 57 SGB Title XI. BARMER stores these data for nine years. The data relating to the insurance contract (Sections 288 SGB Title V, 99 SGB Title XI) will be stored for a maximum of 30 years.
Where the legal requirements are satisfied, you have a right to information, rectification and erasure or restriction as well as the right to data portability.

You may file an objection against the processing of your personal data with us or with the German Federal Commissioner for Data Protection and Freedom of Information. Our Data Protection Officer can be reached at datenschutz@barmer.de or Lichtscheider Str. 89, 42285 Wuppertal, Germany.

GS-Nummer

GP-Nummer Vertriebspartner

Family insurance – I am applying for the following family members to be co-insured free of charge from the month my membership commences

Privacy notice: Your data will be processed for clarification of the insurance relationship in accordance with Sections 10 Social Security Code V (SGB V) and 25 Social Security Code XI (SGB XI). BARMER stores these data for 9 years and then deletes them. Provided that the legal requirements are met, you have a right to information, correction and deletion or restriction as well as the right to data portability.

	Spouse/civil partner [1]	Dependant	Dependant	Dependant
First name				
Last name				
Address (if different)				
Date of birth				
Last name at birth [2]				
Place of birth [2]				
Nationality [2]				
Pension insurance number				
Gender (f = female, m = male, o = other, u = undefined)	☐ f ☐ m ☐ o ☐ u	☐ f ☐ m ☐ o ☐ u	☐ f ☐ m ☐ o ☐ u	☐ f ☐ m ☐ o ☐ u
Relationship (please add: daughter, son, stepchild, grandchild, foster child, adopted child)				
Is the spouse/civil partner related to the child? (Please only cross if they are not related)		☐ no	☐ no	☐ no
The previous insurance ☐ ended on:				
☐ was with (name of health insurance company):				
Type of previous insurance	☐ membership ☐ family insurance ☐ not statutory	☐ membership ☐ family insurance ☐ not statutory	☐ membership ☐ family insurance ☐ not statutory	☐ membership ☐ family insurance ☐ not statutory
If there was family insurance, last name and first name of the person from whose membership the family insurance was derived	First name Last name	First name Last name	First name Last name	First name Last name
The previous insurance still exists with (name of health insurance company/ health insurer):				
Employed / self-employed?	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
If yes, please state the date (from/to) and answer questions a) to c)				
a) Regular gross monthly income (If self-employed: Please enclose current income tax assessment!)	€	€	€	€
b) Marginal employment from/to				
c) Regular gross monthly income in the case of marginal employment	€	€	€	€
Other monthly income as defined by income tax law (e.g. pension, civil servant payments, rent, lease, interest income)	€	€	€	€
School/studies from/to (for children aged 23 and over, please enclose or subsequently submit certificate of enrolment)				
Type of school/college/university (e.g. "Hauptschule", "Realschule", "Gymnasium") [3]				
Grade/semester [3]				
Military service or voluntary service regulated by law from/to (please enclose or subsequently submit a certificate of service)				

I will inform you immediately of any future changes. This applies in particular if the gross income of the family members named above increases or if one of these family members becomes a member of a (different) health insurance fund. With my signature I declare that my family members consent to me providing the information required. In the case of family members living separately from the BARMER member, the signature may be provided either by the BARMER member or by these family members.

Date	Signature	Signature of family members aged 15 years and over

[1] We require your spouse/civil partner's information even if we are only providing family insurance for your children. Civil partners are same-sex civil partnerships as defined by the Civil Partnership Act (Lebenspartnerschaftsgesetz).
[2] Only required if no pension insurance number is provided
[3] Optional information