



Sender

BARMER
73523 Schwäbisch Gmünd

Date
Insurance Number

Questionnaire for the inclusion of family members in the family insurance as of

► Reason for including the family member in the family insurance

☐ Beginning of my membership	☐ Birth of a child	☐ Marriage	☐ Termination of my family member's previous membership	☐ Other (e.g. previous family insurance elsewhere, moved from abroad, etc.) _____
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► Marital status of the BARMER member

☐ Single	☐ Married	☐ Registered civil partnership¹	☐ Separated	☐ Divorced	☐ Widowed
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Important note. Please enter the details of your family members to be included in the family insurance in sections 1 to 4 below. sollen.

If you only require family insurance for children, we always need information about your spouse or civil partner¹ under section 1 and section 2 if they are related to at least one of the children. If your spouse or civil partner¹ does not have public insurance (e.g. they have private insurance), additional information is required under section 3. Please attach appropriate supporting documents.

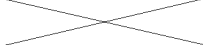
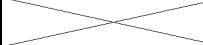
1. General information about family members				
	Spouse or civil partner¹	Child	Child	Child
Last name*				
* If the last names of the BARMER member and their family members are different, the relationship must be demonstrated by supporting documents (e.g. marriage certificate, civil partnership certificate, birth certificate).				
First name				
Gender (m = male, f = female, d = diverse, o = other)	☐ (m) ☐ (d) ☐ (f) ☐ (o)	☐ (m) ☐ (d) ☐ (f) ☐ (o)	☐ (m) ☐ (d) ☐ (f) ☐ (o)	☐ (m) ☐ (d) ☐ (f) ☐ (o)
Date of birth				
Address if different from that of the BARMER member				
Relationship between the BARMER member and the child (* "Biological child" should also be selected in the case of adoption.)		☐ Biological child* ☐ Stepchild ☐ Grandchild ☐ Foster child	☐ Biological child* ☐ Stepchild ☐ Grandchild ☐ Foster child	☐ Biological child* ☐ Stepchild ☐ Grandchild ☐ Foster child
Is your spouse or civil partner¹ related to the child? (Please only cross if they are not related)		☐ No	☐ No	☐ No

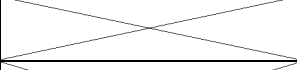
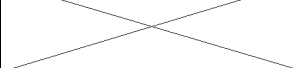
Please return documents loose and not stapled or bound.

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Name

Insurance Number

2. Information about family members' previous or current insurance				
	Spouse or civil partner ¹	Child	Child	Child
The previous insurance ended on:	_____	_____	_____	_____
The previous insurance is still in place:	☐ Yes			
Name of the health insurance:	_____	_____	_____	_____
Type of previous insurance:	☐ Membership ☐ Family insurance ☐ Not public (e.g. private)	☐ Membership ☐ Family insurance ☐ Not public (e.g. private)	☐ Membership ☐ Family insurance ☐ Not public (e.g. private)	☐ Membership ☐ Family insurance ☐ Not public (e.g. private)
If the family member was previously covered by family insurance with another health insurance provider, please state the last name and first name of the person on whose membership the family insurance was based.	_____	_____	_____	_____
	(first name)	(first name)	(first name)	(first name)
	_____	_____	_____	_____
	(last name)	(last name)	(last name)	(last name)

3. Additional information about family members				
	Spouse or civil partner ¹	Child	Child	Child
Self-employed?	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Self-employment accounts for more than 20 hours per week on average?	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Monthly income from self-employment (Please attach a copy of the most recent income tax assessment)	_____ euro	_____ euro	_____ euro	_____ euro
Monthly gross income from marginal employment ("mini job"). Please include payments such as Christmas bonuses at a rate of 1/12.	_____ euro	_____ euro	_____ euro	_____ euro
Monthly gross income from more than marginal employment ("mini job"). Please include payments such as Christmas bonuses at a rate of 1/12.	_____ euro	_____ euro	_____ euro	_____ euro
Statutory pension, civil servant payments, company pensions, foreign pensions or other pensions (amount paid monthly)	_____ euro	_____ euro	_____ euro	_____ euro
Other monthly income as defined by income tax law (e.g. income from renting and leasing, income from capital investments, severance pay for loss of job).	_____ euro	_____ euro	_____ euro	_____ euro
	_____ (Type of income)	_____ (Type of income)	_____ (Type of income)	_____ (Type of income)
School/studies (for children aged 23 and over, please provide confirmation of (school) student status)		from _____ to _____	from _____ to _____	from _____ to _____
Are they doing/Have they done voluntary service or German military service regulated by law? (Please attach a certificate of service)		☐ Yes ²	☐ Yes ²	☐ Yes ²

4. Information for the allocation of a health insurance number for family members covered by family insurance				
	Spouse or civil partner ¹	Child	Child	Child
Own German Social Security Number (RV-Nr.)	_____	_____	_____	_____
Last name at birth	_____	_____	_____	_____
City/Place of birth	_____	_____	_____	_____
Country of birth	_____	_____	_____	_____
Nationality	_____	_____	_____	_____
I can be reached during the daytime at:	Telephone number ² _____		My email address ² _____	

I confirm that the information provided is accurate. I will inform you immediately of any changes. This applies in particular if the income of my above-mentioned family members changes (e.g. new income tax assessment in the case of self-employment) or if they become a member of another health insurance company.

Date _____ Signature of BARMER member _____

If applicable, signature of family member*

With my signature I declare that my family members consent to me providing the information required.

*The signature of the family member is sufficient only in the case of separated family members.

1) Same-sex civil partnership as defined by the German Civil Partnership Act (LPartG).
2) Optional information.