

Last Name
First Name
Street, No.
Postcode, City
Health Insurance No.

Non-contributory Dependants Co-insurance

Deutsche Post 🗶

Techniker Krankenkasse

ANTWORT

Start date of non-contributory	Pension Insurance No		
dependants co-insurance cover I for my spouse/life partner* Day Month Year	Please give the following details if your spouse/life partner' does not have a German Pension Insurance Number yet:		
Start date of non-contributory dependants co-insurance	Last Name at birth		
for my child/children Day Month Year	Place and country of birth		
Please indicate a date. If you do not specify a date or indicate "as of now" this information is not legally valid.	Nationality		
Reason for applying for non-contributory dependants co-insurance	Different address, if applicable		
Commencement of my own membership	Street, No		
Marriage Birth of my child	Postcode and city		
Termination of previous membership	Previous health insurance of spouse/life partner*		
of my dependant	Membership		
Other	Non-contributory dependants co-insurance		
Marital status	Not covered by statutory health insurance		
Married Separated Widowed Single Divorced	from		
Registered Partnership*	Health insurance		
Previous health insurance	Non-contributory dependants co-insurance of		
Membership	membership of: Last Name, First Name		
Non-contributory dependants co-insurance			
Not covered by statutory health insurance	My spouse/life partner* has a personal income yes no		
Health insurance	If so, please answer the following questions for your		
Spouse or Life Partner*	spouse/life partner*		
We need the following details, even if you do not wish to have your spouse/life partner* co-insured with us.	Date paid employment (including mini-job) started		
Last Name Please enclose marriage certificate if different from member's last name.	Average monthly gross income Day Month Year from marginal employment EUR		
First Name	Date self-employment started		
TK Insurance Number, if applicable	Day Month Year Average monthly profit EUR		
Date of birth	Average working hours per week		

* pursuant to the Lebenspartnerschaftsgesetz [German Life Partnership Law] (LPartG)

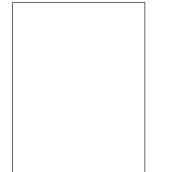
Self-employed childminder	yes no 🛛	Other average mon	thly income EUR	
Date Unemployment Benefit II started		Гуре of income (e.		
Pensions and related benefits/ company pensions, foreign, national or other pensions monthly amount payable EUR	Day Month Year Please send us a complete copy of your last income tax assessment.			
	1 st child		2 nd child	
Last Name				
First Name Please enclose birth certificate in case of different last names.				
Gender	male	female	male	female
Date of birth or TK Insurance No.				
Different address, if applicable:				
Street, No.				
Postcode and city				
Relationship	Birth child	Foster child	Birth child	Foster child
My spouse/life partner is child's birth parent	Stepchild	Grandchild	Stepchild	Grandchild
Pension Insurance Number				
Please give the following details if you do not have a Pension Insurance Number yet:				
Last Name at birth				
Place and country of birth				
Nationality				
Previous insurance	 Membership Non-contributory dependants co-ir Not covered by s health insurance 	nsurance statutory		utory co-insurance l by statutory
Period of cover	Day Month Year	Day Month Year	Day Month Year	」- <mark></mark> Day Month Year
Name of health insurance				
Postcode and city				
Average monthly gross income EUR				
Average monthly gross income from mini-job EUR				
Monthly profit from self-employed work EUR				
Self-employment as childminder	🗌 yes	no	yes	no

Pension and related benefits/ company pensions, foreign, national, or other pensions; monthly amount payable EUR		
Other average monthly income EUR		
Entitlement to Unemployment Benefit II	yes no	yes no
School attendance Please enclose certificate of school attendance for children 23 and over.	Day Month Year Day Month Year	Day Month Year Day Month Year
Type of school (optional information)		
Higher education Please enclose current enrolment receipt for children 23 and over.	Day Month Year Day Month Year	Day Month Year Day Month Year
Type of university/college (optional information)		
Basic military service or alternative community service Please enclose a certificate of service.	Day Month Year Day Month Year	Day Month Year Day Month Year
Contact details		
Phone E-mail		
Date		
Signature I hereby declare that my dependants have given their consent to the processing of the required dat	Signature of Dependant if applica In case you are separated, you have to sig	

We need your personal data ("social data") to correctly perform our tasks for you. Based on the Sozialgesetzbuch (SGB V) [Social Security Code book V], we have legal responsibility to comprehensively protect your personal data.



Your photograph for the electronic health card



We need your passport photo (except for insurees under age 15) so that you get your electronic health card in time for the beginning of your insurance cover.

Please print this form and stick your original photo onto the box provided.

Unfortunately, we may not accept any photos submitted by e-mail.

Personal Information	Mr Ms	
Last Name		
First Name		
Date of Birth	Day Month Year	
Postcode, town/city		
Health Insurance Number		
German Pension Insurance Number		
Phone number (optional information)		
E-mail (optional information)		

I hereby certify that this photograph is a true likeness of me.

Date

Day Month Year

Signature

Information on the photograph

It would be best to submit a photograph that corresponds to a passport photo. However, it must not meet the biometric requirements of the new passports. The specifications are as follows:

- > approx. 45 mm x 35 mm in size
- > preferably a neutral background
- > clearly recognisable full face and front view

It is your choice to send us a colour or black-and-white photo. Please do not use any copies or do not print out the photo yourself. These cannot be used because it is unlikely that they meet the quality requirements.



Techniker Krankenkasse 20901 Hamburg