Family insurance

Deutsche Post
ANTWORT

SBK
80227 München

Health insurance number

Last name, first name of insurant

Address

Questions? sbk.org/family-insurance

Information for assessing family insurance (new insurants)

If you are married, we need your spouse's information as well, even if only your child(ren) is (are) covered by family insurance through us. If your spouse has private insurance or is not insured, we need information about their income. Please include evidence of the income of your family members. Consult the accompanying guide for useful tips on completing this form.

General information about the member

Information about your previous health insurance

☐ Member of SBK
☐ Member of _____
☐ Family member of _____ (Health insurer)
☐ No statutory health insurance

Marital status

☐ Married since ....
☐ Widowed
☐ Separated
☐ Divorced since ....
☐ Single
☐ Civil partnership
(Please provide details for them under 'Spouse')

Contact details in the event of question

Landline phone number private* _____ Landline phone number business* _____

Mobile phone number private* _____ Mobile phone number business* _____

Email address* _____

General information about your spouse

My spouse has their own insurance

☐ No ☐ Yes _____ (Health insurer)

Health insurer's address _____

Reason for including family members

My spouse ❶ _____
should be covered by my family insurance because:

☐ We were married on ....
☐ They were covered by my family insurance with my last health insurer
☐ They previously had their own health insurance until now
☐ Other reason

Start of spouse's family insurance cover with SBK:
.....

My child(ren) ❷ _____
should be covered by my family insurance because:

☐ They were born on .... ☐ Multiple birth
☐ They were covered by my family insurance with my last health insurer
☐ They were covered by my spouse's family insurance until
.....

Health insurer

☐ They previously had their own health insurance until ....
☐ Other reason

Start of child(ren)'s family insurance with SBK:
.....

We are on your side.

Health insurance number

Last name, first name

Information about your family members

	Spouse ❶	Child ❷	Child ❷	Child ❷
First name:				
Last name:				

If your last name is different to that of your family members, please send us a marriage or birth certificate with this form if we do not have this already.

Gender:	☐ Female ☐ Male ☐ Rather not say ☐ Other	☐ Female ☐ Male ☐ Rather not say ☐ Other	☐ Female ☐ Male ☐ Rather not say ☐ Other	☐ Female ☐ Male ☐ Rather not say ☐ Other
Date of birth:				
Landline phone number:*				
Mobile phone number:*				
Email address:*				
Address, if different:				
Relationship to member: Adopted children are considered biological children.		☐ Biological child ☐ Stepchild ☐ Grandchild ☐ Foster child	☐ Biological child ☐ Stepchild ☐ Grandchild ☐ Foster child	☐ Biological child ☐ Stepchild ☐ Grandchild ☐ Foster child
Relationship of child to spouse:		☐ None Please only select 'None' if there is no relationship.	☐ None	☐ None
The previous insurance ended on:				
It was provided by (health insurer):				
Type of insurance:	☐ Membership ☐ Family insurance ☐ Not statutory	☐ Membership ☐ Family insurance ☐ Not statutory	☐ Membership ☐ Family insurance ☐ Not statutory	☐ Membership ☐ Family insurance ☐ Not statutory
If previous insurance was family insurance, please provide the full name of the person who was the primary insurant on that policy:				
The previous insurance continues to be active with (health insurer):				

Health insurance number

Last name, first name

	Child ❷	Child ❷	Child ❷
First name:			
Last name:			
Is your child in school or at university? For children 22 years and older, please include school attendance or registration certificate.	☐ School ☐ University ☐ No	☐ School ☐ University ☐ No	☐ School ☐ University ☐ No
	Since	Since	Since
When do they anticipate finishing school/university?* Please specify for children 14 years and older.	On	On	On
Do you already know what the plan is after they finish school/ university?*			
Have they done their national service or statutory voluntary service (e.g. voluntary social/ ecological year)? If yes, please include a certificate of service if we do not already have this.	☐ Yes	☐ Yes	☐ Yes
	From	From	From
	To	To	To

Information about employment and income ❸

	Spouse ❶	Child ❷	Child ❷	Child ❷
Self-employed:	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Income from self-employed work (monthly) in €:	Please send us a copy of the most recent income tax assessment with this form.			
Gross (monthly) salary from employed work in €:				
Gross (monthly) salary from part-time work in €:				
Statutory pension, pension income, workplace pension, foreign pension, other types of pension (monthly) in €:	Please include evidence.			
Other regular monthly income as defined by income tax law, e.g. from letting and leasing or Assets, as well as other income, e.g. severance payment for job loss in €:	Please include income tax assessment and/or other documentation.			
	Type of income	Type of income	Type of income	Type of income

Health insurance number

Last name, first name

Information for allocating an insurance number

Spouse ❶

Last name | First name | Own pension insurance number

The following information is only needed if no pension insurance number has been allocated yet.

Name at birth | Place of birth | Country of birth | Nationality

Child ❷

Last name | First name | Own pension insurance number

The following information is only needed if no pension insurance number has been allocated yet.

Name at birth | Place of birth | Country of birth | Nationality

Child ❷

Last name | First name | Own pension insurance number

The following information is only needed if no pension insurance number has been allocated yet.

Name at birth | Place of birth | Country of birth | Nationality

Child ❷

Last name | First name | Own pension insurance number

The following information is only needed if no pension insurance number has been allocated yet.

Name at birth | Place of birth | Country of birth | Nationality

Please sign this form and send it to your SBK by fax or using the enclosed return envelope. ❹

Data protection notice pursuant to Article 13 of Regulation (EU) 2016/679: We need your help in accordance with section 10, paragraph 6, section 289, of the German Social Security Code (SGB V) in order to evaluate your family insurance. This data must be collected in order to establish the insurance relationship (sections 10 and 284 of the German Social Security Code (SGB V), section 7 of the KVLG 1989, section 25 of the German Social Security Code (SGB XI)). The information marked with an asterisk (*) is provided on a voluntary basis and is processed for the purpose of providing insurance. Your data will of course be protected and treated confidentially. We will not share any data with third parties. By signing this form, you are consenting to the processing of your data. You can find out more about the data processed by SBK at sbk.org/data-protection or from your personal SBK consultant. You can withdraw your consent informally at any time with future effect and without having to provide a reason by sending an email to widerruf@sbk.org or speaking with your personal SBK consultant.

I confirm that my details are correct. I will inform you immediately if any information changes. I will especially do so if there are changes to the income of my family members (e.g. new income tax assessment in the case of self-employed work) or if someone in my family becomes a member of another health insurer.

Place, date | Member's signature | Family member's signature, if applicable

By signing this form, I am stating that I have the consent of my family members to provide the required information.

For family members living separately, the signature of the family member is sufficient.

Für SBK-Zwecke ☐ nur archivieren	Kurzzeichen