

General information of the member

Last name, first name

Health insurance no.

Street, number

Postal code

City

Up to now, I was,

- based on my own membership, insured with: _____
 (Name of the health insurance company)
- based on a family insurance, insured with: _____
 (Name of the health insurance company)
- not insured by the statutory health insurance

- unmarried
 married
 separated
 divorced
 widowed
- registered civil partnership according to the Civil Partnership Act – LPartG (In this case, the information has to be provided under "Spouse" heading.)

Marital status

- Start of my membership
 Birth of a child
 Marriage
 Termination of the previous own membership of the family member
- Other: _____

The reason for the inclusion in the family insurance

Beginning of the family insurance

I am available at the following telephone number during the day.

E-mail address

Instructions for completing the form

The following data is required only for those family members who are to be co-insured under the family insurance policy. Notwithstanding this, we need some individual information about your spouse/life partner even if only a co-insurance for your children is taken out with us. In this case, information on the insurance of the spouse/partner and – if the spouse/partner is not statutorily insured and is related to the children – information on his or her income is required in addition to the general information. It is mandatory that proof of income be provided. Supplements that are paid in consideration of marital status have to be disregarded with respect to the information concerning income.

Please note that a simultaneous implementation of family insurance at different health insurance companies is legally inadmissible. Please make sure that your information excludes the possibility of a double family insurance.

Pension insurance number

Please fill in. If this is not known, please enter name at birth and place of birth.

Different address (if applicable)

If the family member no longer lives with you, please enter their current address.

Photograph

Enter the **web code 1000** at **www.ikk-suedwest.de** to upload digital images. An electronic health data card photo is compulsory for all insured persons. Children aged under 15 do not have to submit a picture. If you have previously submitted a picture, this will still be saved. In this event, you are not required to submit an additional photo.

School/university attendance, military service

Please enter the beginning date of your children's school education and/or studies together with the anticipated end date. If your child has undertaken alternative service, please enter the time period. For children aged 23 or over, please enter a current school or study certificate or a service certificate for military or alternative service, as family insurance in principle ends at the age of 23/25.

Self-employment

If a family member is self-employed, please enter the time period and their earnings. Please attach a copy of their most recent income tax assessment as proof.

Net income, type of income

Please enter the total gross earnings for your family member and details of the income to which this relates. Please attach copies of relevant proof of income. Please note that family insurance in principle ceases with an income of more than 1/7 of the monthly reference value.

Signature

Please sign the questionnaire, as it is not valid without a signature. For family members living separately from the insurance holder, the signature may be supplied by the holder or by the family member living separately.

General information about your family members with photographs

Please attach a marriage certificate or a birth certificate if your spouse / life partner and your children have a different surname and you have not previously submitted this documentation.

<div style="border: 1px dashed black; padding: 5px;"> <p>45 mm</p> <p>To upload the photograph, please click</p> <p>35 mm</p> </div>	Spouse	
	Surname	
	First name	
	Date of birth	Place of birth
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Male <input type="checkbox"/> Female	
	Pension insurance number	Member of a health insurance company himself/herself
	<input type="checkbox"/> Employee <input type="checkbox"/> Self-employed <input type="checkbox"/> Public servant <input type="checkbox"/> Other, namely: _____	
	Insured himself/herself as	
	Different address (if applicable)	
<input type="checkbox"/> I uploaded it on the Internet at: www.ikk-suedwest.de <input type="checkbox"/> Is available at IKK Südwest <input type="checkbox"/> I will hand it in later		
The photograph for the Electronic Health Card		

<div style="border: 1px dashed black; padding: 5px;"> <p>45 mm</p> <p>To upload the photograph, please click</p> <p>35 mm</p> </div>	Child	
	Surname	
	First name	
	Date of birth	Place of birth
	Name at birth	
	Pension insurance number	School/university attendance from/to
	<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Grandchild <input type="checkbox"/> Stepchild <input type="checkbox"/> Adopted child <input type="checkbox"/> Foster child	
	Military service from/to	
	Family relationship with the member	
	Different address (if applicable)	
<input type="checkbox"/> I uploaded it on the Internet at: www.ikk-suedwest.de <input type="checkbox"/> Is available at IKK Südwest <input type="checkbox"/> I will hand it in later		
The photograph for the Electronic Health Card		

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	Surname	
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	Military service from/to	
	Family relationship with the member	
	Different address (if applicable)	
<input type="checkbox"/> I uploaded it on the Internet at: www.ikk-suedwest.de <input type="checkbox"/> Is available at IKK Südwest <input type="checkbox"/> I will hand it in later		
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	Surname	
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	Date of birth	Place of birth
	Name at birth	
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	Military service from/to	
	Family relationship with the member	
	Different address (if applicable)	
<input type="checkbox"/> I uploaded it on the Internet at: www.ikk-suedwest.de <input type="checkbox"/> Is available at IKK Südwest <input type="checkbox"/> I will hand it in later		
The photograph for the Electronic Health Card		

Information on the last previous or still existing insurance of family members

	Spouse	Child	Child	Child
Previous insurance - ended on:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Date	Date	Date	Date
- existed with:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	(Name of the health insurance company)	(Name of the health insurance company)	(Name of the health insurance company)	(Name of the health insurance company)
Type of previous insurance	<input type="checkbox"/> Membership <input type="checkbox"/> Family insurance <input type="checkbox"/> Not statutorily insured	<input type="checkbox"/> Membership <input type="checkbox"/> Family insurance <input type="checkbox"/> Not statutorily insured	<input type="checkbox"/> Membership <input type="checkbox"/> Family insurance <input type="checkbox"/> Not statutorily insured	<input type="checkbox"/> Membership <input type="checkbox"/> Family insurance <input type="checkbox"/> Not statutorily insured
If a family insurance recently existed, last name and first name of the person from whose membership the family insurance was derived.	<input type="text"/> First name <input type="text"/> Last name	<input type="text"/> First name <input type="text"/> Last name	<input type="text"/> First name <input type="text"/> Last name	<input type="text"/> First name <input type="text"/> Last name
The previous insurance continues to exist with: (Name of the health insurance company)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Other particulars of family members

	Spouse	Child	Child	Child
Self-employed	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Net income from self-employment (monthly) Please attach a copy of the latest income tax statement.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	EUR	EUR	EUR	EUR
Gross earnings from marginal employment (monthly)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	EUR	EUR	EUR	EUR
Did you get Unemployment Benefits II?	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Statutory pension, pension benefits, company pension, foreign pension, other pensions (monthly amount paid)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	EUR	EUR	EUR	EUR
Other regular monthly income within the meaning of income tax legislation (e.g. gross earnings from more than marginal employment, income from rental and leasing income, income from capital assets)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	EUR	EUR	EUR	EUR
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Type of income	Type of income	Type of income	Type of income
School/university (For children of at least 23 years of age, please attach school/university enrolment certificate.)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	from	from	from	from
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	to	to	to	to
German federal volunteer service, military service or civilian service (Please attach length of service certificate)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	from	from	from	from
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	to	to	to	to

Signature

I declare that I have answered all questions fully and correctly. I will notify IKK Südwest immediately about any changes. I attach the confirmation of termination obtained from my health insurance company.

City, date, signature

Signature of the family member, if necessary