Family name, first name: _____

Street, house no.: _____

Postcode, town/city: _____

Insurance number: _____ Date of birth: _____

Die Techniker

Techniker Krankenkasse
20901 Hamburg

Non-contributory dependants' insurance

Please tick the appropriate box or fill in where necessary and do not forget to sign the form.

My married or civil partner
pursuant to the LPartG [German Civil Partnership Act]
is to be insured as of ___ ___ ___ (Day Month Year)

My child/children is/are to be insured as of ___ ___ ___ (Day Month Year)

Please state a date. Entries such as "immediately" are not legally valid.

Reason for dependants' insurance

- ☐ start of my membership
- ☐ birth of a child
- ☐ end of membership of my family member/s
- ☐ marriage
- ☐ other _____

Marital status

- ☐ single
- ☐ separated
- ☐ widowed
- ☐ married since ___ ___ ___ (Day Month Year)
- ☐ registered civil partnership pursuant to the LPartG ___ ___ ___ (Day Month Year)
- ☐ divorced since ___ ___ ___ (Day Month Year)

Previous health insurance in Germany

- ☐ member in a statutory health insurance fund
- ☐ dependant in a statutory health insurance fund
- ☐ privately covered/not covered by statutory insurance

_____
Name of health insurance / health insurance fund

Married/civil partner We require this information – even if you do not wish to insure your married/civil partner as a dependant with us.

- ☐ female
- ☐ male
- ☐ non-binary

_____
Family name, first name (attach a marriage certificate if family names differ)

Insurance number _____ Date of birth (DD MM YYYY) _____

Pension insurance number _____
If a number has not been assigned yet, we require the following information:

_____
Name at birth, nationality

_____
Place and country of birth

Address of married/civil partner if different from yours

_____
Street, house no.

_____
Postcode, town/city

Previous cover of my married/civil partner in Germany

- ☐ member in a statutory health insurance fund
- ☐ dependant in a statutory health insurance fund
- ☐ privately covered/not covered by statutory insurance
  Please send us proof of income – even if only your child/children is/are to be insured.

from ___ ___ ___ (Day Month Year) to ___ ___ ___ (Day Month Year)

_____
Name of health insurance / health insurance fund

Person via whom dependants' insurance was provided, if relevant:

_____
Family name, first name

My married/civil partner has his/her own income. ☐ yes ☐ no

If you ticked yes, we require the following information:

Employed since (including mini-job) ___ ___ ___ (Day Month Year)

Gross earned income (monthly average) ___ . ___ EUR

Self-employed since ___ ___ ___ (Day Month Year)

Profit (monthly average) ___ . ___ EUR

Working hours (weekly average) ___ . ___

Employs others ☐ yes ☐ no

Bürgergeld since [Citizens' Basic Income] ___ ___ ___ (Day Month Year)

All pensions (payments received per month) ___ . ___ EUR

Other income (monthly average) ___ . ___ EUR

_____
Type of income, e.g. from rent, interest, maintenance, redundancy pay. Please send us a complete copy of your last income tax assessment – if you have income from interest, please also include an interest certificate.

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	1st child	2nd child
Family name Attach a birth certificate if family names differ		
First name		
Gender	☐ female ☐ male ☐ non-binary ☐ indeterminate	☐ female ☐ male ☐ non-binary ☐ indeterminate
Date of birth		
Insurance number		
Address if different:	Street, house no. Postcode, town/city	Street, house no. Postcode, town/city
Relationship with child	☐ biological/adopted ☐ stepchild ☐ foster child ☐ grandchild	☐ biological/adopted ☐ stepchild ☐ foster child ☐ grandchild
My married/civil partner is the biological parent of my child.	☐ yes ☐ no	☐ yes ☐ no
Pension insurance number If a number has not been assigned yet, we require the following information:	Name at birth, nationality Place and country of birth	Name at birth, nationality Place and country of birth
Previous health insurance cover in Germany	☐ statutory health insurance member ☐ statutory dependants' insurance ☐ private/no statutory insurance	☐ statutory health insurance member ☐ statutory dependants' insurance ☐ private/no statutory insurance
	Day Month Year - Day Month Year Name of health insurance / health insurance fund	Day Month Year - Day Month Year Name of health insurance / health insurance fund
School/higher education We need a copy of the current school/ enrolment certificate for children over 23	Day Month Year - Day Month Year	Day Month Year - Day Month Year
Type of school/higher education optional information		
Military or statutory voluntary service Please send a copy of confirmation of service or proof of voluntary service	Day Month Year - Day Month Year	Day Month Year - Day Month Year
Employed since including mini-job	Day Month Year	Day Month Year
Gross earned income monthly average	. EUR	. EUR
Self-employed since	Day Month Year	Day Month Year
Profit monthly average	. EUR	. EUR
Working hours weekly average	.	.
Employees	☐ yes ☐ no	☐ yes ☐ no
Bürgergeld since [Citizens' Basic Income]	Day Month Year	Day Month Year
All pensions (payments received per month)	. EUR	. EUR
Other income monthly average Please send us a complete copy of your last income tax assessment – if you have income from interest, please also include an interest certificate.	. EUR Type of income, e.g., from rent, interest, maintenance, redundancy pay	. EUR

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Information on main form of maintenance

Important: We **only** need this information **for stepchildren and grandchildren**.

	1st child		2nd child	
My step/grandchild has been living with me for an extended period in a shared household.	☐ yes	☐ no	☐ yes	☐ no
I care and provide for my step/ grandchild	☐ yes	☐ no	☐ yes	☐ no
We need this information if your step/grandchild has his/her own household at his/her place of training/ study: My step/grandchild remains part of the shared household.	☐ yes	☐ no	☐ yes	☐ no
We need this information if your step/grandchild does not live in your household and is also not part of your shared household: I pay regular maintenance. cash or non-cash payments	☐ yes	☐ no	☐ yes	☐ no
monthly amount	⌊_____⌋ . ⌊__⌋ EUR		⌊_____⌋ . ⌊__⌋ EUR	
	Type of payment		Type of payment	

Details in the event of further questions

⌊_____⌋

Telephone number, optional information

Date, signature (of legal representative, if applicable)

Your signature confirms that the information you have provided is correct. Please inform us about any changes as quickly as possible.

We require your personal information to complete our work for you correctly. The legal bases for this are Section 284 SGB V [German Social Code book V] and Section 94 SGB XI [German Social Code book XI].

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