_____,
First name, surname

_____
Date of birth: DD.MM.YYYY

Deutsche Post
ANTWORT

Techniker Krankenkasse
20902 Hamburg

Application for non-contributory dependants' insurance

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

I would like to apply for non-contributory dependants' insurance

☐ for my married partner or civil partner pursuant to the German Civil Partnership Act [LPartG] as of Day Month Year

Reason for non-contributory dependants' insurance

☐ Start of my membership ☐ Birth of a child ☐ Marriage

☐ Termination of my dependant's/dependants' own membership ☐ Other

Other

Personal information

☐ Married since Day Month Year ☐ Registered civil partnership since pursuant to the German Civil Partnership Act [LPartG] Day Month Year

☐ Divorced since Day Month Year ☐ Separated ☐ Widowed ☐ Single

Previous health insurance

Prior to my membership with Techniker Krankenkasse

☐ I had private/no statutory insurance cover (e.g. medical care, cover for civil servants' medical expenses)

☐ I had statutory insurance cover ☐ as a dependant ☐ as a member

Name of health insurance fund/private health insurance from Day Month Year to Day Month Year

Contact information

Telephone (optional information)

E-Mail (optional information)

Details about my married partner / civil partner

Information about your married partner or civil partner is also required if you only apply for non-contributory dependants' insurance for your children. In addition to general information, we also require details about your married partner's or civil partner's health insurance cover.

☐ Male ☐ Female ☐ Non-binary Date of Birth (DD MM YY)

First name

Surname (Please submit a marriage certificate or civil partnership certificate in case of different surnames.)

Address, if different: Street, Street no.

Post code City

Health insurance number German pension insurance number

If no German pension insurance number has been assigned, we will require the following information:

Surname at birth Place of birth

Country of birth Nationality

Health insurance

My married partner/civil partner has/had

☐ private /no statutory insurance cover (e.g. medical care, cover for civil servants' medical expenses)

☐ statutory insurance cover ☐ as a dependant ☐ as a member

Name of health insurance fund/private health insurance from Day Month Year to Day Month Year

If applicable, first name and surname of the person who provided non-contributory health insurance cover.

My married partner's/civil partner's income

This information and proof of income are also required if you only apply for non-contributory dependants' insurance for your children and your married partner/civil partner does not have statutory health insurance cover and is related to the children.

☐ Marginal employment/"mini-job" from Day Month Year to Day Month Year

Average monthly gross pay . EUR

☐ More than marginal employment from Day Month Year to Day Month Year

Average monthly gross pay . EUR

☐ Self-employment from Day Month Year to Day Month Year
Please attach a complete copy of the last income tax assessment.

☐ As a childminder
We need this information only for the time before 2019.

☐ I employ several workers at the same time whose gross pay combined exceeds the marginal earnings threshold.

Working hours/week . hours Monthly profit . EUR

☐ Pension payments; company pensions; foreign, statutory or other pensions from Day Month Year to Day Month Year
Please attach a copy of the proof of such payments.

Type of income Monthly payment . EUR

☐ Other income (e.g. income from rent/leases or capital investment, maintenance, compensation for loss of employment) from Day Month Year to Day Month Year
Please attach a complete copy of the last income tax assessment or a certificate of interest on capital investments.

Type of income Monthly income . EUR

I confirm that the information I have provided is correct. I will inform you immediately of any changes, in particular if my dependants' income changes (e.g. new income tax assessment for self-employment) or if they become members of a (different) health insurance fund.

Day Month Year

Signature (legal representative, if applicable)

With this signature, I confirm that my dependants have agreed to the transmission of the required information.

Dependants' signature, if applicable

For dependants living away from you, their signature is sufficient.

Data processing information (Article 13 of Regulation (EU) 2016/679): To allow us to evaluate non-contributory dependants' insurance, we require your cooperation pursuant to Sections 10 Paragraph 6 and 284 SGB V [German Social Code Book V]. This information is necessary to determine the insurance cover (Sections 10 and 284 SGB V [German Social Code Book V], Section 7 KVLG 1989 [German Farmers Health Insurance], Sections 25 and 94 [SGB XI [German Social Code Book XI]). Optional information about contact data will be used exclusively for any questions we may have about your insurance cover. The information about TK's data processing pursuant to Article 13 GDPR [EU General Data Protection Regulation] is available at **tk.de, search code 2029224**