Techniker Krankenkasse

Last Name

First Name

Street, No.

Postcode, City

Health Insurance No.

Non-contributory Dependants Co-insurance

Start date of non-contributory dependants co-insurance cover for my spouse/life partner* Day Month Year

Start date of non-contributory dependants co-insurance for my child/children Day Month Year

Please indicate a date. If you do not specify a date or indicate "as of now" this information is not legally valid.

Reason for applying for non-contributory dependants co-insurance

☐ Commencement of my own membership

☐ Marriage ☐ Birth of my child

☐ Termination of previous membership of my dependant

☐ Other ____

Marital status

☐ Married ☐ Separated ☐ Widowed

☐ Single ☐ Divorced

☐ Registered Partnership*

Previous health insurance

☐ Membership

☐ Non-contributory dependants co-insurance

☐ Not covered by statutory health insurance

Health insurance ____

Spouse or Life Partner*

We need the following details, even if you do not wish to have your spouse/life partner* co-insured with us.

Last Name ____

Please enclose marriage certificate if different from member's last name.

First Name ____

TK Insurance Number, if applicable

Date of birth Day Month Year

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

Pension Insurance No

Please give the following details if your spouse/life partner* does not have a German Pension Insurance Number yet:

Last Name at birth ____

Place and country of birth ____

Nationality ____

Different address, if applicable

Street, No. ____

Postcode and city ____

Previous health insurance of spouse/life partner*

☐ Membership

☐ Non-contributory dependants co-insurance

☐ Not covered by statutory health insurance

from Day Month Year - Day Month Year

Health insurance ____

Non-contributory dependants co-insurance of membership of:
Last Name, First Name

____

My spouse/life partner* has a personal income ☐ yes ☐ no

If so, please answer the following questions for your spouse/life partner*

Date paid employment (including mini-job) started Day Month Year

Average monthly gross income from marginal employment EUR ____

Date self-employment started Day Month Year

Average monthly profit EUR ____

Average working hours per week ____

W307001E

Self-employed childminder ☐ yes ☐ no

Date Unemployment Benefit II started |_|_|_|_|_|_| Day Month Year

Pensions and related benefits/ company pensions, foreign, national or other pensions monthly amount payable EUR ________________

Other average monthly income EUR ________________

Type of income (e. g. income from lease, interest)

____

Please send us a complete copy of your last income tax assessment.

	1st child		**2nd 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
	☐ Stepchild	☐ Grandchild	☐ Stepchild	☐ Grandchild
My spouse/life partner is child's birth parent	☐ yes	☐ no	☐ yes	☐ no
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		☐ Membership	
	☐ Non-contributory dependants co-insurance		☐ Non-contributory dependants co-insurance	
	☐ Not covered by statutory health insurance		☐ Not covered by statutory health insurance	
Period of cover	Day Month Year - Day Month Year		Day Month Year - 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
Day Month Year

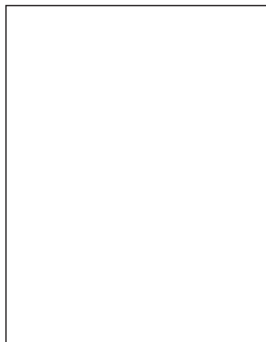
Signature ____________
I hereby declare that my dependants have given their consent to the processing of the required data.

Signature of Dependant if applicable ____________
In case you are separated, you have to sign only.

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.

Die Techniker

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.

300332 06/2016

Techniker Krankenkasse
20901 Hamburg