

Membership application



BKK ZF & Partner

Partner für Ihre Gesundheit



Personal details	Yes, I would like to become a member of BKK ZF & Partner as of _____.		
	<input type="checkbox"/> female <input type="checkbox"/> male		
	First name, surname		
	Date of birth	Place of birth	Name at birth
	Nationality	E-mail address	Telephone number
	Street, house number	Postal code	City
	Bank account: IBAN	BIC	Bank
Statutory pension insurance number	<input type="checkbox"/> Please apply for a statutory pension insurance number on my behalf (specify place of birth/name at birth)		
Family insurance	I have children <input type="checkbox"/> yes <input type="checkbox"/> no		
	<input type="checkbox"/> My spouse / partner is insured with _____		
	<input type="checkbox"/> Yes, I would like to insure my family for no additional contribution		
Insurance basis	I want to be insured as:		For the last 18 months I have been insured with:
	<input type="checkbox"/> an employee	<input type="checkbox"/> an employee with voluntary insurance	_____
	<input type="checkbox"/> a recipient of benefits from the Federal Employment Agency* <small>* Please enclose current notice of granting</small>	<input type="checkbox"/> a trainee	Name of health insurance fund
	<input type="checkbox"/> a pensioner I been receiving a pension since _____ <small>Please enclose current pension certificate (including pension payment).</small>	<input type="checkbox"/> an intern	<input type="checkbox"/> on a compulsory basis <input type="checkbox"/> insured on a voluntary basis
	<input type="checkbox"/> I am on parental leave until _____	<input type="checkbox"/> a student	<input type="checkbox"/> as a family member <input type="checkbox"/> private insurance
		<input type="checkbox"/> a person insured on a voluntary basis	<input type="checkbox"/> insured abroad
		<input type="checkbox"/> a self-employed person	<input type="checkbox"/> insurance already cancelled
		<input type="checkbox"/> I am entitled to support	Confirmation of cancellation with the previous health insurance fund
	We will inform the tax office of paid health insurance and long-term care insurance contributions in the case of persons insured on a voluntary basis (please state tax ID).		<input type="checkbox"/> is enclosed <input type="checkbox"/> will be submitted later
	Consent to transfer of data to the tax office		Your membership with BKK ZF & Partner can only commence once confirmation of cancellation has been received!
<input type="checkbox"/> yes <input type="checkbox"/> no, I object			
<input type="checkbox"/> I will pay my contributions myself. Direct debit requested.	Tax identification number: _ _ _ _ _ _ _ _ _ _ _ (11-digit number)		
Employer's address:			
Company	employed since		
Street, house number	Postal code	City	
Telephone number	E-mail address		
<input type="checkbox"/> I am interested in supplemental insurance. <input type="checkbox"/> I am interested in elective premiums.			

Date, signature

This data is compiled in accordance with the regulations of the German Social Security Act and is only used to fulfil statutory obligations at our health insurance fund. Your data will be treated confidentially and is subject to data protection law. You are not required to provide a telephone number or e-mail address.