



YES, I WOULD LIKE TO BECOME A MEMBER OF THE NOVITAS BKK WITH EFFECT FROM

Start date (DD.MM.YYYY) (Beginn-Datum)

- I am a compulsorily insured employee (pflicht.ArbN) an artist (Künstler) a trainee (Azubi) unemployed (Arbeitslos)
 a voluntarily insured employee (freiwill.ArbN) a seasonal worker (SaisonA) a school student (Schüler) Jobcenter
 self-employed (Selbstst.) a pensioner (Rentner) a student (Student) Agentur für Arbeit

PERSONAL DETAILS

My gender is: (Geschl.) female (weibl.) male (männl.) nonbinary (divers) indeterminate (unbest.)

Last name (Nachname) First name (Vorname)

Date of birth (DD.MM.YYYY) (GebT.) Place of birth (GebOrt) Civil status (Familienstand)

Post code (PLZ) Location (Ort) State pension fund number (RVNr.)

Road, house number (Straße, Hausnummer) Health insurance fund no (KVNr.)

Phone number/mobile phone number (Telefon) Email address (E-Mail-Adresse)

Contact by phone and/or email: (Angabe der Telefonnummer und der E-Mail-Adresse)

By ticking this option I declare that I consent to being contacted by Novitas BKK by phone or by email on my phone or mobile phone number or at my email address, regarding my claims for health insurance benefits, additional benefits offered by the fund, our own services as well as legal changes to the statutory health insurance, or in other matters concerning my insurance cover. This consent can be withdrawn from Novitas BKK at any time by letter, fax, email or phone. No data is forwarded to third parties. You provide your data voluntarily. Nonresponse does not have any negative consequences for you.

I AM EMPLOYED BY

Name of your employer or training company (Name AG) employed since (DD.MM.YYYY) (besch.)

Post code (PLZ) Location (Ort) Road, house number (Straße, Hausnummer)

My gross monthly wage is: (Brutto-Arbeitsentgelt) up to 450 euros per month (Minijob) more than 5.362,50 euros per month

DETAILS OF HEALTH INSURANCE TO DATE

I was last insured (zuletzt versichert)

from (DD.MM.YYYY) (vom) until (DD.MM.YYYY) (bis) with the health insurance fund (Krankenkasse)

- individually insured (selbst versichert)
 covered by family health insurance as a dependent of (familienversichert über)

Last name, First name (Name, Vorname) Date of birth (DD.MM.YYYY) (GebT.) Health insurance number (KVNr.)

no statutory insurance (nicht gesetzlich versichert)

since (DD.MM.YYYY) (seit) Reason (e.g. privately insured, abroad) (Grund)

- Reason for changing health insurance fund: Change in insured person relationship (e.g. change in employer, start of unemployment benefit, etc.) (Vers.-verhältnis) (Anlass des Kassenwechsels)
 Expiry of the commitment period (minimum contract term - 12 months) (Bindungsfrist)

FURTHER INFORMATION

- Yes, I have dependants, who are also to be insured free of charge under my policy. Please send me the form. (Fami)
 I know other persons who are interested in membership of the Novitas BKK. (MwM)

SIGNATURE

Place, Date and Signature

MA (to be completed by Novitas BKK)

Vermittler – ID

Data privacy: The data are collected on the basis of legal authorisations and are required to carry out the tasks of the Novitas BKK. With the start of your membership of the Novitas BKK you automatically receive nursing care insurance protection. For further information on data processing under Article 13 GDPR, visit novitas-bkk.de/datenschutz. Issued: BE-E 04 | 2021

