YOUR PROVIDENT HEALTH INSURANCE FUND.

☒ 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)*
- ☐ a voluntarily insured employee *(freiw.ArbN)*
- ☐ self-employed *(Selbstst.)*
- ☐ an artist *(Künstler)*
- ☐ a seasonal worker *(SaisonA)*
- ☐ a pensioner *(Rentner)*
- ☐ a trainee *(Azubi)*
- ☐ a school student *(Schüler)*
- ☐ a student *(Student)*
- ☐ unemployed *(Arbeitslos)*
- ☐ Jobcenter
- ☐ 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)*

Yes, I would like to be kept up to date with the latest information. I agree to allow Novitas BKK to contact me by telephone and email about individual entitlements to and benefits of insurance and for the purpose of improving quality and service through customer surveys. This consent is voluntary and may be withdrawn at any time and without any specific requirements regarding form.

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 556 euros per month (Minijob) ☐ more than 6.150 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: *(Anlass des Kassenwechsels)*
- ☐ Change in insured person relationship (e.g. change of employer, receipt of unemployment benefits etc.) *(Vers.-verhältnis)*
- ☐ Termination *(Kündigung)*

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

Privacy notice: The information is collected, stored and used in accordance with Section 284 (1) of the German Social Security Code Volumen V (Sozialgesetzbuch (SGB) V and 94 German Social Security Code Volume XI to fulfil the statutory tasks of Novitas BKK. Further information on data processing in accordance with Article 13 of the General Data Protection Regulation (GDPR) can be found at www.novitas-bkk.de/datenschutz. Issued: BE-E 12/2024

Novitas BKK • 47050 Duisburg • 24h service: 0800 664 8233 (freephone)
Email address: info@novitas-bkk.de • Internet: novitas-bkk.de

NOVITAS BKK