mhplus

Membership declaration

To be filled in only by mhplus: Intermediary number/surname, first name of employee

I would like to become a ☐ mandatory member ☐ voluntary member of mhplus from T T M M J J J J

Intermediary number

My details

Surname | First name

Street | House Number

Postcode | Town

Nationality | Federal state

Phone | Email (voluntary)

Marital status | Gender ☐ female (f) ☐ male (m) ☐ other (o) ☐ undefined (x)

Social insurance number

I do not yet have a social insurance number. Please apply for a social insurance number for me using the following details:

Date of birth T T M M J J J J | Name at birth

Place of birth | Country of birth

My tax ID (You will find this on your tax assessment notice.)

Reason for membership

☐ My insurance contract has changed. (e.g. change of employer)

☐ My insurance contract has not changed for more than 12 months. (change of health insurance provider with an unchanged insurance contract)

☐ My previous health insurance provider increased the additional contribution rate.

☐ I am taking out an insurance policy with a statutory health insurance provider for the first time.

☐ I am working in Germany for the first time.

☐ Other

I am an ☐ employee ☐ trainee ☐ a student on a dual study programme ☐ working student

☐ I am a voluntarily insured employee. This applies if your annual salary is over 66,600 euros.

☐ My employer pays the voluntary health and nursing care insurance contributions.

☐ I pay the contributions for voluntary health and nursing care insurance contributions to mhplus.

Details for calculating the contribution for nursing care insurance: ☐ I have children (please enclose **evidence**).

☐ I receive unemployment benefit/basic income (please provide **confirmation**). I have applied for ☐ unemployment benefit ☐ basic income.

Note: For other groups, please fill in the following page

Information about your employer (Please request your eight-digit company registration number from your employer.)

Company name | Phone

Adress

Company registration number | Employed since T T M M J J J J

Other information (please tick as applicable)

☐ I am also self-employed (please fill in the **next page**).

☐ I study alongside my employment (please provide your **certificate of enrolment** and fill in the **next page**). Number of working hours (per week)

☐ I draw a pension from Deutsche Rentenversicherung or a comparable provider abroad (please provide **pension approval certificate**).

☐ I receive pension benefits such as, a civil servant's pension, company pension or retirement pension supplement (please provide **confirmation** from the provider).

☐ I have been exempted upon request from compulsory health insurance (please provide a copy of the **confirmation**).

☐ I am receiving benefits from statutory long-term care insurance.

Details of previous health insurance

Until now, I was ☐ compulsorily insured ☐ voluntarily insured ☐ insured as a dependant ☐ privately insured ☐ insured abroad

Name of **previous health insurer** | from D D M M Y Y Y Y until D D M M Y Y Y Y

Family insurance policy

I would like my dependants to be co-insured at no extra cost. ☐ Please send me an application. ☐ The application is enclosed.

T T M M J J J J

Date | Signature

01/2023

Privacy notice: We collect and process your data on the basis of legal requirements. We require the data in order to execute your insurance contract in pursuant to Section 5 ff.of the Social Security Code (SGB V) and for calculating your contributions pursuant to Section 226 ff. SGB V, and Section 57 SGB XI. You can find information about data privacy and your rights at www.mhplus-krankenkasse.de/datenschutz.

Surname, first name

Date of birth D D M M Y Y Y Y

I am a

- civil servant
- retired civil servant
- housewife/house husband
- recipient of income support
- school pupil (please send your **certificate of enrolment**)
- student (please send your **certificate of enrolment**)
- pensioner (please send **pension approval certificate**)
- Pension was applied for on application date D D M M Y Y Y Y

- self-employed as a
- entrepreneur with a business grant (please send **confirmation**)

Additional details of self-employed activity

- Number of working hours per week
- Number of employees of which those in marginal employment total
- This is my main occupation
- Please send me information about insurance with sick pay from the start of the seventh week (only for those in self-employment as their main occupation)

Details of earning capacity

- My monthly gross income exceeds €4,987.50 (annual income over €59,850.00).
- My spouse is **not** covered by statutory health insurance (please send **proof of income**).

Number of dependent children (without own income): number of those children resulting from marriage

Details of your income	**monthly € amount**	**annual € amount**	**Please enclose copies of the following supporting documents**
Income from self-employed activity (this includes income from a photovoltaic system)			Last income tax assessment (complete) and business registration
Wages/salary from employment			Last payslip
Gross monthly remuneration			
One-off payments from the last 12 months			Evidence of the one-off payment
Other non-cash benefits (e.g. company car)			Evidence of the non-cash benefit
Pension(s) e.g. old-age, survivor's and accident pensions, foreign pensions			
Type			Current pension approval certificate
Type			Current pension approval certificate
Gross pension benefits e.g. retirement pensions, company and supplementary pension benefits			
Type			Current pension approval certificate
Type			Current pension approval certificate
One-off payments			Evidence of the one-off payment
Income from letting and leasing			Last income tax assessment (complete)
Interest and other income from capital assets			Last income tax assessment (complete)
Redundancy			Compensation agreement
Social benefits/basic provision			Certificate of income support
Other income – type			Evidence of the income

- My monthly income is under €1,131.67. My livelihood is ensured by

We only require these details for applications for minors

First name, surname, date of birth of legal representative and address if different from that of the applicant

Details for the purpose of calculating contributions for long-term care insurance

- I have children (please provide **evidence**, e.g. birth certificate or certificate of descent).

I guarantee that all information provided is true and correct. I will immediately inform you of any future changes. I will send you appropriate evidence for this purpose (e. g. income tax assessment). I am aware that incomplete or false information will lead to contributions being recalculated.

D D M M Y Y Y Y

Date

Signature

mhplus

Information for the purpose of being added to family insurance cover

A. Member details (main insurant)

Surname, first name

Insurance number
(You can find this on your mhplus health card.)

Until now, I was*
☐ insured as a member
☐ insured as a dependant with
name of health insurance provider
☐ not insured by statutory health insurance

*) It is only necessary to give this information at the start of a membership with mhplus (e.g. when changing health insurers).

Marital status

☐ Single ☐ Married** ☐ Separated** ☐ Divorced since D D M M Y Y Y Y ☐ Widowed
☐ Registered civil partnership in acc. with the Act on Recognition of Same-Sex Unions in Germany (LPartG)**

**) Please enter further information in the column marked "Spouse".

Reason for family insurance

☐ Start of my membership
☐ Birth of a child
☐ Relocation from abroad
☐ End of my own membership or that of my dependant(s)
☐ Marriage
☐ Other

Contact details **(voluntary disclosure)**

My phone number

My email address

B. Information about dependants

Please only give the following information for the dependants that you wish to co-insure with mhplus at no extra cost. We also need the general details regarding your spouse/civil partner (e.g. name, date of birth, name of health insurer) if

+ you only want to co-insure your child(ren) and
+ your spouse/civil partner is related to the child(ren).

If your spouse/civil partner is not covered by statutory health insurance, please also give information of their income. In this case, please also provide proof of income for your spouse/civil partner. Supplements paid with regard to marital status shall not be taken into account.

Family insurance may only be provided by a single health insurer. Please ensure therefore that you are only applying to one health insurer with this information.

Family member	**Spouse**	**Child**	**Child**	**Child**
Start of family insurance cover	D D M M Y Y Y Y	D D M M Y Y Y Y	D D M M Y Y Y Y	D D M M Y Y Y Y
Surname***				
First name				
Date of birth	D D M M Y Y Y Y	D D M M Y Y Y Y	D D M M Y Y Y Y	D D M M Y Y Y Y
Gender male (m), female (f), other (o), undefined (x)	☐ (m) ☐ (f) ☐ (o) ☐ (x)	☐ (m) ☐ (f) ☐ (o) ☐ (x)	☐ (m) ☐ (f) ☐ (o) ☐ (x)	☐ (m) ☐ (f) ☐ (o) ☐ (x)
Address if different from that of the member				
Relation to member		☐ Biological child/ adoptive child ☐ Stepchild ☐ Grandchild ☐ Foster child	☐ Biological child/ adoptive child ☐ Stepchild ☐ Grandchild ☐ Foster child	☐ Biological child/ adoptive child ☐ Stepchild ☐ Grandchild ☐ Foster child
Is your spouse/civil partner related to your child?		☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

***) If the dependant and the member have different surnames, please provide us with a birth certificate, marriage certificate, certificate of civil union or certificate of descent. If that is not possible, please send us other appropriate supporting documents (e.g. confirmation of child allowance).

Surname, first name **Insurance number**

Dependant	**Spouse**	**Child**	**Child**	**Child**
First name				

Details of previous or continuing insurance of dependants

The previous insurance				
• will remain in place	☐ No ☐ Yes			
• ended on	D D M M Y Y Y Y	D D M M Y Y Y Y	D D M M Y Y Y Y	D D M M Y Y Y Y
• with (name of health insurance provider/ health insurance)				
• Type of insurance: membership (1), family insurance* (2), covered by statutory health insurance (3) (please tick)	1 2 3	1 2 3	1 2 3	1 2 3
*) **Important for you:** Family insurance can only be provided by a single health insurer.				
Was there already family insurance cover in place? If so, please state the surname and first name of the person through which the dependants were insured.	(First name) (Surname)	(First name) (Surname)	(First name) (Surname)	(First name) (Surname)

Details of income of dependants

My dependant(s) has/have their own income	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If the answer is yes, please send supporting evidence (e.g. copy of the current income tax assessment).				
Self-employed sinde	D D M M Y Y Y Y	D D M M Y Y Y Y	D D M M Y Y Y Y	D D M M Y Y Y Y
Monthly earnings from self-employment	euros	euros	euros	euros
Monthly gross pay from **occupation**	euros	euros	euros	euros
Redundancy payment (e.g. compensation)	euros	euros	euros	euros
Monthly gross pay from **marginal employment**	euros	euros	euros	euros
Statutory pension, tax-privileged pension benefits, company pension, foreign pension, other pensions Monthly payment amount	euros	euros	euros	euros
Other regular income within the meaning of income tax law (e.g. income from renting and leasing, income from capital assets)	euros	euros	euros	euros
Type of income				
My dependant(s) recieves/receive unemployment benefit or basic income payments	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

Surname, first name **Insurance number**

Dependant	**Spouse**	**Child**	**Child**	**Child**
First name				

Additional information about dependants

School attendance/studies (For children over 23 years of age, please provide certificate of enrolment.)		D D M M Y Y Y Y from D D M M Y Y Y Y until	D D M M Y Y Y Y from D D M M Y Y Y Y until	D D M M Y Y Y Y from D D M M Y Y Y Y until
Military service or legally regulated voluntary service (Please provide certificate of service.)		D D M M Y Y Y Y from D D M M Y Y Y Y until	D D M M Y Y Y Y from D D M M Y Y Y Y until	D D M M Y Y Y Y from D D M M Y Y Y Y until

Details for the allocation of a health insurance number for dependants covered by your health insurance

Pension insurance number				

The following details will only be needed if a pension insurance number has not yet been allocated.

Name at birth				
Place of birth				
Country of birth				
Nationality				

I confirm that these details are correct. I will inform you promptly of any changes. This also applies if my dependants' income changes (e.g. new income tax assessment in the case of self-employment) or if they become members of a (different) health insurance fund.

D D M M Y Y Y Y
Date

Signature of member

By signing this form, I declare that I have obtained the consent of the dependants to provide the required data.

Signature of family member

In the case of dependants who live separately, the signature of the dependant(s) is sufficient.

Data protection notice (Article 13 of EU Regulation 2016/679): In order for us to be able to assess your family insurance, we require your cooperation in accordance with section 10, paragraph 6, and section 289, of SGB V. We need the data so that we can verify if we can insure your dependants at no extra charge (sections 10 and 284 of SGB V, section 7 of the Second Act on Health Insurance for Farmers (KVLG 1989) and section 25 of SGB XI. We will only use the contact information you have given to answer questions about your insurance contract. You can find more information about how we process your data and about your rights at www.mhplus-krankenkasse.de/datenschutz.

Note: By giving my consent, mhplus can offer me the best possible service. This information is voluntary.

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Declaration of consent

To be filled in only by mhplus: Surname, first name of employee

My declaration of consent for the use of my data

My details

☐ I am already a member of the mhplus health insurance fund.

☐ I am not yet a member of mhplus. Consent applies if you become a member.

Surname

First name

Date of birth T T M M J J J J

Street, house number

Postcode

Town

Phone

Mobile phone number

Email

Consent to be contacted by mhplus

I consent to the following:

☐ mhplus may inform and advise me
+ about my insurance cover and
+ about new services and
+ ask me about service quality in order to improve the service. mhplus may employ a service provider for this purpose.

☐ mhplus can contact me about and advise me of offers from its private health insurance partners. mhplus may employ a service provider for this purpose.

mhplus may contact me in the following ways: ☐ Phone ☐ Email ☐ SMS

I also agree to the following:

Sales partners

☐ mhplus may forward information to the sales partner that has applied for the membership on my behalf.

Private supplementary health insurance

I have private supplementary health insurance with the following cooperation partner of mhplus

☐ Süddeutsche Krankenversicherung a. G. ☐ HALLESCHE Krankenversicherung a. G.

mhplus may:

☐ forward information or my comments directly to them.

☐ store information about my private health insurance.

You can find information about how mhplus uses your data on the information sheet (see overleaf).

T T M M J J J J

Date

Signature

To be submitted to your reporting office (e.g. employer, employment agency)

Please submit this document promptly.

First name, surname

Street, house number

Postcode, town

Date of birth

Information regarding my new health insurance provider

I have selected the mhplus Betriebskrankenkasse as my future health insurance provider.

Requested change of health insurance provider on: _____

Here are the details of mhplus in brief: mhplus Betriebskrankenkasse, 71632 Ludwigsburg

General contribution rate	14.6 %
Additional contribution	1.58 %
Company registration number	63494759
Bank details	Commerzbank Ludwigsburg, IBAN DE29 6048 0008 0500 9005 00, BIC DRESDEFF604 KSK Ludwigsburg, IBAN DE19 6045 0050 0000 0772 08, BIC SOLADES1LBG

Please keep this certificate for your records and register me with mhplus.

If a change of health insurance provider is not possible on the requested start date,
I will notify you of this.

Best regards,

Place, date, signature

Data protection.

Protecting your data is very important to us. That's why we would like to inform you what kind of data we process.

Purpose of your consent
mhplus will provide you with information about your insurance coverage. You will receive information from us about new services. In addition, we will also tell you about offers from our partners who provide private health insurance. This will allow you to benefit from exciting extras! These are tailored specifically to your occupational or private needs.

mhplus may also invite you to participate in customer surveys from time to time – after all, your opinion and experiences are important to us! They help us to optimise our service for you. mhplus may also appoint a service provider to obtain certain information from you. This includes information about quality, services and insurance policies.

What data does mhplus process?
mhplus only processes the data that you specify in your consent.

Is this data forwarded to third parties?
If we appoint an authorised service provider, we will only forward the data that you specify in your consent. This allows the service to be provided.

How long is data stored for?
The data subject to your consent will be stored as long as you are insured with us or until you withdraw your consent. The data that we send to a service provider in order for them to perform their duties may be stored by them until their duties are complete. As soon as they have fulfilled their duties, the service provider must delete the data. mhplus receives written confirmation of this from the service provider.

How do you withdraw your consent?
Simply send a message to info@mhplus.de.
Or give us a call: +49 (0)7141 979 00. Important: Use the keyword "declaration of consent". You can withdraw your consent at any time with immediate effect or with future effect, completely or to a partial extent.

Information about additional consent (Sales partners and private supplementary insurance)
Have you instructed a sales partner to apply for your membership of mhplus? In this case, mhplus can pass on information that directly relates to your membership:
+ Start, end or non-conclusion of the mhplus membership
+ Changes to the insurance contract

Do you have private supplementary insurance via one of the partners of mhplus? In this case, we will forward or process the following data:
+ Start, end or non-conclusion of the mhplus membership
+ Start, end, type of supplementary private health insurance and name of insurance company

How you benefit: this means you are guaranteed to enjoy all the benefits and premium advantages of the partnership.

Legal basis for processing your data
The data is processed on the basis of consent in accordance with pursuant to Article 6 Paragraph 1 Clause 1a of the General Data Protection Regulation (GDPR).

You can find further information about data protection and our data protection officer here: www.mhplus-krankenkasse.de/datenschutz