Your application forms.

# The *easy* way to becoming a member.

It works faster than you might expect.

mhplus Krankenkasse.

Sign up for mhplus with just a few steps.

If you have any questions:
Give us a call!
07141 9790-1000

# Send us your *application.*

This booklet contains all the forms you need. Spend 15 minutes. That's all it takes. Within no time, your membership is almost done.

Or just sort it out online:

# mhplus

## Membership declaration

**This will be filled out by mhplus:** agent number/name, employee's first name

**Please sign me up from** ☐ as a compulsory member ☐ as a voluntary member of mhplus.

Agent number

**My data**

Surname | First name

Street | House number

Postcode | Town/city

Nationality | State

Phone number (voluntary information) | Email address (voluntary information)

Civil status | Gender ☐ female (f) ☐ male (m) ☐ diverse (d) ☐ undetermined (x)

**Social security number**

I don't have a social security number yet. Please apply for this on my behalf using the following information:

Date of birth | Birth name

Place of birth | Country of birth

**My tax ID** (You can find this ID on your tax statement.)

**Reason for membership**

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

☐ My insurance status has remained unchanged for more than 12 months. (Change of health insurance provider with unchanged insurance status)

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

☐ This is the first time I have taken out health insurance with a statutory health insurance provider.

☐ I am taking up employment in the UK for the first time.

☐ Miscellaneous

**I** ☐ am working ☐ doing an apprenticeship ☐ doing applied studies (please send proof of enrolment) ☐ a student employee

☐ I am employed and voluntarily insured. My annual salary is more than € 77,400 .

☐ My employer pays the contributions for a voluntary health and long-term care insurance.

☐ I pay the contributions for voluntary health and long-term care insurance to mhplus myself.

Information on how to calculate the contribution to long-term care insurance:

☐ I have children (please send **proof**) .

☐ I receive unemployment benefits/citizen's income (please send **proof of benefits/income**). I have applied for ☐ unemployment benefits ☐ citizen's income.

**Please note:** Other groups of persons – please fill out the following page

**Employer details** (please ask your employer for the company number – always 8 digits).

Company name | Phone number

Address

Company number | employed since

**Other information (please tick as appropriate)**

☐ I am also self-employed (please fill out the following page).

☐ I am studying and working (please send proof of enrolment and also fill out the following page). Number of hours (weekly)

☐ I receive a pension from the German Pension Insurance or a comparable institution abroad (please send pension statement).

☐ I receive benefits, e.g. pensions, company pensions and supplementary pensions (please send the notification from the pension centre).

☐ I was exempted from compulsory health insurance upon application (please send a copy of the notification).

☐ I receive benefits from the statutory long-term care insurance.

**Information about previous health insurance**

**I was previously** ☐ compulsorily insurance ☐ voluntarily insured ☐ insured though a family insurance ☐ privately insured ☐ insured abroad

Name of the health insurance company | from | to

☐ I chose an optional tariff there.

**Family insurance**

I would like to include my family members in my insurance free of charge. ☐ Please send me an application. ☐ The application is included.

Date | Signature

01/2026

Privacy notice: We collect and process your data based on legal regulations. We need the data to administer your insurance relationship in accordance with §§ 5 et seq. of the German Social Code, Book Five (SGB V) and to calculate your contributions in accordance with §§ 226 et seq. of SGB V and § 57 of SGB XI. Information on data protection and your rights can be found at: www.mhplus-krankenkasse.de/datenschutz.

Surname, first name

Date of birth

**I**

☐ am a civil servant ☐ am retired ☐ manage the household ☐ receive benefits

☐ go to school (please send school certificate) ☐ am studying (please send proof of enrolment)

☐ am retired (please attach pension statement) ☐ applied for a pension on

☐ am self-employed as ☐ am a business founder with a start-up grant (please send the notification)

Further information about self-employment

☐ Number of weekly working hours

☐ Number of employees of whom marginally employed

☐ I do this work full-time.

☐ Please send me information about insurance with sickness benefits from the beginning of the 7th week (only for people who are self-employed as their main occupation) .

**Information about income levels**

☐ My monthly gross income is more than € 5,812.50 (€ 69,750 per year).

☐ My spouse is **not** covered by statutory health insurance (please **send proof of income** ) .

Number of dependent children (excluding their own income): of whom the two of us are the parents

| Information about my income | monthly in euros | annually in euros | please send copies of the following documents |
|---|---|---|---|
| **income from self-employment** | | | last income tax statement (complete) and business registration |
| **Wage/salary** from employment<br>Monthly gross salary | | | Most recent payslip |
| One-off payments from the past 12 months | | | proof of the one-time payment |
| Other benefits in kind (e.g. company car) | | | proof of the monetary benefit |
| **Pension(s)**<br>e.g. old-age, survivors' and accident benefits, foreign pensions<br>Type | | | current pension statement |
| Type | | | current pension statement |
| **Gross pension benefits**<br>e.g. pensions, company pensions and supplementary pensions<br>Type | | | current pension statement |
| Type | | | current pension statement |
| One-time payments | | | proof of the one-time payment |
| **Income from rent and lease** | | | most recent income tax statement (complete) |
| **Interest and other income from capital assets** | | | most recent income tax statement (complete) |
| **Gratuity** | | | gratuity agreement |
| **Benefits/basic income support** | | | notice about benefits |
| **Other income** – Type | | | proof of income |

My monthly income is less than € 1,318.33. My subsistence is secured by

**We only need this information for applications from minors.**

First name, surname, date of birth of the legal representative and, if applicable, a different address.

I certify that all information provided is true. I will inform you about all future changes immediately. I will send you suitable supporting documents (e.g., income tax statement).
I am aware that incomplete or untrue information will lead to a recalculation of the contribution.

Date Signature

Please note: By giving my consent, mhplus can offer me the best possible service. My information is voluntary.

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# Declaration of consent

**To be filled out by mhplus only:** Employee's surname, first name

## My consent to the use of my data

**My details**

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

☐ I am not yet a member of mhplus. The consent remains valid during the membership.

Surname

First name Date of birth

Street, house no.

Postcode Town/city

Phone number

Mobile number

Email

**Consent to be contacted by mhplus**

I agree to the following:

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

mhplus is permitted to use the following contact methods:

by phone: ☐ Yes ☐ No

by email: ☐ Yes ☐ No

via SMS: ☐ Yes ☐ No

**Please note:**

The legal age limit for giving independent consent is 16 years.
For children under 16 years of age, the consent of the parents or guardians is required.

The information sheet (see reverse) explains how mhplus uses the data.

Date

Signature

# Data protection.

**Data protection is very important to us. For this reason, we inform you about the type of data that we process.**

**Purpose of your consent**
mhplus provides information about your insurance coverage. We will send you information about new services and products. Furthermore, we will also inform you about the offers from our partners, the private health insurance companies. In this way, you will benefit from attractive extras! These are specifically tailored to your work-related or private needs.

From time to time, mhplus might also ask you to participate in a customer survey. Because your opinion and experiences are important to us! This helps us optimise our services for you. To obtain or request certain information from you, a service provider from mhplus may also be commissioned. This includes information on quality, services and insurances.

**Which data does mhplus process?**
mhplus only processes the data that you have provided within your consent.

**Will the data be forwarded to third parties?**
When we commission a legitimate service provider, we only forward the data within your consent. This allows the service to be provided.

**How long will the data be stored?**
The data within your consent will be stored as long as you are insured with us or until you withdraw your consent. Data that we send to a service provider in order for them to do their work may be stored by them until the work has been completed. Once the work has been completed, the service provider must delete the data. mhplus will receive written confirmation of this from the service provider.

**Where can you withdraw your consent?**
Simply send a message to info@mhplus.de. Or give us a call: 07141 9790-0. Important: Enter "declaration of consent" as the keyword. You can withdraw your consent at any time, immediately, for the future, or only partially.

**Legal basis for data processing**
The data is processed on the basis of consent pursuant to Article 6 paragraph 1 sentence 1a of the General Data Protection Regulation (GDPR).

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

Always there for your family.

# *Simply.* **More. You.**

**Whatever you do in your daily life. Let us take care of things so that you can take care of your family. Whether you are using our services or have any questions. We are here to make it easy for you. For good health and a good feeling.**

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# Information on inclusion in family insurance

## A. Member details (main policy holder)

**Surname, First name**

**Insurance number**
(This is shown on your mhplus health card.)

I was previously ☐ insured as a member ☐ insured through a family insurance at

Name of the health insurance company

☐ not covered by statutory health insurance

**Civil status**

☐ single ☐ married* ☐ separated* ☐ divorced since ☐ widowed

☐ registered civil partnership according to the German Registered Life Partnership Act*

*) Please provide further details in the column "Spouse".

**Reason for family insurance**

☐ Start of my membership ☐ Birth of the child ☐ Moving in from abroad

☐ End of my relative's own membership ☐ Marriage ☐ Miscellaneous

**Contact**

My phone number (voluntary information)

My email address (voluntary information)

## B. Information about family members

The following data is generally only required for family members who are to be covered through our family insurance. Contrary to the above, we also require certain details about your spouse/partner if you only intend to provide family insurance for your children with us and your spouse/partner is related to these children. In this case, in addition to the general information, details of the spouse's/partner's insurance and – if they are not legally insured – additional information on their income are required; income must be substantiated by proof of income; supplements paid in consideration of civil status are not included in the income information.

**General information about family members**

| | Spouse | Child | Child | Child |
|---|---|---|---|---|
| Start of family insurance | | | | |
| Name** | | | | |
| **) If the family name differs between the member and the family member, the civil status relationship must be documented by suitable documents (e.g. marriage certificate, civil partnership certificate, birth certificate) or – if such documents cannot be provided – must be proven once by other suitable documents (e.g. notice of child allowance). | | | | |
| First name | | | | |
| Date of birth | | | | |
| Gender<br>male (m), female (f), diverse (d), undetermined (x) | ☐ (m) ☐ (f) ☐ (d) ☐ (x) | ☐ (m) ☐ (f) ☐ (d) ☐ (x) | ☐ (m) ☐ (f) ☐ (d) ☐ (x) | ☐ (m) ☐ (f) ☐ (d) ☐ (x) |
| Address if it differs from the member's address | | | | |
| Relationship of the member to the child | | ☐ biological child/ adopted child<br>☐ Stepchild<br>☐ Grandchild<br>☐ Foster child | ☐ biological child/ adopted child<br>☐ Stepchild<br>☐ Grandchild<br>☐ Foster child | ☐ biological child/ adopted child<br>☐ Stepchild<br>☐ Grandchild<br>☐ Foster child |
| Is your spouse/partner related to the child?<br>(Please only fill out if there is no family relationship). | | ☐ No | ☐ No | ☐ No |

**Surname, First name** **Insurance number**

| | Spouse | Child | Child | Child |
|---|---|---|---|---|
| First name | | | | |

**Information about the family members' previous insurance**

| **The previous insurance** | | | | |
|---|---|---|---|---|
| • continues | ☐ Yes ☐ No | | | |
| • ended on | | | | |
| • at (Name of health insurance company/ health insurance) | | | | |
| • Type of insurance Membership (1), Family insurance (2), Not legally insured (3) (pease tick) | 1 2 3 | 1 2 3 | 1 2 3 | 1 2 3 |
| Was there a family insurance policy in place at the time? If yes, please provide the surname and the first name of the person through whom the relatives were previously insured. | (First name) (Surname) | (First name) (Surname) | (First name) (Surname) | (First name) (Surname) |

**Information about the family members' income**

| | | | | |
|---|---|---|---|---|
| **Self-employment** | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes |
| monthly profit from self-employment | Euro | Euro | Euro | Euro |
| Please send a copy of the most recent income tax statement. | | | | |
| Monthly gross earnings from **employment** | Euro | Euro | Euro | Euro |
| Dismissal compensation (e.g. gratuity) | Euro | Euro | Euro | Euro |
| Part-time employment **(mini job)** | ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes |
| **Statutory pension, pension benefits, company pension, foreign pension, other pensions** Monthly payment amount | Euro | Euro | Euro | Euro |
| **Other regular income as defined by income tax law** (e.g. income from rent and lease, income from capital assets) | Euro | Euro | Euro | Euro |
| Type of income | | | | |
| Please send a copy of the most recent income tax statement. | | | | |
| **Unemployment benefits/citizen's income** since | | | | |

**Surname, First name** **Insurance number**

| | Spouse | Child | Child | Child |
|---|---|---|---|---|
| First name | | | | |

**Further information about family members**

| | | | | |
|---|---|---|---|---|
| **School attendance/studies**<br>(Please note: for children aged 23 and over, please send a school or university certificate.) | | Yes<br>until | Yes<br>until | Yes<br>until |
| **Voluntary military service**<br>(Please attach your service record.) | | Yes | Yes | Yes |

**Information about the allocation of a health insurance number for family members covered by family insurance**

| | | | | |
|---|---|---|---|---|
| Pension insurance number | | | | |

The following information is only required if a pension insurance number has not yet been assigned.

| | | | | |
|---|---|---|---|---|
| Birth name | | | | |
| Place of birth | | | | |
| Country of birth | | | | |
| Nationality | | | | |

I confirm the accuracy of the information. I will inform you immediately of any changes. This applies in particular if the income of my aforementioned relatives changes (e.g. B. new income tax statement in the case of self-employment) or – in the case of family-insured children – the other parent is no longer a member of a statutory health insurance. The marriage of the parents must also be reported if the other parent is not covered by statutory health insurance.

Date Place

The member's signature

y signing, I declare that the family members have consented to this submission.

The family member's signature

In case of a separation, the signature of the family member(s) is sufficient.



In order for us to assess the family insurance, your cooperation is necessary according to §§ 10 paragraph 6, 289 SGB V. We need the data so that we can check whether we can insure your relatives free of charge (§§ 10, 284 SGB V, § 7 KVLG 1989, § 25 SGB XI). We will only use your contact details for questions regarding your insurance policy. You can find more information about data processing and your rights at: www.mhplus.de/datenschutz.

**For submission to your reporting authority, e.g. employer, employment agency**

**Please forward it in time.**

First name, surname

Street, house number

Postcode, town/city

Date of birth

Information about my new health insurance company

I have chosen the mhplus company health insurance as my future health insurance provider.

Requested change of health insurance provider as of: _____

Here is the most important information about mhplus:
mhplus Betriebskrankenkasse, 71632 Ludwigsburg

| | |
|---|---|
| Company number | 63494759 |
| Bank details | Commerzbank Ludwigsburg,<br>IBAN DE29 6048 0008 0500 9005 00,<br>BIC DRESDEFF604<br>KSK Ludwigsburg,<br>IBAN DE19 6045 0050 0000 0772 08,<br>BIC SOLADES1LBG |

**Our core data at a glance**

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

Should a change of health insurance provider
not yet be possible at the requested start date, I will inform you accordingly.

Kind regards

Town/city, date, signature

***Always there for you 07141 9790-0 info@mhplus.de***
***facebook.com/mhplus instagram.com/deine_mhplus***
***mhplus Service-App www.mhplus.de***

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