

Optional Application for Voluntary Coverage
-Through DKV Health Insurance-

Please fill out and return to Fulbright Commission
Oranienburger Str. 13-14, 10178 Berlin, fax: +49-30-28 4443-773, email: americanprograms@fulbright.de

German address:

Grantee:

name:
birthday:

Street:
Area Code / City:
Phone (private:)

Coverage extension:

from:	to:
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number of days:

I hereby request health insurance coverage through the Commission's DKV-plan for a period outside my actual grant period (or as a travel grant recipient) and agree to pay the premiums promptly and directly to the Fulbright Commission. My request is optional.

Premiums: depend on age and duration of coverage, per person

- Under 30 yrs of age: Euro 1.38 per day
- Child up to 14: Euro 1.38 per day (up to 14th birthday)
- Over 30 yrs of age: Euro 2.05 per day

Voluntary coverage is requested for:

(Please calculate your particular premium(s) by multiplying the number of calendar days by the age-related premium, and compute the total premiums if several persons are registered).

last name	first name	relation-ship	gender	birthday	coverage extension from:	to:	number of days	amount of premiums

Please make a bank transfer (Banküberweisung) in the total amount to:

Fulbright Commission
Dresdner Bank/Commerzbank
BLZ: 12 08 00 00
Kto: 41 00 00 07 00

within 10 days of the requested inception date. Under „Verwendungszweck“ on the transfer form write: Voluntary Health insurance coverage and your name (write clearly please).

For questions, please contact the Fulbright Commission at americanprograms@fulbright.de

Signature

Date

If you send this electronically your signature on the Fulbright grant document will cover this signature also.