

Attachment

for another person aged 15 or over in the community of need

– For children under 15 years of age, please fill out the KI attachment –



Please tick as appropriate.



As a general rule, please do not submit original documents, but rather copies.



Here you will find a video to help you fill it out. At www.jobcenter.digital You will receive information about our digital offers, the information sheet SGB II and other attachments to the application.



For more information, see the respective number in the instructions for filling out the form at www.arbeitsagentur.de/fragen-alg2.

The following data is subject to social secrecy (see "Information sheet SGB II"). Your information is collected based on Sections 60 - 65 of the First Book of the Social Code (SGB I) and Sections 67a, b, c of the Tenth Book of the Social Code (SGB X) for the benefits according to the Second Book of the Social Code (SGB II). You can obtain data protection information from the job center responsible for you and also online at www.arbeitsagentur.de/datenernahme.

1. Personal data of the applicant

| | |
|--|------------|
| Salutation | First name |
| family name | birth date |
| Number of the community of needs (if available) Customer number (if available) | |

2. The information in this appendix refers to the following additional person 15 years in the needs community 4

2.1 Personal data of the other person

| | |
|--|---|
| Salutation | First name |
| family name | Birth name (if different) |
| Place of birth | birth date |
| country of birth | nationality |
| y Please enter the date of entry into Germany here if there is no other person has German nationality. Entry date | |
| pension insurance number | <input type="checkbox"/> Pension insurance number does not yet exist and has been requested |

2.2 Marital status of the additional person

single
 married
 widowed
 registered life partnership

living separately since: _____

divorced since: _____

civil partnership dissolved since: _____



WEP

2

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Entry stamp

Department

team

Customer number of the additional person

The other person has himself

reported by:

- ID card
 passport
 Other identification paper (e.g. electronic Residence permit):

Date of Expiry

AZR number of the additional person

Personal identification number of the other Person (for Romanian and Bulgarian citizens)

Data checked in STEP on

Hand sign, date

2.3 Personal information about another person

| | |
|--|--|
| <input type="checkbox"/> I am related to the other person . | |
| <input type="checkbox"/> My partner is related to the other person . | |
| <input type="text"/> Family relationship | |
| The other person has already applied for or received benefits from another job center for the month in which the application was submitted. <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| <input type="text"/> Name of the other job center | |
| ÿ If yes, please provide relevant evidence. | |
| The other person feels physically able to do so regularly to carry out an activity for at least three hours a day . <input type="checkbox"/> Yes <input type="checkbox"/> No (9) | |
| The other person is entitled under the Asylum Seekers Benefits Act . ÿ If yes, please provide relevant evidence <input type="checkbox"/> Yes <input type="checkbox"/> No (9) (e.g. residence permit, residence permit, toleration, decision from the Federal Office for Migration and Refugees (BAMF)). | |
| The other person is a school pupil, student or trainee . <input type="checkbox"/> Yes <input type="checkbox"/> No (10) | |
| <input type="text"/> Duration of school education from - to | ÿ If yes, please provide current evidence (e.g. school certificate). |
| <input type="text"/> Duration of study from - to | ÿ If yes, please provide current evidence (e.g. certificate of enrollment). |
| <input type="text"/> Duration of training from - to | ÿ If yes, please provide the training contract before. |
| <input type="checkbox"/> During the training, the other person is accommodated in a dormitory, boarding school, a special facility for people with disabilities or with the trainer with full board or other accommodation and board reimbursement. (10) | |
| ÿ If yes, please provide current evidence. | |
| The other person is currently or will soon be in an inpatient facility (e.g. hospital, retirement home, correctional facility). <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| <input type="text"/> Duration of accommodation from - to | <input type="text"/> Type of inpatient facility (11) |
| ÿ If yes, please provide a valid certificate of stay and duration. | |

3. Examination of additional requirements

ÿ The information is voluntary and only required if you would like to request additional requirements.

| | |
|--|--|
| <input type="checkbox"/> The other person is pregnant . ÿ Please provide proof showing the expected date of delivery. (12) | |
| <input type="checkbox"/> The other person requires expensive nutrition for medical reasons . (14) ÿ Please fill out the MEB attachment out of. | |
| <input type="checkbox"/> The other person has a disability and receives (15) <ul style="list-style-type: none"> • Benefits for participation in working life in accordance with Section 49, Book Nine of the Social Security Code (SGB IX) or • other assistance to obtain a suitable job or • Integration assistance in accordance with Section 112 SGB IX. ÿ Please provide a corresponding notice. | |
| <input type="checkbox"/> The other person is not fit for work and is the holder of an ID card in accordance with Section 152 Paragraph 5 SGB IX with the symbol G or aG . ÿ Please provide current proof (e.g. severely disabled person's ID card). (16) | |

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| | |
|--------------------------|--|
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The **other person** has an **unavoidable special need** that they cannot cover through savings or other means (e.g. costs of exercising access rights for separated parents).

ÿ Please fill out **attachment BB** out of. 17

The **other person** is a **student** and has costs for **school books/workbooks**.

ÿ Please provide relevant evidence. 18

4. Income and assets 19 ÿ To check the 20

income of the other person, please fill out the **EK appendix** out of.
If you are self-employed, please **also** fill out the **EKS appendix** .

ÿ When submitting an application, bank statements must always be submitted. Please provide bank statements from the last three months. 43

ÿ If you have significant assets, please fill out **attachment VM** out of. Short-term is significant for the Assets usable for subsistence over 30,000 euros for each additional person in the community of need. Examples: Cash, savings, overnight money, securities savings plans and deposits. Assets that are not freely available are not to be included in the relevance test. This includes, in particular, owner-occupied residential properties and typical retirement provision products such as capital life or pension insurance.

If the other person has significant assets and is currently self-employed or has already done so in their professional life, the following information is required:

The total number of years the other person has been self-employed exercised is: _____

5. Living situation of the other person

5.1 Priority services 21

ÿ The following information is used to check whether there is a claim to other services or to third parties could exist.

ÿ Multiple entries are possible here. Please provide relevant evidence.

In the last 5 years 22

the other person was **busy**.

| | | |
|---------|----------|---|
| from to | Employer | <input type="checkbox"/> subject to social insurance contributions <input type="checkbox"/> Mini job |
| from to | Employer | <input type="checkbox"/> subject to social insurance contributions <input type="checkbox"/> Mini job |

the **other person** was self- employed.

| | |
|---------|------------------|
| from to | Type of activity |
|---------|------------------|

the **other person** has completed military **service** or **voluntary service** (e.g. voluntary social year, federal voluntary service).

the **other person** has **cared for relatives** (care in accordance with the Eleventh Book of the Social Security Code).

the **other person** has received compensation benefits (e.g. sickness benefit, unemployment benefit, maternity benefit, parental benefit, transitional benefit).

| | |
|---------|-------------|
| from to | Performance |
|---------|-------------|

none of these points apply to the **other person** . The other person has theirs **Living expenses are covered as follows** (e.g. financial support through Relatives/acquaintances, savings, inheritance):

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Appendix BB

Annex EK

EKS facility

Bank statements

Plant VM

5.2 Claims against third parties 23 24

The **other person** has already **applied for** other benefits or **intends to apply**. These include, for example, benefits under the Federal Training Assistance Act (BAföG), vocational training allowance (BAB), housing benefit, unemployment benefit, pensions (old-age, survivor's and basic pensions), sickness benefit, child benefit and child supplement.

| | |
|--------------|------------------|
| Service type | Application date |
|--------------|------------------|

| |
|-------------------------------------|
| Social benefit provider/family fund |
|-------------------------------------|

ÿ Please provide current proof.

The **other person** makes claims against a (former) employer for outstanding wage or salary payments (for example in the event of insolvency/ Insolvency of the employer) or for times after leaving the company (for example if severance payments are still outstanding).

| | |
|----------|---------|
| Employer | Address |
|----------|---------|

| |
|--------|
| Reason |
|--------|

ÿ Please provide appropriate evidence (e.g. correspondence with your lawyer or the court).

The **other person** lives separately from their spouse or registered life partner.

ÿ Please fill out **attachment UH1** out of.

The **other person** is divorced or the registered civil partnership has been annulled.

ÿ Please fill out **attachment UH1** out of.

The **other person** is pregnant or is caring for an illegitimate child under the age of 3.

ÿ Please fill out **attachment UH2** out of.

The **other person** is

- under 18 years old or
- between 18 and 24 years old and doing school or vocational training or wants to start one soon

and at least one parent lives outside the community of need.

ÿ Please fill out **attachment UH3** if the other person is the child.

ÿ Please fill out **attachment UH4** if the other person is not the child and you are in one with them Live partnership.

The **other person** has suffered damage to their health at the hands of a third party (e.g. work, traffic, gambling or sports accident, medical treatment error or physical altercation). The other person must therefore apply for benefits at the job center.

ÿ Please fill out the **UF attachment** out of.

The **other person** has a claim against third parties (for example from contractual payment claims or claims for damages).

| |
|-------------------|
| Name of the claim |
|-------------------|

ÿ Please provide proof of the claim with current documents.

For the **other person**, a declaration of commitment was made to the immigration authorities or the diplomatic mission abroad. 25 Yes No

ÿ Please present the declaration of commitment or suitable documents.

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Appendix UH1

Appendix UH1

Appendix UH2

Appendix UH3

Appendix UH4

Facility UF

6. Health and nursing care insurance 26 6.1



Compulsory insurance in statutory health and nursing care insurance

The **other person** is or was most recently compulsorily or family insured under **statutory health and nursing care insurance** .

When the entitlement to unemployment benefit II begins, the additional person would like to be insured with:

the previous health insurance company.

| | |
|------------------------------|------------------------------------|
| name of the health insurance | Health insurance number (if known) |
|------------------------------|------------------------------------|

ÿ Please provide a membership certificate or other current proof of membership
Health insurance company informs you about the insurance of the other person. Alternatively, you can also present the other person's valid electronic health card; this will not be kept on file.

another health insurance company.

| | |
|------------------------------|------------------------------------|
| name of the health insurance | Health insurance number (if known) |
|------------------------------|------------------------------------|

ÿ Please provide a membership certificate or other current proof of membership 26
Health insurance company about the choice of health insurance company if the other person changes health insurance company.

6.2 Private, voluntary statutory health and nursing care insurance or no health insurance

| | |
|--|--|
| <input type="checkbox"/> The other person is private or Voluntarily legally insured. ÿ Please fill out Appendix SV, Section 3 . | <input type="checkbox"/> The other person is not insured. ÿ Please fill out Appendix SV, Section 4 . |
|--|--|

I confirm that the information is correct.

| | |
|-------------|--|
| Place, date | Signature of the applicant (for minors: signature of the legal representative) |
|-------------|--|

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Appendix SV

In the following Sections were in Presence of the customer
Customer changes made:

Hand sign, date

Signature of the customer