MEDICARE EGÉSZSÉGPÉNZTÁR

Pénztár tölti ki! To be completed by the Fund!

Fund Member ID		
Documents attached	☐ Yes	☐ No
Customer's risk level	☐ Low	☐ Average ☐ High
It is on the sanctions list	☐ Yes	☐ No

BELÉPÉSI NYILATKOZAT - ENTRY STATEMENT

*Please complete this form in **CAPITAL LETTERS**.*
*Data marked with an asterisk (*) are mandatory. **Please sign all pages!***

1. Belépő adatai - Data of entering person

Név /Name*					
Születési név*/ Name at birth*		Anyja születési név/Mother's name*			
Születési idő*/Date of birth*		Születési hely Place of birth*			
Adóazonosító jel/ Tax ID*		Állampolg. Citizenship*	☐ Magyar / Hungarian ☐ külföldi / foreign:		
Közszereplői nyilatkozat Statement about being a politically exposed person*	☐ NEM vagyok kiemelt közszereplő /I am NOT a politically exposed person ☐ IGEN, kiemelt közszereplő / kiemelt közszereplő közeli hozzátartozója/ kiemelt közsszereplővel közeli kapcsolatban álló személy vagyok /YES, I am a politically exposed person/a close relative of a politically exposed pers./a person in close contact with a politically exposed pers. *IGEN válasz jelölése esetén a "Nyilatkozat a kiemelt közsszereplői státuszról" nyomtatványt is kötelező csatolni!* *If YES, the form "Declaration on Status as a Politically Exposed Person" must be attached!*				
Személyazonosító okmány típus / Type of personal identification doc.*	☐ személyazonosító igazolvány /identity card ☐ útlevél/ passport ☐ jogosítvány /driving license card		Okmány érvényessége		
Személyazonosító okm. száma Number of personal id. doc.*			Lakcímkártya száma Address card number*		
Állandó lakcím Permanent address* *(place of residence in case of a foreign national)*	Irányítószám /Postal code		Település Settlement		
	Utca, házszám/Str, St.No.				
Levelezési cím Mailing address*	IRSZ - Postal code		Település Settlement		
	Utca, házszám Street, St.No.				
Bankszámlaszám / Bank account number					
E-mail cím/Email address			Telefonszám/Phone No.		

2. Tagdíjfizetés - Membership fee payment

Alulírott vállalom, hogy legalább a Medicare Egészségpénztár Alapszabályában rögzített mindenkori egységes alaptagdíját, a fizetési határidők figyelembevételével megfizetem. *I, the undersigned, undertake to pay within the payment deadline at least the current basic membership fee set out in the Statutes of the Medicare Health Fund.*

Tagdíjfizetés módja / *Membership fee payment method* * *	☐ egyénileg, banki átutalással vagy munkáltató által bérből történő befizetéssel /*individual, by bank transfer* ☐ munkáltatói tagdíjvállalással / *by employer's membership fee assumption*	Tagdíjfizetés gyakorisága */Membership fee payment frequency*	☐ havi/*monthly* ☐ negyedéves/*quarterly* ☐ féléves/*semi-annual* ☐ éves/*annual*
Egységes tagdíjon felül vált tagdíj összege *Amount of membership fee undertaken in addition to the standard membership fee:*	_____ Ft (HUF), azaz/that is _____		

3. Munkáltató adatai – – *Kitöltése csak akkor szükséges, ha munkáltatója a tagdíj egy részének/egészének megfizetését átvállalja*.

Hozzájárulok, hogy a Pénztár munkáltatóm kérésére tagságomról (név, adóazonosító megadásával) információt adjon.

***Employer details** – To be completed if your employer assumes payment of part / all of the fund membership fee.*
I consent to the Fund providing information on my membership (name, tax id. number) at the request of my employer

Munkáltató neve *Employer's name*		Munkáltató címe *Employer's address*	

Pénztárba lépő aláírása
Signature of the person entering the Fund

4. Szolgáltatás igénybevételére jogosult közeli hozzátartozók – Close relatives entitled to use the service

I hereby declare that my following relatives are entitled to use the fund service to the debit of my individual account:

Name of close relative						
Name at birth			Mother's name			
Place and date of birth		year	m.	d.	Relationship[1] *(required!):* ☐ Spouse ☐ Life partner ☐ Child ☐ Parent ☐ Grandchild ☐ Brother ☐ Grandparent, Great grandp.	
Address						
Name of close relative						
Name at birth			Mother's name			
Place and date of birth		year	m.	d.	Relationship[1] *(required!):* ☐ Spouse ☐ Life partner ☐ Child ☐ Parent ☐ Grandchild ☐ Brother ☐ Grandparent, Great grandp.	
Address						
Name of close relative						
Name at birth			Mother's name			
Place and date of birth		year	m.	d.	Relationship[1] *(required!):* ☐ Spouse ☐ Life partner ☐ Child ☐ Parent ☐ Grandchild ☐ Brother ☐ Grandparent, Great grandp.	
Address						

To name additional individuals, please use the form "" Designation of Persons Entitled to the Service" on the website of the Fund.

*[1]According to the applicable laws, **persons entitled to use the service**, named by a member are **restricted to close relatives**, that is, spouse, linear relatives, adopted, step and foster children, adoptive, step and foster parents, further, brothers and sisters, and common-law spouse.*

5. Elektronikus ügyintézés igénylése - Request for electronic administration

With this undersigned declaration, I authorize the Medicare Health Fund to keep in touch with me electronically and to send me the documents related to my membership of the fund as electronic documents. I understand that, in the event of a request, the Fund will send the notification about the delivery of the electronic document to the e-mail address I provided, and I can view the document on the Member Portal (www.medicareegeszsegpenztar.hu).

☐ **Yes**, I would like e-administration *(in this case, entering the e-mail address is mandatory!)* ☐ No, do not request e-administration

6. Haláleseti kedvezményezettek megjelölése - Naming of death beneficiaries

In the event of my death, I, the undersigned designate the following person(s) as death beneficiary (beneficiaries):

Beneficiary's name				
Name at birth				
Place, and date of birth		Mother's name		
Address			Entitlement ratio[2]	%
Beneficiary's name				
Name at birth				
Place, and date of birth		Mother's name		
Address			Entitlement ratio[2]	%

An additional form should be completed to name more than two death beneficiaries.

*[2] If more than one person is named, **the total of the entitlement (share) percentage** of the death beneficiaries **must be 100%**!*

***To designate a death beneficiary and in the case of requesting electronic administration**, at least a fully certified private document, that is, **the signatures of at least two witnesses[3] are required** for the designation to be valid.*

The designated death beneficiary cannot be shown as witness.

Name of witness 1		Name of witness 2	
Permanent address of W1		Permanent address of W2	
Signature of witness 1		Signature of witness 2	

[3]In the case of AVDH authentication through the customer portal, the declaration is considered a private document with full probative value, in this case the signatures of the two witnesses are not required.

Date: ______________, _____ (day) _____ (month) ____ (year)

Signature of the person entering the Fund

7. Adatkezeléssel kapcsolatos hozzájárulás - Consent to data processing

I, the undersigned, give my voluntary explicit consent, valid until its withdrawal, to Medicare Health Fund for my above registered data, including any subsequent changes to them,

A.) **to be processed for marketing purposes**, including **sending me newsletters, information about promotions, new services, or special offers** related to fund services in general and the fund-related services of the Medicare companies operating in Hungary.

By email: ☐ Yes ☐ No By telephone: ☐ Yes ☐ No By post: ☐ Yes ☐ No

B.) **to be transferred to the Medicare companies** operating in Hungary so that they can **send me newsletters, information about promotions, new services, or special offers**. I consent that they can directly contact me for these purposes.

By email: ☐ Yes ☐ No By telephone: ☐ Yes ☐ No By post: ☐ Yes ☐No

I, the undersigned, declare that I wish to become a member of the Medicare Health Fund. I declare that I have read the Statutes of the Fund and accept to be bound by them, and that I am acting in my own name and for my own benefit.

I undertake to pay in due time the standard membership fee and the agreed membership fee specified in this Entry Statement.

In the case of membership fee assumption by the employer, I am aware that if the employer does not pay the amount of the employer's contribution to the fund for any reason, I shall be obliged to pay the amount of the membership fee undertaken by me to the fund. I, the undersigned declare that I have provided complete and truthful data in this Entry Statement. I, the undersigned agree to notify the Fund of any changes in the data given in this Entry Statement immediately, no later than 5 working days after such change. I shall be responsible for any consequences of failure to do so.

Date:_____, _____ (day) _____ (month) ____ (year)

Signature of the person entering the Fund

Mandatory appendices to the entry statement:

a.) **for Hungarian citizens**: **copy of personal identity card with photo** (identity card, driving license, passport) and **a copy of the first page of the official address card**

b.) **for foreign nationals:** copy of travel document **or personal identification document**, provided that it certifies entitlement to reside in Hungary, or **copy of document certifying right of residence** or **permission to reside.**

Privacy Information

The personal data provided in this entry statement will be processed by Medicare Health Fund (1134 Budapest, Váci út 29-31.), hereinafter the Fund. The purpose of processing of personal data is to provide health fund services, maintain contact and fulfill legal obligations, and its legal basis is the fund membership relationship/fulfillment of contract, and the fulfillment of a legal obligation (GDPR Article 6(1), paragraphs (a) and (c)). The purpose of the data processing under section 7 is direct marketing, sending information for marketing purposes, and its legal basis is your consent. After the termination of membership, the Fund will continue to process personal data until the end of the period of limitation (5 years) and is obliged to process data related to the fulfillment of its obligation under the Act on the Prevention and Combating of Money Laundering and Terrorist Financing (hereinafter Money Laundering Act) for 8 years after the termination of membership. The personal data affected by consent to marketing under section 7 will be processed by the Fund until the consent is withdrawn. The data provided by you will be handed over by the Fund to the persons specified by, and according to the provisions of, the law, and may also be reviewed by the data processors. The Fund ensures that personal data is only transferred to such data processors who provide adequate guarantees to ensure the safety of data processing and the security of your personal data. The Fund does not transfer the personal data provided by you to any country outside the European Union (and the European Economic Area) and does not use such data for automatic decision-making. Giving the personal data specified in sections 1 and 6 above is mandatory in order to fulfill the obligations under the Money Laundering Act. If you do not provide the said data, the Fund is obliged to refuse to establish a membership relationship in accordance with the applicable laws. You have the right to request information from the Fund about data processing. You can contact the Fund's Data Protection Officer as follows: E-mail: info@medicareep.hu, Letter address: 1134 Budapest, Váci út 29-31. In connection with data processing by the Insurer, the Insured may request information about the processing of his/her personal data, request the correction of any of his/her incorrect personal data, the deletion of his/her data, has the right to protest against or request the limitation of data processing, to withdraw his/her consent, is entitled to data portability, as well as to turn to the competent court/authority to enforce his/her rights: National Authority for Data Protection and Freedom of Information, Headquarters: 1055 Budapest, Falk Miksa u. 9-11, Mailing address: 1363 Budapest, Pf .: 9., Email: ugyfelszolgalat@naih.hu, Telephone:+36 (1) 391-1400, Website: www.naih.hu.

For additional information about data processing, please read the Medicare Health Insurance Fund Data Processing Information on the www.medicareegeszsegpenztar.hu website.

To be completed by the Fund!

ZÁRADÉK - CLAUSE

A Belépési nyilatkozatot a Medicare Egészségpénztár az alulírott helyen és napon elfogadta, a Pénztártag részrée megadott és a Pénztárban rögzített adatok alapján Tagsági okirat kiállításra került.

The entry form was accepted by Medicare Health Fund at the place and date given below, and a Membership Certificate was issued on the basis of the information provided to the Fund Member and recorded in the Fund.

Budapest, _____ _____

Signature of the Fund's representative