MEDICOVER

DECLARATION OF ACCESSION AND AUTHORIZATION

for application for, and payment of the regular premiums of, the Medicover Health Package
provided by Medicover Zrt. to the members and service recipients of the Medicover Health Fund

Name of Fund member (Policyholder)			Fund Member ID	
Email		Telephone No.		

I hereby declare that I wish to use the following Medicover Health Package(s) *(please check the appropriate box)*

Recipient	☐ As a Fund member, for myself ☐ For my service recipient: ____________________ (name) *Important:* ***One Recipient can be named on each Declaration Form****; for several persons, it is possible to complete more than one form.*		
Recipient's date of birth		Recipient's social security number	

Package chosen, its basic premium* and payment frequency			
	☐ Medicare	**(HUF 135,000**/year)	Premium payment: ☐ six-month ☐ annual
	☐ Medicare Plus	**(HUF 180,000**/year)	Premium payment: ☐ quarterly ☐ six-month ☐ annual
	☐ MediScreen	**(HUF 60,000**/year)	Preumium payment: annual (not optional)
	☐ MedicLab	**(HUF 19,500**/year)	
	☐ SmartLab	**(HUF 8,900**/year)	

**The premium shown on your Medicover Zrt. invoice may include an additional discount above the preferential premium.*
As a new member of the Medicover Health Fund, a ***one-off additional payment of HUF 2,000*** *will be required at the time of the first payment.*

Bank account of the Medicover Health Fund: **12001008-01667874-00100002**
(Please include your name, member or tax ID or date of birth and the text "individual payment of Health Package premium" in the Note column)

Declaration and Authorization

I, the undersigned, understand and accept that the services provided by the chosen Medicover Health Package(s) of Medicover Egészségközpont Zrt. (registered office: 1134 Budapest, Váci út 29-31., Hungary, hereinafter referred to as "Medicover") may **only** be used by **members of the Medicover Health Fund** (hereinafter referred to as "the Fund") and **their close relatives who have been registered as recipients entitled to such services**; **I can settle the premium for the packages through the Fund**, by credit transfer to the bank account number indicated above.

I agree that if I am not a member of the Medicover Health Fund yet, I **will join the Fund within 8 days of signing this Declaration**.

By signing this Declaration, **I hereby authorize Medicover and the Fund to share** with each other and with the Medicover Group members and to reconcile with them the **data** (name, date of birth, member ID, package name, payment frequency, email address) **necessary** for the implementation the chosen health package.

This authorization is valid until withdrawn for the premium of the Health Package of my choice that becomes due after the date of signature.

I agree to **transfer** the amount corresponding to the applicable premium for the service to **my personal account with the Fund by the 15th of the month preceding the start of the period to be covered** by the premium.

I, the undersigned, hereby **instruct the Fund** to **block the amount of the premium for the Health Package indicated above** from the amount registered in my personal Fund account **at the specified payment intervals, and to transfer such amount to my Medicover account on the due date**.

I understand and accept that the Fund **can successfully fulfill** the instruction only **if the premium installment (required full coverage) is available in my individual account**.

I hereby acknowledge that if the premium due for the Health Package is not paid for any reason from the amount held in my individual account, I will be obliged to pay the fee for the health service used to Medicover under the Health Package at the time of the conclusion of the Health Package contract, in accordance with the General Terms of Contract.

I hereby declare that I have read and understood the Privacy Policy of both the Fund and Medicover.

I declare that the information provided is correct.

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

Client/Fund Member signature

Once completed, you can forward the Declaration in its **original format or via Identification Based Document Authentication (AVDH):**

by **e-mail** with AVDH authentication **through a client portal** to **avdhugyintezes@medicoverep.hu** or by **post** to Medicover Egészségpénztár, 1134 Budapest, Váci út 29-31, Hungary, or **in person** at any Medicover Reception, in a sealed envelope.

If required, the **Enrollment Statement** of Medicover Health Fund can be downloaded from www.medicoverep.hu/nyomtatvanyok.