MEDICOVER Egészségpénztár

REQUEST FORM FOR HEALTH CARD/ PARTNER CARD

The preparation of the Medicover Health Card for new entrants/transferees is automatic, it is not necessary to fill out the application form!
After registration, the Fund will send the Medicover health card free of charge to your mailing address,
if there is an amount equivalent to at least two months' basic membership fee (currently HUF 1,000) available in your individual account.

Igénylő Pénztártag adatai - Data of the Fund Member

Data marked with an asterisk (*) are mandatory.

Pénztártag neve*/Name		Fund Member ID	
Születési idő*/ Date of birth	y / m / d	Place of birth*	
E-mail cím/ E-mail address			

I hereby order the Medicover Health Card/Partner Card from Medicover Health Fund **(please mark the correct one!)**

☐ **For myself**, because

☐ the card was lost/stolen/damaged/destroyed ☐ I would like a new card because of a name change

☐ other: ..... *(In case of a name change, please fill the Notice of Data Change form)*

☐ **For the person entitled to the service,** who I hereby designate as a co-cardholder and hereby declare that my designated close relative is entitled to use the Fund's services charged to my individual account:

Data of Co-cardholder (entitled for the service):

Társkártya birtokos neve*/ Name of the co-cardholder*		Date of birth*	
Name written on card *(max. 26 characters including spaces)*			
Mailing address *(where we can send the card)**	Postcode	City	
	St. name, number		

***Requesting a partner card is only possible for those entitled to the service registered in the Health Fund**. If the direct relative indicated above is entitled to a service that has not yet been declared, the following data must also be provided:*

Születési neve*/Birth name		*Relationship[1] *(required!):* ☐ Spouse ☐ Partner ☐Child ☐ Parent ☐ Sibling ☐Grandparent, Great-Grandparent ☐ Grandchild	
Anyja születési neve* / Mother's birth name			

[1]*Based on relevant legislation, **only close relatives** (spouse; consanguineous relatives; adopted, step- and foster children; adoptive, step- and foster parents, and siblings) and partners can be designated as eligible for services.*

As the applicant for a Health Card/Partner Card I declare that I have read and accept the Fund's Policy and Card Usage Regulations. I understand that **the fee of the ordered card is HUF 1,000**, which will be deducted from the individual account.

I acknowledge that the tax liability of the lifestyle-enhancing or illegal service used with the companion card is **always borne by me as a fund member.** I am aware that the condition for issuing the partner card is **the existence of a valid and active main card**, otherwise the Fund will not fulfil my request. I declare that I provide the appropriate coverage on the individual health account, I am aware that otherwise the application for the card may be delayed.

I understand and agree that the recipient of the card/companion card will send the invoice directly to the Fund in the event of refund, taking the data protection legislation into account.

By signing the application form, I agree that the data required for the preparation and use of the health card/companion card will be handled, processed and forwarded to the card service provider by the Fund in accordance with the provisions of the act on the protection of personal data, who may use them in connection with the preparation and operation of the health card.

Aware of my criminal liability, I declare that the information I have provided corresponds to reality, and that there is a close family relationship regarding to the persons indicated above as required by law. With my signature, I acknowledge that I have read the Fund's Privacy Policy, which can be found on the Fund's website (www.medicoveregeszsegpenztar.hu), and I acknowledge its contents. If the personal data provided by me originates from a third party (a partner cardholder entitled to the service), I acknowledge that I have the authorization of the person(s) concerned to transfer their personal data to the Fund, and I have provided them with information related to data management, and **I ensure that the Partner Cardholder is acquainted with the Fund's Policy and Card Usage Regulations.**

Date: _____, _____ year ____ month ___ day

Fund member's signature

After signing, please send the document in its original form by post, or drop it off at any Medicover reception desk, or send it by e-mail after authentication through the Client Gate ("Ügyfélkapu" and "AVDH") to avdhugyintezes@medicoverep.hu.