

<b>Fund Member ID</b>	
Documents attached	<input type="checkbox"/> Yes <input type="checkbox"/> No
Customer's risk level	<input type="checkbox"/> Low <input type="checkbox"/> Average <input type="checkbox"/> High
It is on the sanctions list	<input type="checkbox"/> Yes <input type="checkbox"/> 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*												
Születési idő*/Date of birth*								Születési hely Place of birth*				
Anyja születési név/Mother's name*												
Adóazonosító jel/ Tax ID*								Állampolg. Citizenship*	<input type="checkbox"/> Magyar / Hungarian	<input type="checkbox"/> külföldi / foreign:		
Közszereplői nyilatkozat Statement about being a politically exposed person *	<input type="checkbox"/> NEM vagyok kiemelt közszereplő / I am NOT a politically exposed person <input type="checkbox"/> IGEN, kiemelt közszereplő / kiemelt közszereplő közeli hozzátartozója/ kiemelt közszereplővel 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. <i>IGEN válasz jelölése esetén a "Nyilatkozat a kiemelt közszereplői státuszról" nyomtatványt is kötelező csatolni!</i> <i>If YES, the form "Declaration on Status as a Politically Exposed Person" must be attached!</i>											
Személyazonosító okmány típus / Type of personal identification doc.*	<input type="checkbox"/> személyazonosító igazolvány /identity card <input type="checkbox"/> útlevél/ passport <input type="checkbox"/> jogosítvány /driving license card							Okmány érvényessége Validity of id. doc.*				
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/Street, 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 Medicover 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 Medicover Health Fund.

Tagdíjfizetés módja / Membership fee payment method*	<input type="checkbox"/> egyénileg, banki átutalással vagy munkáltató által bérből történő befizetéssel /individual, by bank transfer <input type="checkbox"/> munkáltatói tagdíjvállalással / by employer's membership fee assumption
Egységes tagdíjon felül vállalt tagdíj összege Amount of membership fee undertaken in addition to the standard membership fee:	_____ Ft (HUF), azaz/that is _____ Ft (HUF)

### 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	
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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			Relationship <sup>1</sup> (required!):
Mother's name at birth			<input type="checkbox"/> Spouse <input type="checkbox"/> Life partner <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Grandchild <input type="checkbox"/> Brother <input type="checkbox"/> Grandparent, Great grandparent
Date of birth		Place of birth	

  

Name of close relative			
Name at birth			Relationship <sup>1</sup> (required!):
Mother's name at birth			<input type="checkbox"/> Spouse <input type="checkbox"/> Life partner <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Grandchild <input type="checkbox"/> Brother <input type="checkbox"/> Grandparent, Great grandparent
Date of birth		Place of birth	

  

Name of close relative			
Name at birth			Relationship <sup>1</sup> (required!):
Mother's name at birth			<input type="checkbox"/> Spouse <input type="checkbox"/> Life partner <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Grandchild <input type="checkbox"/> Brother <input type="checkbox"/> Grandparent, Great grandparent
Date of birth		Place of birth	

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

<sup>1</sup>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 Medicover 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.medicoveregeszsegpenzta.hu](http://www.medicoveregeszsegpenzta.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			
Date of birth		Place of birth	
Mother's name at birth		Entitlement ratio <sup>2</sup>	%

  

Beneficiary's name			
Name at birth			
Date of birth		Place of birth	
Mother's name at birth		Entitlement ratio <sup>2</sup>	%

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

<sup>2</sup>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<sup>3</sup> 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	

<sup>3</sup>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:

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 Medicover 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 Medicover companies operating in Hungary.

By email:  Yes  No

By telephone:  Yes  No

By post:  Yes  No

B.) **to be transferred to the Medicover 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 Medicover 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:

*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 Medicover 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@medicoverep.hu](mailto:info@medicoverep.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](mailto:ugyfelszolgalat@naih.hu), Telephone: +36 (1) 391-1400, Website: [www.naih.hu](http://www.naih.hu).

For additional information about data processing, please read the Medicover Health Insurance Fund Data Processing Information on the [www.medicoveregeszsegpenztar.hu](http://www.medicoveregeszsegpenztar.hu) website.

*To be completed by the Fund!*

### ZÁRADÉK - CLAUSE

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

*The entry form was accepted by Medicover 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