

Policyholder: _____

Data of the insured:

Family name and given name: _____

Mother's maiden name: _____

Place and date of birth: _____ Social Security Number*: _____

** Lacking Social Security Number, please, fill in the tax identification number, in the absence of tax identification number, please, give any other alphanumeric identifier (passport number e.g.).*

Permanent address: _____

1. I, the undersigned, hereby acknowledge that _____ as policyholder (hereinafter "Policyholder") and UNION Vienna Insurance Group Biztosító Zrt. as insurer (hereinafter "Insurer") have concluded an Unimed health insurance policy (hereinafter "Policy") with each other.

2. I grant my consent for the Policyholder to report my eligibility for the benefits provided as part of the Insurance to the Insurer, by providing my following personal data: type and number of identification document, name, mother's name, place and date of birth, address and mailing address, mobile number and e-mail address.

3. I hereby declare that prior to signing this Declaration, I received adequate and appropriate information on the key data of the Insurer and the key characteristics of the insurance policy, I am aware of the insurance terms and conditions and the contents of the Data Processing Information Document, and I have received the insurance product profile, the summary information on such insurance terms and conditions, and I hereby confirm the above with my signature.

4. I declare that prior to providing my personal data, I was given detailed and clear information, which I have understood, regarding the processing of my data by the Insurer. The purpose of data processing is to establish and maintain the insurance relationship, and to determine the premiums and requirements related to the insurance relationship. My personal data to be given to the Insurer are the following: name, mother's name, place and date of birth, address, mailing address, Social Security Number or tax identification number, lacking of these two, any other alphanumeric identifier (passport number e.g.), mobile number and e-mail address.

5. I am aware that

- the Insurer may employ third party organisations, data processors and reinsurers to perform its duties and obligations. The list of such organisations as well as the Data Processing Information Document is available on the website www.union.hu/adatvedelem.
- the Insurer uses the services of a care organiser to organise the provision of the healthcare services as specified in the Policy.
- I am entitled to exercise my rights of access, rectification and data portability in respect of the personal data communicated to the Insurer during the establishment and maintenance of the insurance relationship or which are received by the insurer or are created during the provision of the services. Comprehensive information on data subjects' rights are included in Chapter III of the Data Processing Information Document.
- personal data qualifying as confidential insurance information may only be transferred to third parties subject to my written consent or with the authorisation granted in the Insurance Act, and the rules of such authorisation are set out in Appendix 1 of the Data Processing Information Document.
- the Insurer is also entitled to process my special (health) data with my voluntary and explicit consent for the duration of the insurance relationship, and also after the termination of the insurance relationship as long as legal claims may be exercised in relation to the insurance relationship. Further details of health data processing are set out in the Data Processing Information Document.

6. Based on appropriate information received from the Insurer regarding the purpose and content of data processing, I hereby voluntarily and explicitly grant my consent to

- that the Insurer collects and registers the data concerning my health condition which are directly related to the assessment of the claims arising from the Insurance Policy and which are absolutely necessary for assessing the claims for benefits and for the settlement of any legal disputes arising therefrom, and that it uses such data for the above purposes.

- that the insurer shall handle and record my Social Security Number or my tax identification number, or in the absence of these any other alphanumeric identifier of mine (passport number e.g.) for the purpose of verifying my insurance coverage, performing and financing my medical service request, and also for related identification.
- that the social security and administrative organisations and authorities (e.g. National Health Insurance Fund of Hungary (NEAK), the Institute of Medical Specialists, the rehabilitation authority, the police, the courts, the public prosecutor's office, healthcare institutions), my treating and examining physicians, who have proceeded in cases related to my Insurance Policy, transfer the data required to assess the claim for benefits to the Insurer. In respect of the above data, I release the persons (e.g. my treating and examining physicians) and organisations (e.g. healthcare institutions, social security administrative bodies, investigative authorities) registering such data pursuant to statutory authorisation from their confidentiality obligation towards the Insurer.

7. I **hereby declare** that I will refrain from entering the policy as policyholder during the term of validity thereof.
8. I, the undersigned, **hereby declare** that the data provided in this Declaration are true and correct. I hereby acknowledge that the Insurer may refuse to grant benefits if the data provided are false.
9. I hereby declare that this Declaration shall remain valid until revoked.

Dated: _____, _____ / _____ / _____ _____
Signature of the insured