Groupama Biztosító

Az OTP Csoport partnere

DECLARATION OF THE INSURED PERSON FOR THE GROUPAMA MEDICARE GROUP HEALTH INSURANCE CONTRACT

1. Data of the contracting party:

Name of the contracting party: **Budapesti Műszaki és Gazdaságtudományi Egyetem**
Registered office: 1111 Budapest, Műegyetem rakpart 3.

2. Data of the Insured person

First name of the insured person:	
Surname of the insured person:	
Nationality:	
Gender:	☐ male ☐ female
Mother's name:	
Date of birth:	
NEPTUN code (unique ID):	
Insurance policy number (card number)	
E-mail address:	
Mobile number:	

3. Declarations

a. **I, the undersigned, hereby agree** to extend the Groupama Medicare Group Health Insurance General Agreement (Agreement) concluded between the contracting party stated in Paragraph 1 and Groupama Biztosító Zrt to me as a policyholder.

b. **I declare** that I have read and understood the terms and conditions of this Policy prior to signing this Policyholder's Declaration and have received appropriate information from the contracting party on key details of the insurer and key features of the contract.

c. **I, the undersigned, hereby declare** that I am familiar with the "Theoretical and practical information concerning the processing of personal details, data deemed to be insurance secrets, and the handling of complaints related to the insurance agreement" (Information). Based on the Information, I acknowledge that the Insurer manages my voluntarily provided personal data as set out in the Information and in the contract.

d. **I, the undersigned, accept** the provisions of the terms and conditions under which the policyholder is the beneficiary.

e. **I declare** that I will not enter the contract as a contracting party during its term.

f. **I, the undersigned policyholder**, **hereby acknowledge** that my data specified below (data) and in the event of any changes to these data, the altered date, are transferred by the insurer to Europ Assistance Magyarország Kft. (Registered office: 1132 Budapest, Váci út 36-38.., company registration number: 01 09 565790) as Care Organizer (Care Organiser) and Semmelweis Egészségügyi Kft. (Registered office: 1085 Budapest, Üllői út 26, company registration number: 01-09-879749) as Care Organizer and Service Provider. Data: name of the policyholder, gender, mother's name, place and date of birth, unique ID, e-mail address, mobile phone number.

g. The Insurer may manage the data directly related to the health status and processed by the Insurer during the existence of the insurance relationship and for the period during which a claim may be enforced under the insurance relationship.
The Insurer is obliged to delete any data directly related to the state of health of its clients, former clients or contracts that were not concluded for which the purpose of data processing terminated or the consent of the data subject is not available or there is no legal ground for its processing. The Insurer shall treat the data received an insurance secret and keep it for an unlimited period of time.

h. **I, the undersigned policyholder agree** that the care organiser will forward the following data to health service provider partners who have a contract with them, or, if there is no service provider contracted by the care organiser capable of providing the service required by the policyholder, to health service providers who do not have a contract with the care organiser: name of the policyholder, date of birth, address, mobile phone number, and health records of the policyholder.
I acknowledge that the health service provider is entitled to process the data to the extent and for the period necessary to complete the service until the service is terminated. At the request of the policyholder, the care organiser shall provide information on the identity of the health service providers that have accessed the data as described above.
I acknowledge that if I refuse to provide medical documentation to the care organiser when using a health service arranged by the care organiser, I will be obliged to pay for the service myself as a policyholder.

i. **I acknowledge** that in order to use the service, I shall identify myself as insured person and the contracting party of the contract by telephone with the following data:

- name of the contracting party
- name of the insured person
- mother's name of the insured person
- insured person 's place and date of birth

For online Health Portal services, identification is based on the email address and password I provided during my first registration.
I acknowledge that in all cases when requesting a service by phone or online, the care organiser identifies me as a as a policyholder.
I acknowledge that the care organiser identifies the policyholder when they use any health service arranged by the care organiser. If the policyholder is not identifiable, the policyholder shall pay the cost of the medical service used at the time of the treatment.

j. **I acknowledge** that if the care organiser arranges the service at a health service provider with which the care organiser has no contract, I will pay the cost of the service to the service provider as policyholder on the basis of an invoice issued by the service provider. On the basis of the invoice submitted by me as policyholder, the care organiser will reimburse me, as the policyholder, the reasonable cost of the service under the terms of the contract.

k. **I acknowledge and agree** that the insurer's cover will cease towards me as policyholder on the following dates:

- based on my request made in a written declaration, at 0 hour of the first day follows the receipt of the declaration by the insurer;
- if I am no longer a member of the insurance group and the contracting party initiates the termination of the relationship with the insurer in writing the insurer's legal relationship will terminate at 0 am on the first day following receipt of the request for the termination of the legal relationship;
- in the event of my death (including accidental death), on the date of death;
- at 0 am of the insurance anniversary following my 65th birthday;
- 100% disability or health damage as a result of an accident, at the time of establishment of the health damage;
- if the general group insurance agreement ceases to exist, at the time of cessation of the general agreement;

l. **I authorize the insurer** to obtain and record the data concerning my state of health and directly related to the conclusion, modification, retention in the portfolio of the contract and the assessment of claims arising from the contract, and to use that information in that context as well as to forward the data to eligible parties for the purposes defined in Sections 138-141 and Section 149 of Act LXXXVIII of 2014 on the Business of Insurance. At the same time, I exempt the persons (such as general practitioners) and organisations (such as social security bodies) who are authorized to register this information by law from their confidentiality obligation.

☐ **I agree**

m. **I declare** that the information provided by me are true as of the date of this Policyholder's declaration. **I acknowledge** that the disclosure of false information may constitute a breach of the disclosure obligation.

Date: _____

_____
signature of the insured person
(employee)