



Declaration of accession (by Insured)

For group sickness insurance

This Declaration constitutes an integral part of the cooperation agreement (hereinafter jointly referred to as "Cooperation Agreement") concluded by and between **UNIQA Biztosító Zrt.** (1134 Budapest, Róbert Károly krt. 70–74; hereinafter: "**Insurer**") and _____ (hereinafter jointly referred to as "**University**").

Detailed information on insurance is provided in the Customer Information and the Insurance Terms and Conditions.

I hereby **declare** that I **wish to join** from 1. September 2019. to 31. January 2020. (study semester) the Cooperation Agreement concluded by the University subject to the following terms and conditions.

Insurer's data

Insurer's company name: **UNIQA Biztosító Zrt.**
Insurer's registered office: 1134 Budapest, Róbert Károly krt. 70–74.
Registration number: 01-10-041515

University data:

Name: _____
Registered office: _____
Institutional ID: _____

Insurance name: **Foreign Visiting Students** (Group sickness insurance)

Insured (and fee-payer) data

Insured's first name: _____
Insured's last name: _____
Gender: ☐ Male ☐ Female
Place of birth: _____
Date of birth: _____ (day) _____ (month) _____ (year)
TAJ number: _____
Education ID: _____ Neptun code: _____
E-mail address: _____

The risk of the insurer starts on the day following the signing of this declaration, but no earlier than 1. September 2019.

I, the Undersigned, by making this Declaration,

- hereby declare that I have received clear and detailed information about the Cooperation Agreement concluded between the University and the Insurer prior to my declaration, and I have received, understood and acknowledged the details of the insurance and the key data of the Insurer, and I make this Declaration in knowledge thereof. At the same time, I declare that I have been made aware of and reviewed the Insurer's Customer Information, Insurance Terms and Conditions and Privacy Notice.
- hereby declare that I require the insurance cover provided by the Cooperation Agreement, I intend to use the Group Sickness Insurance Services provided by the Insurer and indicated in this Declaration, and at the same time, I request that the scope of the Cooperation Agreement between the University and the Insurer be extended to me as Insured.
- hereby acknowledge that this document does not fully cover the provisions of the insurance relationship and it does not replace knowledge of the Insurance Terms and Conditions and the Customer Information, and in this regard, I hereby acknowledge that the details of the insurance are contained in the Customer Information and the Insurance Terms and Conditions.

Date: _____ (day) _____ (month) _____ (year) _____
Insured

Declaration concerning Data Processing

For detailed information on data processing performed by UNIQA Biztosító Zrt. (hereinafter: "Insurer"), please refer to *Sections 113–117. of the Group Sickness Insurance Terms and Conditions and Privacy Notice*. I, the Undersigned, by making this Declaration,

- hereby authorise the University to provide my personal and other data required to extend the scope of the Cooperation Agreement to the Insurer for the purpose of ensuring that the insured relationship is established between the Insurer and myself and that the Insurer provide the insurance service to me. Data processed by the Insurer: name, gender, place of birth, date of birth, TAJ number, Education ID, Neptun code, e-mail address, and the fact of the insurance contract's conclusion or termination. The University and the Insurer may manage and process personal data on the legal basis and for the purposes contained in the present Declaration of Accession and in the above section of the Insurance Terms and Conditions during the existence of the insurance relationship and during the period where a claim may be exercised in relation to the insurance relationship. The Insurer qualifies as data controller, and the University is considered a data processors.
- acknowledge that all data provided during the conclusion of the contract or the existence of the insurance contract are considered to be insurance secrets which the Insurer processes for the purpose of the conclusion, modification and maintenance on the records of the insurance contract and for the purposes of assessing the claims arising out of the insurance contract;
- agree that the Insurer forward the insurance secret to those entitled to it as well as to third-country (re)insurance companies, in the scope of other purposes set forth in the prevailing Act on Insurance Activities;
- authorise the Insurer to verify the data disclosed;
- declare that this Declaration and the consents contained in the Declaration have been made voluntarily and after having been appropriately informed.

I declare that I have read, understood and acknowledged the above referenced data protection provisions of the Insurance Terms and Conditions and this Declaration.

Date: ____ (day) ____ (month) ____ (year)

Insured

Declaration on the Processing of Data concerning Health

For detailed information on data processing performed by UNIQA Biztosító Zrt. (hereinafter: "Insurer"), please refer to *Sections 113–117. of the Group Sickness Insurance Terms and Conditions and Privacy Notice*. I, the Undersigned, by making this Declaration,

- I declare that I am aware of the fact that, pursuant to the legislation in force, data concerning my physical, intellectual and mental condition, my addictions, and the circumstances of an illness or death, the cause of death or any data perceived, examined, measured, mapped or derived by the healthcare supply network; as well as any data that may be related to or affecting the above (e.g. behaviour, environment, occupation) qualify as data concerning health. I expressly consent to the processing by the Insurer of my data related to my health condition for the purposes of performing the insurance contract.
- I consent to the Insurer obtaining my data concerning health from all - legal or natural - persons providing healthcare services or performing the professional supervision or control thereof (e.g. family doctor, internal specialist), who/which manage my health and personal data. At the same time, I exempt these data controllers and other entities maintaining records of my health data based on legislative authorisation (e.g. National Health Insurance Fund of Hungary) from their confidentiality obligation and I consent to the transfer of my health and personal data by these data controllers and entities to the Insurer, and I consent to the transfer of my health data by the Insurer to these data controllers, and to the processing of such data by the Insurer in accordance with the provisions set forth hereunder. The purpose of data processing may be purposes required for the conclusion, modification, maintenance on the records of the insurance, the assessment of claims arising out of the insurance contracts (e.g. claims settlement and procedures related to the performance of the insurance service), or any other purpose specified in the Act on Insurance.
- If data are transferred to a third country pursuant to the GDPR, depending on the location of the insured event occurring, the Insured consents to the data provided to be transferred by the Insurer to a third country for the purpose of fulfilling its obligation contained in the insurance contract. Data transfer may only take place if, given the nature of the product, this is essential for the performance of the contractual service in order for the Data Subject to be provided healthcare abroad or to use services abroad.
- I declare that
 - my answers provided in the Healthcare Declaration are true.
 - I have made this Declaration regarding the processing and transfer of my health data voluntarily and having been properly informed.
 - I have acknowledged the data protection information contained in these provisions and the above referenced provisions of the Insurance Terms and Conditions and I have provided this consent voluntarily.
 - with this Declaration, I acknowledge that my eligibility as Insured will also cease to exist at the date of termination of the Cooperation Agreement, of which I shall be informed by the University.
 - I acknowledge that I am entitled to request information from the Insurer regarding the processing of my personal data, I am entitled to request a rectification, erasure or blocking of my personal data, and in the event of data processing deemed to be unlawful I am entitled to object to the processing thereof, and in the case of any infringement concerning the processing of my data I am entitled to seek assistance from the data protection officer of the Insurer (adatvedelem@uniqa.hu), the National Authority for Data Protection and Freedom of Information, and the court .
 - I acknowledge that at the time of this declaration, the care organiser service provider is Teladoc Hungary Kft. (registered seat: 1092 Budapest, Köztelek utca 6., company registration number: 01 09 864388) which, pursuant to a separate agreement concluded with the insurer, is entitled to organise care provision activity in respect of the insured persons within the framework of this insurance. The insurer is entitled to change the care organiser service provider – while notifying the policyholder of this fact – at any time during the term of the contract.

For the sake of legal completeness, the Insurer also publishes detailed Data Processing documents on its website and at its Customer Service Offices.

I declare that I have read, understood and acknowledged the above referenced data protection provisions of the Insurance Terms and Conditions and this Declaration.

Date: ____ (day) ____ (month) ____ (year)

Insured