Application form and registration sheet for insured persons

Date of receipt, ZP MV ČR stamp and signature

ZP MV ČR - code 211

The form will be processed electronically. Please fill it in legibly in block letters according to the prescribed handwriting pattern, preferably in black ballpoint pen. Mark the checkboxes with an x.

0 1 2 3 4 5 6 7 8 9 A Á B C Č D Ď E Ě F G H I Í J K L M N Ň O Ó P Q R Ř S Š T Ť U Ú Ů V W X Y Ý Z

1. Basic identification of the insured person

Last name

Name

Title *(optional)*

Former last name *(optional)*

Date of birth

Policyholder number (personal number) /

2. Permanent residence address and other identification data

PERMANENT RESIDENCE ADDRESS: Street

House number

Street number /

Sex male ❍ female ❍

Postcode

City

Provide the mother's policyholder number (pers. No.) for newborn infants /

Country

Citizenship

E-mail *(optional)*

Telephone *(optional)*

3. Mailing address *(optional)*

Street

House number

Street number /

Postcode

City

Country

4. Insured person category

A - category type

- ❍ **The premium payer is the STATE**
- ❍ **The premium payer is the EMPLOYER**
- ❍ **The premium payer is the insured person - self-employed**
- ❍ **The premium payer is the insured person - without income**

B - category specification if the premium payer is the STATE

- ❍ **a dependent child aged under 15** - no proof required
- ❍ **a dependent child aged 15 to 26** - provide proof of studies
- ❍ **a pensioner** - provide proof of old-age, disability, widow's/widower's or orphan's pension
- ❍ **a jobseeker registered with the labour office** - submit confirmation from the labour office
- ❍ **a person on maternity or parental leave, recipient of parental allowance** - submit proof of receipt of the benefit (maternity allowance or parental allowance), and notify your employer of the change of health insurance company if you are still employed
- ❍ **other category** - submit proof (see instructions)

5. Code and name of the existing health insurance company

Code

Name of health insurance company

Current insurance number

6. Validity date of the data, date of completion and signature of the insured person

With my signature I confirm my willingness to become an insured person with the Zdravotní pojišťovna ministerstva vnitra České republiky (hereinafter **"ZP MV ČR"**), and I declare that I have met the terms and conditions set forth for changing my health insurance company in Section 11a of Act No. 48/1997, on public health insurance, as amended.

With my signature I certify that I am aware that if this application for insurance is submitted between 1 April and 30 June, it will take effect on 1 July of the same year, and the change of health insurer will take place on 1 January of the following year. If this application is submitted between 1 October and 31 December, it will take effect on 1 January of the following year, and the change of health insurer will take place on 1 July of the following year.

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Explanatory notes on how to complete the items are given in the Instructions for this form. To fill in the form on a PC, you can use the electronic PDF form available on the website ***www.zpmvcr.cz***

Personal data is processed in accordance with Regulation (EU) 2016/679 (GDPR), and only for the purpose of providing public health insurance.

By signing this form, I certify that all the information about the insured person I have provided in this application is true and complete, and is provided voluntarily, knowingly and freely.

With my signature below, I confirm that **I have read the contents of the document "GDPR Information Memorandum" and that this document was given to me in printed form.** I have also been informed that the document in question is available on the website under the link https://www.zpmvcr.cz/ (in the "About Us" section) and at each health insurance company branch.

If a representative acts on behalf of the insured person:
By signing this application form for the insured person, on whose behalf I am authorized to act, I further confirm that all the information relating to my person which I have provided in this application form is true and complete and is given voluntarily, knowingly and freely. I am aware that I am obliged to prove my authority to act on behalf of the insured person by submitting the relevant legal title (document) at the request of ZP MV ČR.

Reason for changing your health insurance company *(This field is optional, but we would appreciate it if you could tell us your reason.)*

Please indicate one (main) reason that led you to register with ZP MV ČR.

- ❍ **referral by physician**
- ❍ **referral by a ZP MV ČR employee**
- ❍ **whole family with one insurance company**
- ❍ **referral by friends**
- ❍ **ZP MV ČR marketing campaign**
- ❍ **referral by employer**
- ❍ **ZP MV ČR benefits and above-standard services**
- ❍ **no comment**

Change of insurance company valid FROM

		.			.				

Completed on

		.			.				

Number of pages of attachments

Signature of the insured person (legal guardian)

Person verifying the identity of the insured person

Identification of the legal guardian

Name

Last name

Date of birth

Relationship to the insured

ZPMVČR 70.01/2021

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