

Admission Statement and identification data sheet

Please complete the form in block capitals, be sure to enter the information in bold and tick the appropriate boxes.

1. New member's data

To be completed by the new member.

Family and given name:

Family and given name at birth:

Mother's name at birth:

Place of birth: Date of birth: Sex: Male Female

Permanent address:
(postal code, city, street address)

Notification address: Nationality:
(postal code, city, street address)

Number of personal identity certificate document: Type*:

Taxpayer ID number: TAJ (social security number): Residence card number:

Bank account number:

The bank account number is required to transfer the consideration for the cash invoices that you wish to be cleared.

Telephone: E-mail (required if the consent in Section 6 is provided):

Name as it appears on the card (max. 20 characters)

Undertaking payment of the membership fee:

- I pay the membership fee individually, the membership fee I agree to pay is: HUF,
or% of my monthly wage, which is currently HUF

I undertake to pay the membership fee specified above, which shall be at least equal to the applicable standard membership fee (currently HUF 2000 per month).

Method of payment of the membership fee: Bank transfer Direct debit order**
 Cheque Employer deduction and transfer from net wage
 Card payment

- My employer will take over payment of the membership fee in whole or in part:
 as part of the cafeteria system according to my choice, which means a monthly amount of HUF
 as a monthly fixed amount of HUF
% of my wage, i.e. HUF per month

I agree to pay the above-mentioned membership fee in the form of an employer's contribution and, that if the amount of the employer's contribution is less than the applicable standard membership fee (currently HUF 2,000 per month), I will make an individual contribution to supplement it. I hereby authorize the Fund to consider the amount of the standard membership fee as my agreed membership fee, if I have not indicated the amount above. I acknowledge that I may supplement my membership fee on an individual or on a regular basis.

Payment of membership fee: Monthly Quarterly (in advance) Semiannually (in advance) Annually (in advance)

* Identity card / Card format diver's license / Passport / Valid residence permit

** If you choose to pay by direct debit order, please attach the relevant completed form, which can be downloaded from our website or requested from our customer service.

2. Switch Statement

Only to be completed when switching from another fund! To be completed by the new member.

Name of transferring fund: Number of membership document at the transferring fund:

I, the undersigned, hereby authorize the Fund to act on my behalf in connection with the switch at the above-mentioned voluntary health fund, mutual fund or health and mutual fund, and in connection to that to process my data classified as fund secrets. I hereby request that you terminate my membership with the above-mentioned voluntary health fund, mutual fund or health and mutual fund, and transfer the balance in my individual account to OTP Országos Egészség- és Önszegélyező Pénztár.

3. Designation of death beneficiaries

To be completed by the new member.

To designate more than two death beneficiaries, please complete the form "Designation of death beneficiaries".

(1) Family and given name: Participation (%):

Place of birth: Date of birth: Sex: Male Female

Family and given name at birth: Mother's name at birth: Nationality:

Permanent address:
(postal code, city, street address)

Postal address:
(postal code, city, street address)

E-mail: Telephone:

Number of personal identity certificate document: Type*:

(2) Family and given name: Participation (%):

Place of birth: Date of birth: Sex: Male Female

Family and given name at birth: Mother's name at birth: Nationality:

Permanent address:
(postal code, city, street address)

Postal address:
(postal code, city, street address)

E-mail: Telephone:

Number of personal identity certificate document: Type*:

I, the undersigned, declare that, in the event of my death I designate the person(s) named in this Admission Statement and identification data sheet as beneficiaries to the extent specified. I acknowledge that if no beneficiary is designated, OTP Health Fund will, subject to legal requirements, consider my legal successor (including the legatee) as the beneficiary, and that the designation of a beneficiary may be revoked or modified only in writing, by an authentic instrument or a private document of full probative force.

4. Designating close relative(s) entitled to use services

To be completed by the new member.

Here you can enter the details of the persons who are entitled to claim services from the Fund at the expense of your individual account. To name more than three close relatives, please complete the form "Designation of service beneficiaries".

(1) Family and given name: Type of relationship*:

Place of birth: Date of birth: Sex: Male Female

Family and given name at birth: Mother's name at birth: Nationality:

Permanent address:
(postal code, city, street address)

TAJ (social security number): Number of personal identity certificate document: Type*:

(2) Family and given name: Type of relationship*:

Place of birth: Date of birth: Sex: Male Female

Family and given name at birth: Mother's name at birth: Nationality:

Permanent address:
(postal code, city, street address)

TAJ (social security number): Number of personal identity certificate document: Type*:

(3) Family and given name: Type of relationship*:

Place of birth: Date of birth: Sex: Male Female

Family and given name at birth: Mother's name at birth: Nationality:

Permanent address:
(postal code, city, street address)

TAJ (social security number): Number of personal identity certificate document: Type*:

**The services organized and provided by the Fund in the manner specified in the Articles of Association of the Fund shall be available exclusively to Fund members or their close relatives in accordance with Act XCVI of 1993 on Voluntary Mutual Insurance Funds. Close relatives: spouse, direct relatives, adopted children, stepchildren, foster children, adoptive parents, step-parents and foster parents as well as siblings and the common-law spouse.*

5. Employer's undertaking of payment of the membership fee

To be completed by the Employer

To be completed in case your employer assumes payment of the membership fee in whole or in part under Act XCVI of 1993 on Voluntary Mutual Insurance Funds (Voluntary Mutual Insurance Funds Act).

Employer's name:

Registered office:

Tax number:

Bank account number:

Contact person's telephone number: Contact person's e-mail address:

I, the undersigned, hereby certify that, under Contract No currently in force between the Employer and the Fund, the employee is receiving an employer contribution specified in the applicable Employment Contract, which shall be paid for the employee starting from 1 20.... by the Employer on a monthly basis by bank transfer to the employee's bank account number 11703006-20411440 managed by the Fund. The Employer acknowledges that in addition to the transfers, it is required to send a declaration to the Fund using the form "Annex of Employer Transfer" or electronically via the Employer Portal.

Under penalty of perjury, I, the undersigned, hereby declare that the data entered in the Admission Statement and the identification data sheet are true, I have checked the identity of the new Fund member against the identification documents (the official certificate suitable for certifying personal identity and the official certificate of residential address), and I have checked the validity of those documents. I agree to inform the Fund of any change in the data presented in this Admission Statement or the identification data sheet within a maximum of 5 days of the change.

Date: 20....

Stamp

Employer's company signature

6. Representations*To be completed by the new member.***Registration for electronic administration**

Registration number of data processing: NAIH-62974/2013.

I, the undersigned, hereby authorize the Fund to send me the required documents, statements and certificates only in the form of electronic documents to the above email address. I acknowledge that the Fund will not send me printed copies by mail of forms, statements and other documents delivered to me in electronic copies. **The registration for electronic data reporting requires the email address (Section 1) and the signatures of two witnesses (Section 7).**

Yes No

Registration for membership-related electronic information (Newsletter)

Registration number of data processing: NAIH-53088/2012.

I, the undersigned, hereby authorize the Fund to send me by e-mail information relating to changes in the law regulating the scope of the service, the terms of use of the services, the accounting of goods and services, prize games and healthy lifestyle. We recommend that you opt for it so that you have up-to-date information about the Fund's services.

Yes No

Statement for sending advertising and marketing materials

Registration number of data processing: NAIH-54350/2012.

I, the undersigned, after being properly informed, in particular about the option that I may revoke this consent at any time, free of charge, by deleting my records (full name, permanent address, postal address, telephone numbers, e-mail) for advertising and marketing purposes, hereby provide my explicit consent to the above data to be processed by the Fund via its agent OTP Pénztárszolgáltató Zrt. (services for pension and health fund), and to send to my contact details advertising and marketing materials relevant to the members of the OTP Group, the Fund, OTP Pension Fund and the health fund service providers contracted by the Fund.

Yes No

The consents to data processing herein can be revoked even separately, at any time, without limitation and justification, by sending a letter to the Fund (mailing address: OTP Egészségpénztár, 1369 Budapest 5, Pf.: 362) or, free of charge, personally at our customer service (1133 Budapest, Váci út 76.), as well via e-mail to info@otpep.hu by providing the name, member ID and date of birth as identification data.

I acknowledge that, pursuant to Article 35/A of the Articles of Association, the fee of the BÁZIS health insurance package (HUF 119) provided to Fund members will be automatically deducted from my individual account and I have the right to cancel the insurance relationship in a separate statement at any time.

I, the undersigned, hereby declare that, acting on my own behalf and for my own benefit, I wish to become a member of the OTP Országos Egészség- és Önsegélyező Pénztár for the purpose of supplementary health care for myself and my close relatives. I have read and understood the Fund's Articles of Association and the Health Fund Card Usage Rules.

Under penalty of perjury, I declare that my data provided in this Admission Statement and the identification data sheet are true and valid. Based on the information pursuant to Articles 16 (1)-(2) of Act CXII of 2011 on the Right of Informational Self-Determination and the Freedom of Information, which is available on the Fund's website and I have read, provided that my agreed membership fee is paid by employer contribution in full or in part, I consent to transferring my data qualified as fund secrets by my employer to the Fund on paper or electronically for the purpose of facilitating the establishment of my fund membership and for the continuous payment of the membership fee. Furthermore, I agree that the Fund and OTP Pénztárszolgáltató Zrt., which provides fund management services to the Fund, process my data and, to the extent justified and necessary, forward it to entities involved in the provision of fund services.

I agree to inform the Fund of any change in the data presented in this Admission Statement or the identification data sheet within a maximum of 5 working days of the change, and that I will be liable for any loss or damage resulting from my failure to fulfil this obligation.

I, the undersigned, hereby declare that I am a member of another voluntary health fund, mutual fund or health and mutual fund:

Yes No

I, the undersigned, hereby declare that the data provided above are true and valid.

7. Signature and witness authentication*To be completed by the new member.*

New member's signature: **Date:**, 20....

Important! Signing up for the electronic data reporting specified in Section 6 requires two witnesses, and in addition to the signature, the witness shall also write his name and address by hand, in a legible manner, otherwise the statement in Section 6 will be invalid.

Witness #1 Name: **Witness #2 Name:**

Home address: **Home address:**

ID card no.: **ID card no.:**

Signature: **Signature:**

8. Admission agent's data and declaration of identity*To be completed by the Admission Agent*

I, the undersigned, declare that I have identified the new Fund member, and that the data contained in the Admission Statement and the identification data sheet are true, and, I have checked the identity of the new member against the identification documents (the official certificate suitable for certifying personal identity and the official certificate of residential address) with regards to the data in **Act LIII of 2017** on the Prevention and Combating of Money Laundering and Terrorist Financing, and I have checked the validity of those documents. *The identification statement must be signed by the person performing the identification (admission agent or any other person acting in that capacity, e.g. customer service representative).*

Date:, 20.... **Admission agent's signature:**

Name of company administering the admission: **Admission agent's ID:**

Date of endorsement:

.....
OTP Országos Egészség- és Önsegélyező Pénztár