

(Application form for a document confirming the right to healthcare in the European Union Member State of residence)

APPLICATION FORM FOR A DOCUMENT CONFIRMING THE RIGHT TO HEALTHCARE IN THE EUROPEAN UNION MEMBER STATE OF RESIDENCE

To the National Health Insurance Fund under the Ministry of Health

_____ (Date of application)

1. I REQUEST to issue of a document confirming the right to receive healthcare funded by the Compulsory Health Insurance Fund in the European Union (hereinafter - EU) Member State of residence _____:

(enter the name of the EU Member State)

- for me personally,
- for my family members.

2. Preferred date of entry into force of the document _____.

3. Institution of the place of residence to which the document must be submitted:

3.1	Name of the institution	
3.2	Code of the institution (if known)	

4. Data of the person insured under the compulsory health insurance in the Republic of Lithuania (hereinafter - the insured person) to whom the document is requested to be issued:

4.1	Name(s)	
4.2	Surname(s)	
4.3	Gender	
4.4	Personal identification number	
4.5	Date of birth	

5. Persons receiving a pension under the laws of the Republic of Lithuania certify that they:

5.1	<input type="checkbox"/>	do not receive a pension from another EU Member State
5.2	<input type="checkbox"/>	receive pension from _____ <i>(enter the name of the EU Member State)</i>

6. Date of declaration of departure to another EU member State or date of departure abroad (only for persons who are not considered to have changed their place of residence):

_____.

7. Address of the insured person in the EU Member State of residence:

7.1	Street	
7.2	Building No	
7.3	Apartment No	
7.4	City	
7.5	Post code	
7.6	Region	
7.7	Country	
7.8	Telephone	
7.9	E-mail	

8. Details¹ of the family member requiring an S1 document:

8.1	Name(s)	
8.2	Surname(s)	
8.3	Gender	
8.4	Personal identification number	
8.5	Date of birth	
8.6	Information about the status of the family member in the EU member State of residence:	
8.6.1	<input type="checkbox"/>	works in the EU Member State of residence
8.6.2	<input type="checkbox"/>	receives _____ pension (<i>enter the name of the EU Member State</i>)
8.6.3	<input type="checkbox"/>	is insured with social insurance in the EU Member State of residence
8.6.4	<input type="checkbox"/>	Is not insured with social insurance in the EU Member State of residence

9. A person wishing to receive a paper copy of a document shall indicate the method of obtaining it:

- Sent by e-mail to the address specified in subparagraph 7.9.
- Sent to the address specified in point 7.
- I will collect it in person at the National Health Insurance Fund under the Ministry of Health.

I UNDERTAKE to inform the National Health Insurance Fund under the Ministry of Health about the termination of the validity of the compulsory health insurance for me and/or my family members specified in the document

(Signature, name and surname of the person applying for the document)

I HAVE BEEN INFORMED that:

- The data I have provided will only be used for the purposes of issuing/terminating my entitlement to benefits in the EU Member State of residence.
- Information on the procedure for implementing the rights of data subjects in the National Health Insurance Fund under the Ministry of Health is available on the website www.ligoniukasa.lrv.lt;
- In accordance with the Order of the Minister of Social Security and Labour of the Republic of Lithuania and the Minister of Health of the Republic of Lithuania of 28 July 2010 No A1-376/V-676 “Regarding the designation of the institutions responsible for the implementation of the regulations on the coordination of the social security systems of the European Union”, the

¹ This section must be completed as many times as there are family members going together.

National Health Insurance Fund under the Ministry of Health has the right to apply to the relevant institutions for the missing information necessary for the implementation of the provisions of the regulations on the coordination of social security systems.

(Signature, name and surname of the person applying for the document)
