

The institution which the application is submitted to

Name (s)											
Surname (s)											
Personal number											
ID number of the insured											
Address (to be filled in if you wish to receive the response by mail)											
E-mail address (filled in if you prefer to receive the response by e-mail)											
Other contact information (phone number or, if necessary, references and/or numbers of other electronic means of communication)											

**APPLICATION  
TO APPROVE THE PERIOD OF VALIDITY OF COMPULSORY HEALTH INSURANCE  
WITH STATE FUNDS (for a person raising a child (children))**

2 0   -   -

1. In accordance with the description of the data processing procedure of the Register of Persons Insured with Compulsory Health Insurance, I hereby submit personal data and ask to confirm the validity period of compulsory health insurance with state funds as I am raising a child up to 8 years old or two or more minor children:

Personal number											
Personal number											
Personal number											
Personal number											

2. Please confirm the period of validity of the compulsory health insurance from (tick or enter the appropriate date):

Date of birth of the child											
Other dates ( <i>enter</i> )											

3. I hereby confirm that I do not work and (or) am not covered by compulsory health insurance in another country of the European Union, the European Economic Area and the Swiss Confederation.

4. I hereby confirm that as one of the parents (adoptive parents) raising a child up to eight years old or two or more minor children, I would like to be insured by the family's choice with the state funds.

5. I am aware that parents cannot be insured with state funds if they do not raise children and according to the Civil Code of the Republic of Lithuania have lost their parental rights or their parental rights are no longer valid (in the cases when child (children) is (are) separated from their parents by a court decision or the authority of the parents is limited temporarily or indefinitely).

**To be filled in by the father (adoptive) / mother (adoptive) of the minor child(ren) who is raising child(ren) alone**

6. I hereby inform you that I am raising my child(ren) alone, and (*tick the appropriate and enter the necessary information*):

I hereby declare that the marriage with the father/mother (adoptive) of the child(ren) is terminated (or we live separately), the place of residence of the child(ren) is determined with me by a court decision, and I hereby attach the court decision.

Please terminate the period of validity of the child's father (adoptive) / mother (adoptive) compulsory health insurance with the state funds (if he is insured as one of the parents) from the date of the court decision, because the child's father (adoptive) / the mother (adoptive) **does not raise the child(ren)**, and I hereby provide his/her personal data:

Personal number												
-----------------	--	--	--	--	--	--	--	--	--	--	--	--

or name, surname, date of birth \_\_\_\_\_.

Unilaterally for objective reasons\* \_\_\_\_\_

\_\_\_\_\_ (*indicate the reasons*) please terminate the period of validity of the compulsory health insurance of the child(ren)'s father (adoptive) / mother (adoptive) with the state funds (if he/she is insured as one of the parents) from the date of \_\_\_\_\_ (specify date) because the father (adoptive) / mother (adoptive) of the child(ren) **does not raise the child(ren)**, and I hereby provide his/her personal data:

Personal number												
-----------------	--	--	--	--	--	--	--	--	--	--	--	--

or name, surname, date of birth \_\_\_\_\_.

\* Cases confirmed by a court decision or other documents (data) are considered objective reasons, when one of the child's parents (adoptive parents) is detained or serving a sentence, or is subject to a court decision regarding indefinite (term-limited) restriction of parental authority, or is permanently lives abroad, is missing, has formed another family, etc.).

7. I hereby provide additional information / attach: \_\_\_\_\_

8. I hereby declare that all the information I have provided is correct. I know that my application would be rejected or the period of state funds validity of **my compulsory health insurance with the state funds, which has already been established, would be cancelled due to false data, claiming damages from the budget of the Compulsory Health Insurance Fund.**

9. I am informed that my personal data will be processed in accordance with item c of paragraph 1 of Article 6 of the Regulation (EU) 2016/679 and only for the purposes of compulsory health insurance<sup>1</sup>.

10. I promise to **immediately inform the health insurance fund** about the changed data specified in this application.

11. Please submit the response to the application (*put a tick in the appropriate box*):

11.1. to the official postal address specified in writing;

11.2. to the specified e-mail address;

11.3. Other way/form \_\_\_\_\_ (*indicate how you would like to receive the response*);

11.4. I do not wish to receive a written response.

\_\_\_\_\_  
*Name, surname, signature*

<sup>1</sup> Information on the exercising of data subject rights: <https://ligoniukasa.lrv.lt/lt/asmens-duomenu-apsauga>