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 nurser or caretaker of a disabled person)

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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, because (*indicate by a check mark in the appropriate box*):

☐ 1.1. I nurse my child with a determined level of disability (disabled child), or a person with a special need for permanent care or a special need for permanent care (assistance) at home, or I take care of a disabled person with total disability, whose disability was recognized before 1 July 2005, and I provide his data:

Personal number											

☐ 1.2. I am appointed as the caregiver or guardian (curator) of a disabled person whose level of disability has been determined (disabled child), or a person who has been determined to have a special need for permanent nursing or a special need for permanent care (assistance), or a disabled person with total disability, whose disability was recognized before 1 July 2005, and I hereby submit an executive document with data on recognition as a guardian (curator) and the periods of guardianship (curatorship) or the decision of the Director of the Disability and Working Capacity Assessment Office at the Ministry of Social Security and Labour or his authorized person on appointment as a caregiver of a disabled person.

Nursed person:

Personal number											

☐ 2. 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.

☐ 3. I hereby declare that all the information I have provided is correct. I know that my application would be rejected or the period of validity of **my compulsory health insurance, which has already been established, would be cancelled due to false data, and the damage caused to the budget of the compulsory health insurance fund will be recovered from me**.

4. 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[1].

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

5. I promise to **notify the Health Insurance Fund immediately** if there are any changes to the information provided in this application.

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

□ 6.1. to the official postal address specified in writing;

□ 6.2. to the specified e-mail address;

□ 6.3. Other way/form _____ (*indicate how you would like to receive the response*);

□ 6.4. I do not wish to receive a written response.

7. ATTACHED (*indicate the number of pages of the attached document*): _____ .

Name, surname, signature