National Tax and Customs Administration

20T1011

DATA SHEET FOR REPORTING DATA AND CHANGES

for taxpayers obliged to pay health services contributions

Place of bar code

TO BE FILLED OUT BY THE AUTHORITY

Date of arrival 2 0 ☐☐☐☐☐☐

Code of receiving person ☐☐☐☐☐☐

Date of mailing 2 0 ☐☐☐☐☐☐

2 0 ☐☐☐☐☐☐ Date

PoS

Signature

TO BE FILLED OUT BY THE DECLARANT

1. **Statement relating to the declarant's tax ID code / tax ID number:**

Do you have a tax ID code? ☐ Yes (1), no (2), if yes, please indicate the number: ☐☐☐☐☐☐☐☐☐☐

Do you have a tax ID number? ☐ Yes (1), no (2), if yes, please indicate the number: ☐☐☐☐☐☐☐☐ — ☐ — ☐☐

2. Social security identification code: ☐☐☐☐☐☐☐☐☐

3. **Declarant's identification data and statements**

Actual name ☐

Name at birth

Mother's name at birth ☐

Place of birth: Date of birth: ☐☐☐☐☐☐☐☐ year month day

Domicile ☐☐☐☐ postal code town, township name of public place

type of public place number/topographical lot number number of building staircase floor door

Nationality ☐☐

Type of the document attached by the non-Hungarian citizen: ☐

1.-settlement permit, 2.-immigration permit, 3.-registration certificate, 4.-residence card, 5.-permanent residence card, 6.-identity card

STATEMENTS

I, the undersigned, hereby declare that I am an EEA citizen and the issue of registration certificate is in progress. ☐

I, the undersigned, hereby declare that I do not have any insurance relationship existing in other EEA country or abroad. Personal scope of none of international convention concluded by Hungary covers me or I do not have either social insurance engendered in the social security system of an international organization, respectively. ☐

Declarant's telephone number

Postal address for data sheet country ☐☐☐☐☐☐☐☐☐☐ town/township

name of public place type of public place number number of building staircase floor door ☐

Type of report, correction of former report:

4. Type of report: ☐

1 – Commencement of contribution payment obligation
2 – Termination of contribution payment obligation (can be reported only if you have previously reported the commencement of contribution payment obligation)
3 – Commencement and termination of contribution payment obligation (with retroactive effect, solely)

Registration number of the Data Sheet to be corrected based on the notice of the tax authority ☐☐☐☐☐☐☐☐☐☐

Being aware of my legal liability, I declare that the data I provided do reflect the truth.

locality

☐☐☐☐☐☐☐☐
year month day

name of taxpayer or representative (proxy)

signature of taxpayer or representative (proxy)

Please mark with an 'X' if you are a proxy and your Power of Attorney is attached! ☐

Please mark with an 'X' if you are a permanent proxy duly registered with the tax authority and entitled to sign this form. ☐

Please note that the Data Sheet, when it is submitted on paper, is void without bearing a signature!

20T1011-A	**Declarant's name:** _____ **Declarant's tax ID code:**

STATEMENT ON PAYMENT OBLIGATIONS

I, the undersigned, hereby declare that, pursuant to the Article 39 (2) of the Act LXXX of 1997 on the Eligibility for Social Security Benefits and Private Pensions and the Funding for These Services (Tbj), I am obliged to pay health services contributions as a Hungarian resident because I do not have any insurance relationship and I am not entitled to receive health services pursuant to points a) to p) and s) to w) of the Article 16 (1) of this Act as well as to provisions of the Article 13 of the Tbj., either.

In the case of fulfilling my obligation to pay health services contributions, I become eligible to claim in-kind health services.

Pursuant to the Article 45/A (1) of the Tbj, I am obliged to declare, in writing and within 15 days, all changes in payment of the health services contributions to the state tax and customs authority

1. Date of commencement of my obligation to pay health services contributions: ☐☐☐☐☐☐☐☐ (year month day)

STATEMENT ON FULFILLMENT OF PAYMENT OBLIGATION BY REMITTANCE

I wish to fulfill my payment obligation by remittance ☐

The remittance must be performed to the NTCA tax collection account for revenues owed to the Health Insurance Fund by private individuals, small-scale agricultural producers, private entrepreneurs and paying agents **(account number: 10032000-06056229).**

Report in relation to take-over of contribution payment:

Name / denomination of person / company taking over the contribution payment:_____

Tax ID number: ☐☐☐☐☐☐☐☐ — ☐ — ☐☐ Tax ID code: ☐☐☐☐☐☐☐☐☐☐

2. Starting date of the take-over: ☐☐☐☐☐☐☐☐ (year month day)

Closing date of the take-over: ☐☐☐☐☐☐☐☐ (year month day)

_____
signature of person or company taking over the payment

STATEMENT ON THE STATUS WITHOUT INSURANCE RELATIONSHIP, WHICH ESTABLISHES THE OBLIGATION OF PAYING HEALTH SERVICES CONTRIBUTIONS, PURSUANT TO THE ARTICLE 8 OF THE TBJ

3. I, the undersigned, hereby declare that, as an attorney / notary public / patent administrator / private entrepreneur having a tax ID number, I do not carry out any economic activity.
Starting date of discontinuation of my economic activity: ☐☐☐☐☐☐☐☐ (year month day)

20T1011-B	Declarant's name: _____ Declarant's tax ID code:

STATEMENT ON TERMINATION OF CONTRIBUTION PAYMENT OBLIGATION AND ITS DATE:

I, the undersigned, make an announcement by this statement concerning the fact that closure date of my contribution payment obligation:

year month day

1. Reason for termination of contribution payment obligation: (filling out is mandatory!)

1 – Establishing a relationship coming with insurance
3 – Becoming entitled to receive health services, pursuant to points a) to p) and s) to w) of the Article 16 (1) of the Tbj and to the Article 13 of the Tbj
5 – Erroneous registration
6 – Other reason

When reporting the date of termination of contribution payment obligation, in each case a documentary certificate must be attached to the Data Sheet, which certifies the further entitlement to health insurance.

Report in relation to take-over of contribution payment:

2. Name / denomination of person / company taking over the contribution payment:_____

Tax ID number: — — Tax ID code:

Starting date of the take-over:

year month day

Closing date of the take-over:

year month day

_____

signature of person or company taking over the payment