

With this form, I apply for an insurance relationship with the Otanmäki health insurance fund.

The insurance relationship must be applied for within **twelve (12) months of the start of the employment relationship** or the employer's affiliation with the sphere of activity.

The insurance relationship begins at the beginning of the calendar month following receipt of the application, provided that the insurance conditions are met. The health insurance fund sends the decision and the membership card separately.

A person who, without terminating the employment relationship, has previously resigned from the Otanmäki health insurance fund, cannot rejoin a sickness insurance fund during the same employment relationship.

***My employment started** ____/____ 20____ **(*attach a copy of the employment contract)**

***Employer's name/place of business**

***Surname**

***Forenames**

***Social security number**

***Bank account number IBAN**

***Street address, postal code and city**

***Telephone number**

***E-mail address**

I undertake to inform the health insurance fund of any changes to the above information, periods of unpaid absences and the date of termination of employment.

I agree that the information I have provided will be stored in the insurance register of the health insurance fund (my personal data is processed for the purpose of managing the insurance relationship), my insurance relationship is recorded in the employer's personal data register for the collection of insurance contributions, and the employer can notify the health insurance fund of any changes in the collection of insurance contributions (termination of employment/unpaid absences).

***Date**

***Signature**

*** Must fill in**

Note! A copy of the employment contract must be attached to the application.

Referrer (must be a member of a health insurance fund):

Name and telephone number of the person who recommended the health insurance fund to me:

Name of referrer

Phone number

(The health insurance fund will give a gift to the referee if the application to join is approved)

RETURN THE FORM TO THE OTANMÄKI HEALTH INSURANCE FUND OR TO THE MAILBOXES OF THE HEALTH INSURANCE FUND (AT THE FACTORY):

Otanmäen sairauskassa, Kokkolantie 1791, 88200 Otanmäki
puh. 040 680 5480 (Mon and Wed 9 am -3 pm)

www.otanmaensairauskassa.fi