Zorg en Zekerheid

Authorisation form for health insurance policy with Zorg en Zekerheid

Postbus 400, 2300 AK Leiden
T. (071) 5 825 825
F. (071) 5 825 011
zorgenzekerheid.nl
K.v.K. Leiden 28050216
AFM nummer 12001019

I, the employee : ______________________
Initials: ______________________
Surname: ______________________
Date of birth: ______________________
Social security number: ______________________

Hereby authorise (name of employer)
______________________ in (town/city) ______________________

To complete the following on my behalf until this authorisation is rescinded:

- ☐ take out health insurance and any supplementary insurance with Zorg en Zekerheid for me as the policyholder (and sole insured person) with effect from the date of employment;
- ☐ provide my BSN/social security number and other necessary information to Zorg en Zekerheid for the registration/cancellation of my policy;
- ☐ cancel the health insurance policy and any supplementary insurance from the date of the termination of employment unless the health insurance obligation remains in effect;
- ☐ pay the premium for the health insurance and any supplementary insurance referred to above to Zorg en Zekerheid on my behalf in a timely fashion;
- ☐ deduct from my wages the payments referred to above that are due to Zorg en Zekerheid if necessary;
- ☐ submit health insurance claims, payment of which will be made to my employer/employment agency or directly to the health care provider
- ☐ forward my postal address as the address of the head office of ______________________
  This address shall serve as the postal address until I specify an alternative (postal) address; ______________________

- ☐ have access to deductible expenditure and to pay these invoices for me or deduct the amount from my wages.

I hereby give/do not give (delete as appropriate) my express consent for
(name of employer) ______________________
and its designated employees to assist me with the administration of the insurance or to perform this on my behalf and to therefore have access to all necessary (medical) information.
This is in accordance with the Dutch Data Protection Act (Wet bescherming persoonsgegevens).

Date: ______________ Place: ______________________

Name and signature of employee: ______________________

8-079-2017