REPUBLIC OF CYPRUS
MINISTRY OF HEALTH

APPLICATION FOR MEDICAL CARD

Asylum Seekers

PERSONAL DETAILS OF APPLICANT

Alien Registration Certificate No. (A.R.C): ______________________

Name: ________________ Surname: ____________________

Date of Birth: ____/____/____ Nationality: ____________________

REQUIRED DOCUMENTS

☐ Alien Card (Copy)

☐ Confirmation Letter (Copy)

DEPENDANTS

Name	Alien Registration Certificate No. (A.R.C)	Date of Birth	Gender (Male/Female)
(Of Spouse)			
________________	________________	___/___/___	________________
(Of Dependant Children)			
________________	________________	___/___/___	________________
________________	________________	___/___/___	________________
________________	________________	___/___/___	________________
________________	________________	___/___/___	________________

Address:

Street: ______________________ No.: ________ Town/Village: ____________________

P.O.Box: ____________ Post Code: ______________ District: ________________

Mobile Tel: ____________________

☐ Send my card by post

DECLARATION

I hereby declare that all the information contained in this application, as well as the certificates and supporting documents accompanyin this application, are true and accurate and that I authorize the Ministry of Health to seek confirmation from any Government Service.

The personal data concerning my person and given by me shall be kept in a filing system and be subject to lawful processing in th meaning of the Regulation (EC) 2016/679 of the European Parliament and of the Council of 27 April 2016, as applicable, by the Controlle who is the Ministry of Health, for the purpose of examining my application for European Health Insurance Card. The recipients of the dat shall be the competent personnel of the Ministry of Health. The personal data included in the file systems kept by the Ministry of Healt Administration Service may be communicated or transmitted between the government services concerned. The management an processing of my personal data shall be done securely and confidentially and shall be subject to the relevant provisions of the legislatio in force

I am also informed that I have the right to information, access and objection and deletion on the personal data concerning my person given under sections 13, 14, 15, 16, 17, 18 and 19 of Regulation (EC) 2016/679 of the European Parliament and of the Council of 27 Apri 2016, in respect of which I can apply to the Controller (Ministry of Health).

Date: ..../......./20........

Signature: ....

In case the application is submitted by a representative:

Name of representative: ____________________

Identity Card No: ____________________

Signature: ____________________

The competent authorities issuing medical cards may request any other documentation deemed necessary.