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**Application of another insured person for maternity benefit**

**Another insured person claiming maternity benefit:**

Name and surname of the insured person (mandatory field)

Birth number/birth date in the case of a foreigner (mandatory field)

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| 1. **As a father of a child/children up to six weeks from the date of birth, I am claiming maternity (paternity) benefit from .................... to .................... (usually not later than six weeks from the date of birth) in connection with the care of the child/children (maximum 14 days)**

name, surname, birth number of the child (birth date in the case of a foreigner)name, surname, birth number of the child (birth date in the case of a foreigner) name, surname, birth number of the child (birth date in the case of a foreigner).**I am applying for an extension** of the six-week **support period** on the grounds that the child named. was in the inpatient care of a health facility for six weeks from the day of birth due to an adverse health condition on the part of the child or its mother (beyond the standard length of postpartum care) from ................. to ..... ......... ... (doctor's report/certificate is enclosed).**If you are not applying for an extension of the support period, please, do not fill in this section.****B. As another insured person, I am claiming maternity benefit from ................ , i.e., from the**  **day I take care of the child/children, until the child reaches three years of age** name, surname, birth number of the child (birth date in the case of a foreigner) name, surname, birth number of the child (birth date in the case of a foreigner)name, surname, birth number of the child (birth date in the case of a foreigner) |

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| **Employer’s confirmation:** Paternity leave / Parental leave / Maternity leave provided from ......... ........... to ....t................ Last day of work was on....... Date:  Imprint of the stamp and signature of the employer |

**Part A** to be filled in by the child's father, who claims the so-called paternity benefit.

**Part B** to be filled in by another insured person who is applying for maternity benefit.

More detailed information on entitlement to benefits and the calendar for payment of benefits is available on the website of the Social Insurance Agency.

**Instruction: If there is a change in the facts stated in this application, it is necessary to submit a new Application of another insured person for maternity benefit.** Filing a new application will not affect the start of the procedure for the right to maternity benefit (the procedure starts on the basis of the original application).

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**Declaration of the Insured Person**

**Name and surname of the insured person** (mandatory field)

Correspondence address (if it is different from the address of permanent residence)

Phone number or e-mail contact (optional)

**I am claiming my right to the maternity benefit and the right to its payment from the date indicated on the first page of this application. I declare that all information in this application is true. I am aware of the obligation to report all facts affecting the right to maternity benefit, especially early termination of paternity leave / parental leave / maternity leave, or termination of the child care for another reason.**

**Insurance relationship from which I am claiming the maternity benefit\***

□ □ employee (indicate the name and address of your employer)

□ □ a self-employed person with compulsory sickness insurance

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□ □ person with voluntary sickness insurance

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I □ do apply\*/ □ do not apply\* the maternity benefit also from other sickness insurance. In the event that the insured person wants to claim maternity benefit from several sickness insurances, he/she must submit a separate application for each sickness insurance.

I request that the sickness insurance period completed in an EU Member State, an EEA State, the Swiss Confederation, the United Kingdom of Great Britain and Northern Ireland or in a State with which the Slovak Republic has an agreement on social security in the last two years before the date from which I am claiming maternity benefit be taken into account.

Please indicate the name of the institution with which you were insured for the purposes of maternity cash benefit

Address of the institution: street number

zip code city state

**I request payment of the maternity benefit\***

**□ to an account in (IBAN) format**

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Additional data (only for a foreign account, otherwise do not fill in)

SWIFT code of the bank

Full name of the bank

Bank address (street, number, zip code, city and state)

**□ in cash to the address** (street, number, zip code, city)

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The benefit is transferred to the bank account or branch of a foreign bank specified in the application or in cash to the address specified in the application. If the account number or the benefit payment address is not specified in the application, the Social Insurance Agency will pay the benefit to the address of the insured person's permanent residence via Slovenská pošta, a.s. (Slovak Post Office).

**I agree** with processing of my personal data in the information system of the Social Insurance Agency. If the benefit is paid to the address, I agree that Social Insurance Agency provides Slovenská pošta, a. s. (Slovak Post Office) my personal data. I am aware that I am obliged to prove all the facts decisive for the creation, duration and termination of the right to the benefit, the right to its payment and the amount.

**With my signature, I confirm the completeness and truthfulness of the data.**

(Without signature of the insured person and without indication of the date from which he/she is entitled to the maternity benefit, the maternity benefit proceedings will be suspended.)

Date: Signature of the insured person

\*Please mark x as appropriate.