**Application Form for Withdrawal from National Health Insurance for Faculty/Staff and Project Personnel (Dependents) at Kaohsiung Medical University**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Insured Person’s Name |  | | Employee ID No. | | | |  | | | | | | | | | National  ID No. |  | |
| ※If only the dependent is withdrawing, please do not fill in the withdrawal date and reason for  the insured person below. | | | | | | | | | | | | | | | | | | |
| Date of Suspension/  Withdrawal | Year/Month/Day | | Reason for Suspension/  Withdrawal | | | * Change of insurance organization * Scheduled to go abroad for more than six months * Change of dependent relationship □other | | | | | | | | | | | | |
| Dependent's Name |  | National  ID No. | |  |  | | |  |  |  |  |  |  |  |  | Reason for Withdrawal/  Transfer out | | * Change of insurance  organization * Change of dependent relationship * Deceased * Other\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date of Withdrawal/  Transfer out | | YYYY/MM/DD | | | | | | | | | | | |
| Dependent's Name |  | National  ID No. | |  |  | | |  |  |  |  |  |  |  |  | Reason for Withdrawal/  Transfer out | | * Change of insurance  organization * Change of dependent relationship * Deceased * Other\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date of Withdrawal/  Transfer out | | YYYY/MM/DD | | | | | | | | | | | |
| Dependent's Name |  | National  ID No. | |  |  | | |  |  |  |  |  |  |  |  | Reason for Withdrawal/  Transfer out | | * Change of insurance  organization * Change of dependent relationship * Deceased * Other\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date of Withdrawal/  Transfer out | | YYYY/MM/DD | | | | | | | | | | | |
| In accordance with Article 8 of the Personal Data Protection Act, Kaohsiung Medical University hereby informs you of the following matters when collecting your personal data:   1. **Name of the Collecting Organization:** Kaohsiung Medical University 2. **Purpose of Collection:** The purpose of collecting personal data of you and your dependents is for the withdrawal from National Health Insurance. The legal specific purpose is: 002 Personnel Management. 3. **Categories of Personal Data Collected:** Identification Information (C001, C003) 4. **Period, Region, Recipients, and Method of Use:**   (1)The University will use your personal data within the Taiwan region (including Penghu, Kinmen, Matsu, and Lienchiang). The period of use is during your employment.  (2)The method and recipient of use: During the aforementioned period, your (and your dependent’s) personal data will be submitted to the National Health Insurance Administration for withdrawal processing.   1. **Rights of the Data Subject:** According to Article 3 of the Personal Data Protection Act, you may request to review, supplement, correct, obtain copies, or request to stop collection, processing, or use, and request deletion of your personal data. Please contact the Human Resources Office at the University to exercise these rights. 2. **Consequences of Not Providing Data:** Failure to provide the required information may affect the processing of your and your dependent's National Health Insurance withdrawal. 3. **Responsibility of the Declarant:** The person filling out this form guarantees lawful authority to provide personal information of dependents and must inform the dependents of the above-mentioned notice. | | | | | | | | | | | | | | | | | | |

**I have** **thoroughly read and fully understood the above notification.**

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Date:** \_\_\_\_\_\_ (YYYY) / \_\_\_\_\_\_ (MM) / \_\_\_\_\_\_ (DD)

Revised on 2014-12-05