

PARTNER / BENEFICIARY - HOLDER

(Employee of an employer covered by the IRT clause referring to SAMS)

☐ Registration ☐ Readmission ☐ Update

Membership No. _____ Beneficiary No. _____

Full name (as per official ID): _____

Residence (full address)

Street, avenue _____ No. _____ Floor _____

City/Town _____ Postcode _____ - _____ Postal designation _____

Country _____

Preferred telephone no. _____ Secondary telephone no. _____ Email _____ Nationality (country) _____

Date of birth (YYYY/MM/DD) _____

Sex

☐ Male ☐ Female

Marital Status⁽¹⁾ ☐

Taxpayer no. _____

ID no. Res. perm. Passp. Birth cert. _____

Number _____

Education (optional) _____

Credit institution _____

Workplace _____

Serv./organisation structure _____

Degree Group Level _____

Category _____ Post _____ Professional situation⁽²⁾ ☐

Date of admission (YYYY/MM/DD)
At the credit institution In the banking sector

If occasional
Contract start date Contract end date

Official health services user:

SNS user ☐ SRS user - Azores ☐ SRS user - Madeira ☐ No. _____

If you are covered by another body, please state:

No. _____

Description of organization _____

Holder

☐ Yes ☐ No

I authorise the amount of the reimbursement and other credits attributed to me be processed by bank transfer, **for myself and my household**, for which purpose I provide the following information.

IBAN

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(1). Marital status: single, married, widow, divorced, separated.

(2). Professional situation: employed, occasional, retired, pensioner, child pens., pre-retir.

REQUIRED DOCUMENTS (amongst others considered necessary by Mais Sindicato or SAMS):

- . Citizen card
- . Residence permit or passport (foreigners)
- . Organization card

- and:
- . if occasional - statement from the employer, confirming the date of admission, duration and professional status;
 - . if pensioner - statement from the credit institution responsible for paying the pension, confirming the situation and the respective start date, or photocopy of the pension receipt.

Holder's full name (as per official ID)

Credit institution

Workplace

I hereby authorize the deduction from my salary or retirement pension of the following discounts:

☐

Union membership, statutorily established, that is, 1% while on the job or 0.5% when retired or disabled, to be credited to MAIS Sindicato.

☐

0.5% contribution to the Union Assistance Fund,⁽¹⁾ to be credited to SAMS.

This declaration can only be revoked at my request and after informing Mais Sindicato, **and shall be valid in a transfer situation to another Credit Institution covered by the IRT clause referring to SAMS.** I further declare that I will communicate a change of employer.

(1). FSA - Union Assistance Fund - Special system that allocates reimbursements as per SAMS regulations.

I hereby authorise the deduction on my salary or retirement/survivor's pension for the payment of services provided by Mais Sindicato and/or SAMS, **for myself and my household.**

I declare that I was made aware of and accept the Regulations and Complementary Standards of SAMS, accessible on www.mais.pt.

I hereby authorise that the information and personal data provided in this form, as well as that obtained by Mais Sindicato and SAMS through the provision of services, is treated and maintained digitally, and that its recipients are the internal services of Mais Sindicato or SAMS. Without prejudice to the above, Mais Sindicato or SAMS may provide third parties with personal data of which they are recipients, strictly insofar as such data are necessary, adequate and relevant for the provision of services and the respective billing, ensuring information security in accordance with the GDPR.

Mais Sindicato is responsible for processing the data contained in this form, in accordance with the respective Privacy Policy, and will ensure its holders' rights to access, rectification, elimination, limitation, portability and opposition, whenever legitimately requested in writing.

The completion of this form is mandatory for registration readmission or update of data related to the status of Member of the Mais Sindicato or Titular Beneficiary of SAMS.

Holder

Date (YYYY/MM/DD)

(Signature as per official ID)

To be completed by our services

Proponent	Services
Date	Date
Signature	Signature
Email	