INSTRUCTIONS FOR COMPLETING THE DECLARATION

Affix a company stamp or enter the company details (at least the name).

Enter your personal data and contact details. Minimum scope of data: first name, last name, date of birth, personal ID number/PESEL (if no personal ID number is available, enter the passport number).

Enter the details of all declared Co-insured Parties. Minimum scope of data: first name, last name, date of birth, personal ID number/PESEL (if no personal ID number is available, enter the passport number).

If the address of the Co-insured Party is the same as yours, you do not need to fill it in again.

Check the insurance type of your choice.

DECLARATION OF ACCESSION TO INSURANCE:

☐ DECLARATION OF ACCESSION ☐ DECLARATION OF CHANGES

Policyholder

Insurance type

☐ Individual ☐ Family

☐ Partner ☐ Parent

Main Insured Person details

First name and surname: .....

Personal ID No (PESEL): ..... Date of birth: .....

Gender: ☐ F ☐ M

When the person joining the insurance is a foreign national:

Nationality: .....

Passport No: .....

Address for correspondence: .....

City: ..... Postal code: .....

Street: ..... Street No/Flat No .....

Contact details:

Home telephone number: ..... Mobile telephone: .....

Email: .....

1. Co-insured

Family relationship towards the Main Insured Person:

☐ Spouse ☐ Partner ☐ Child ☐ Parent

First name and surname: .....

Personal ID No (PESEL): ..... Date of birth: .....

Gender: ☐ F ☐ M

When the person joining the insurance is a foreign national:

Nationality: .....

Passport No: .....

Mailing address *(insert if the mailing address is different from the address of the Main Insured Person)*:

City: ..... Postal code: .....

Street: ..... Street No/Flat No .....

Contact details:

Home telephone number: ..... Mobile telephone: .....

Email: .....

2. Co-insured

Family relationship towards the Main Insured Person:

☐ Spouse ☐ Partner ☐ Child ☐ Parent

First name and surname: .....

Personal ID No (PESEL): ..... Date of birth: .....

Gender: ☐ F ☐ M

When the person joining the insurance is a foreign national:

Nationality: .....

Passport No: .....

Mailing address *(insert if the mailing address is different from the address of the Main Insured Person)*:

City: ..... Postal code: .....

Street: ..... Street No/Flat No .....

Contact details:

Home telephone number: ..... Mobile telephone: .....

Email: .....

3. Co-insured

Family relationship towards the Main Insured Person:

☐ Spouse ☐ Partner ☐ Child ☐ Parent

First name and surname: .....

Personal ID No (PESEL): ..... Date of birth: .....

Gender: ☐ F ☐ M

When the person joining the insurance is a foreign national:

Nationality: .....

Passport No: .....

Mailing address *(insert if the mailing address is different from the address of the Main Insured Person)*:

City: ..... Postal code: .....

Street: ..... Street No/Flat No .....

Contact details:

Home telephone number: ..... Mobile telephone: .....

Email: .....

4. Co-insured

Family relationship towards the Main Insured Person:

☐ Spouse ☐ Partner ☐ Child ☐ Parent

First name and surname: .....

Personal ID No (PESEL): ..... Date of birth: .....

Gender: ☐ F ☐ M

When the person joining the insurance is a foreign national:

Nationality: .....

Passport No: .....

Mailing address *(insert if the mailing address is different from the address of the Main Insured Person)*:

City: ..... Postal code: .....

Street: ..... Street No/Flat No .....

Contact details:

Home telephone number: ..... Mobile telephone: .....

Email: .....

5. Co-insured

Family relationship towards the Main Insured Person:

☐ Spouse ☐ Partner ☐ Child ☐ Parent

First name and surname: .....

Personal ID No (PESEL): ..... Date of birth: .....

Gender: ☐ F ☐ M

When the person joining the insurance is a foreign national:

Nationality: .....

Passport No: .....

Mailing address *(insert if the mailing address is different from the address of the Main Insured Person)*:

City: ..... Postal code: .....

Street: ..... Street No/Flat No .....

Contact details:

Home telephone number: ..... Mobile telephone: .....

Email: .....

LUXMED UBEZPIECZENIA
luxmed.pl

LMG Försäkrings AB S.A. Oddział w Polsce
ul. Postępu 21C, 02-676 Warszawa
t: 22 450 45 00, 22 450 50 10, f: 22 331 85 85
Sąd Rejonowy dla m.st. Warszawy w Warszawie
XIII Wydział Gospodarczy Krajowego Rejestru Sądowego
nr KRS: 0000395438
NIP: 108 001 14 94, REGON: 145156729
Wysokość kapitału zakładowego: 4 800 000,00 euro

Declarations of the Main Insured Person:

1. I hereby declare that all of the information provided in the Declaration of Accession and the data provided for the purpose of insurance risk assessment are complete and true to the best of my knowledge.
2. I declare that prior to entering into the Insurance Contract, I received the General Terms and Conditions of Health Care Services (GTC) and Special Conditions of Insurance (SCI) in a manner which enabled me to read them.
3. I undertake to inform the persons covered by the insurance (Co-insured), on the basis of the Declaration of Accession about the scope of insurance and the rights and obligations arising from the GTC/SCI, and I undertake to make the GTC/SCI available to the Co-insured so that they can become familiar with them.
4. I declare that the persons registered by me for insurance coverage have expressed their wish to be covered by the insurance and the personal data of the Co-insured provided by me are true and up-to-date, to the best of my knowledge. I understand that the Co-insured should individually confirm their accession to the insurance, about which I will inform them.
5. I authorise healthcare entities to provide information to LMG Forsakrings AB Spółka Akcyjna Branch in Poland about the services provided to me, including those indicating, even indirectly, my health condition.
6. I hereby grant my consent to make available to LMG Forsakrings AB S.A., with its registered office in Stockholm (102 51), Sweden, Box 27093, acting through the Branch in Poland with its registered office in Warsaw (02-676) at ul. Postępu 21C (hereinafter referred to as 'LMG') and to LUX MED sp. z o.o. with its registered office in Warsaw, ul. Postępu 21C, 02-676 Warsaw, acting upon request of LMG (hereinafter referred to as: 'LUX MED') by the healthcare entities whose services I have used or am using, my medical records and information on my health condition within the scope covered by the application submitted by LMG or LUX MED in order to enable LMG to provide health services under the Insurance Contract to which I am subject, including as a part of ensuring coordination of the hospitalisation and treatment process, and to settle them, and I agree for LMG and LUX MED to authorise the personnel acting on their behalf to have access to information on my health condition and to obtain medical records from the health services provided to me.
7. I hereby grant my consent to make available by LMG Forsakrings AB S.A., with its registered office in Stockholm (102 51), Sweden, Box 27093, acting through the Branch in Poland with its registered office in Warsaw (02-676) at ul. Postępu 21C (hereinafter referred to as 'LMG') and LUX MED sp. z o.o., with its registered office in Warsaw, ul. Postępu 21C, 02-676 Warsaw, acting upon request of LMG (hereinafter referred to as: 'LUX MED') my medical records and information on my health condition which I have provided to LMG (and the entities acting on its behalf) by myself or which have been obtained on the basis of my consent given to other healthcare entities that will provide healthcare service to me, as regards which LMG provides services of treatment coordination within the scope resulting from the insurance coverage to which I am subject, in order to enable me to use the services covered by the insurance contract and to settle them.
8. I consent to the disclosure of my personal data, including data about my health condition, to reinsurance entities that will take reassurance actions relating to reinsurance of the risks assumed by the Insurer under the Insurance Contract.

Co-insured Representations:

1. I hereby declare that all of the information provided in the Declaration of Accession and the data provided for the purpose of insurance risk assessment are complete and true to the best of my knowledge.
2. I declare that prior to entering into the Insurance Contract, I received the General Terms and Conditions of Health Care Services (GTC) and Special Conditions of Insurance (SCI) in a manner which enabled me to read them.
3. I hereby authorise healthcare entities to provide LMG Forsakrings AB S.A., with its registered office in Stockholm (102 51), Sweden, Box 27093, operating through the Branch in Poland with its registered office in Warsaw (02-676) at ul. Postępu 21C, with information on services provided to me, including information indicating, even indirectly, my health condition.
4. I hereby grant my consent to make available to LMG Forsakrings AB S.A., with its registered office in Stockholm (102 51), Sweden, Box 27093, acting through the Branch in Poland with its registered office in Warsaw (02-676) at ul. Postępu 21C (hereinafter referred to as 'LMG') and to LUX MED sp. z o.o. with its registered office in Warsaw, ul. Postępu 21C, 02-676 Warsaw, acting upon request of LMG (hereinafter referred to as: 'LUX MED') by the healthcare entities whose services I have used or am using, my medical records and information on my health condition within the scope covered by the application submitted by LMG or LUX MED in order to enable LMG to provide health services under the Insurance Contract to which I am subject, including as a part of ensuring coordination of the hospitalisation and treatment process, and to settle them, and I agree for LMG and LUX MED to authorise their personnel acting on their behalf to have access to information on my health condition and to obtain medical records from the health services provided to me.
5. I hereby grant my consent to make available to LMG Forsakrings AB S.A., with its registered office in Stockholm (102 51), Sweden, Box 27093, acting through the Branch in Poland with its registered office in Warsaw (02-676) at ul. Postępu 21C (hereinafter referred to as 'LMG') and to LUX MED sp. z o.o. with its registered office in Warsaw, ul. Postępu 21C, 02-676 Warsaw, acting upon request of LMG (hereinafter referred to as: 'LUX MED') my medical records and information on my health condition which I have provided to LMG (and the entities acting on its behalf) by myself or which have been obtained on the basis of my consent given to other healthcare entities that will provide healthcare service to me, as regards which LMG provides services of treatment coordination within the scope resulting from the insurance coverage to which I am subject, in order to enable me to use the services covered by the insurance contract and to settle them.
6. I consent to the disclosure of my personal data, including data about my health condition, to reinsurance entities that will take reassurance actions relating to reinsurance of the risks assumed by the Insurer under the Insurance Contract.

Klauzule marketingowe:

1. I hereby agree to receive marketing communication from LMG Forsakrings AB SA Branch in Poland and other companies from the LUX MED Group intended to promote the services and goods offered by these companies, to inform about events related to their activities and to promote a healthy lifestyle. I hereby agree to the use of my data for communication purposes:
   a. email address (to receive email messages)
   b. telephone number (to receive text messages, MMS, and incoming phone calls)
2. I hereby give my consent to LMG Forsakrings AB SA Branch in Poland and other LUX MED Group companies to process my personal data for marketing purposes, including through profiling, obtained when ordering or using the services of these companies, or which I myself disclosed on their contact forms. This consent applies in particular to all my personal data, which include information on the way I use the services of the above-mentioned companies.

Signature of the Insured
Mark with a cross (**X**) the statements you accept.

*** Submitting declarations 1-8 for the Main Insured Person and 1-6 for the Co-insured are voluntary, but refusal to submit them may result in an inability to be covered by insurance. Granting the marketing consents is voluntary and does not affect your insurance coverage.**

	Main Insured Person	1. Co-insured	2. Co-insured	3. Co-insured	4. Co-insured	5. Co-insured
Declarations*	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐
Marketing clauses*	1a ☐ 1b ☐ 2 ☐	1a ☐ 1b ☐ 2 ☐	1a ☐ 1b ☐ 2 ☐	1a ☐ 1b ☐ 2 ☐	1a ☐ 1b ☐ 2 ☐	1a ☐ 1b ☐ 2 ☐
Date						
Signature						

Information about the data controller, legal bases, purposes of processing your data and other issues related to the processing of data provided to us are given at the end of the declaration form.

Check the statements 1-8 for the Main Insured Party and 1-6 for the Co-insured Party.

Checking the statements is mandatory.

Note that each of the Insured Parties has an individual column for checking the statements – according to the personal data entered on the first page of the declaration.

Check the marketing clauses to which you consent.

Enter the current completion date of the declaration.

Sign by hand or using a qualified signature.

This is where the spouse/partner or child (if aged over 18) affixes a handwritten signature. If the child is aged under 18, the document is signed for him/her by the parent or legal guardian.