

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.

DECLARATION OF ACCESSION – LUX MED GROUP INSURANCE

DECLARATION OF ACCESSION

DECLARATION OF CHANGES

Policyholder:

Data of the Main Insured Person:

Name and Surname:
 Personal ID number (PESEL): Date of birth:
 Sex: ☐ F ☐ M ☐ Other
 If the person declared for insurance purposes is a foreign national:
 Nationality:
 Passport No.:
 Address for correspondence:
 City/town: Postal code:
 Street: Street No./
 Contact details: Flat No.:
 Mobile telephone number:

E-mail:

1. Co-insured

Name and Surname:
 Personal ID number (PESEL): Date of birth:
 Sex: ☐ F ☐ M ☐ Other
 If the person declared for insurance purposes is a foreign national:
 Nationality:
 Passport No.:
 Address for correspondence (insert if the address for correspondence is different from the address of the Main Insured Person):
 City/town: Postal code:
 Street: Street No./
 Contact details: Flat No.:
 Mobile telephone number:

E-mail:

2. Co-insured

Name and Surname:
 Personal ID number (PESEL): Date of birth:
 Sex: ☐ F ☐ M ☐ Other
 If the person declared for insurance purposes is a foreign national:
 Nationality:
 Passport No.:
 Address for correspondence (insert if the address for correspondence is different from the address of the Main Insured Person):
 City/town: Postal code:
 Street: Street No./
 Contact details: Flat No.:
 Mobile telephone number:

E-mail:

3. Co-insured

Name and Surname:
 Personal ID number (PESEL): Date of birth:
 Sex: ☐ F ☐ M ☐ Other
 If the person declared for insurance purposes is a foreign national:
 Nationality:
 Passport No.:
 Address for correspondence (insert if the address for correspondence is different from the address of the Main Insured Person):
 City/town: Postal code:
 Street: Street No./
 Contact details: Flat No.:
 Mobile telephone number:

E-mail:

4. Co-insured

Name and Surname:
 Personal ID number (PESEL): Date of birth:
 Sex: ☐ F ☐ M ☐ Other
 If the person declared for insurance purposes is a foreign national:
 Nationality:
 Passport No.:
 Address for correspondence (insert if the address for correspondence is different from the address of the Main Insured Person):
 City/town: Postal code:
 Street: Street No./
 Contact details: Flat No.:
 Mobile telephone number:

E-mail:

5. Co-insured

Name and Surname:
 Personal ID number (PESEL): Date of birth:
 Sex: ☐ F ☐ M ☐ Other
 If the person declared for insurance purposes is a foreign national:
 Nationality:
 Passport No.:
 Address for correspondence (insert if the address for correspondence is different from the address of the Main Insured Person):
 City/town: Postal code:
 Street: Street No./
 Contact details: Flat No.:
 Mobile telephone number:

E-mail:

LMG FÖRSÄKRINGS AB S.A.
 ODDZIAŁ W POLSCE
 GRUPA LUXMED
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LMG Försäkrings AB S.A. Oddział w Polsce
 ul. Szturmowa 2, 02-678 Warszawa
 t: 22 450 45 00, 22 450 50 10
 Sąd Rejonowy dla m.st. Warszawy w Warszawie
 XIII Wydział Gospodarczy Krajowego Rejestru Sądowego
 KRS: 0000395438
 NIP: 108 001 14 94, REGON: 140166729
 Wysokość kapitału zakładowego: 5 800 000,00 euro

Representations by the Main Insured Person

1. I hereby declare that all of the information provided in the Declaration and the data provided for the purpose of insurance risk assessment (if applicable in the case 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 Healthcare Services (GTC) related to the LUX MED Group Insurance in force on the day of the Insurance Contract I am entering, 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 about the scope of insurance and the rights and obligations arising from the GTC, and I undertake to make the GTC 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 is 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 hereby authorise healthcare entities to provide LMG Försäkrings AB, with its registered office in Stockholm (102 51), Sweden, Box 27093, operating through LMG Försäkrings AB S.A., the Branch in Poland with its registered office in Warsaw (02-678) at Szturmowa 2 Street, with information on services provided to me, including information indicating, even indirectly, my health condition.
6. I hereby grant my consent to make available to LMG Försäkrings AB with its registered office in Stockholm (102 51), Sweden, Box 27093, acting through LMG Försäkrings AB S.A., the Branch in Poland with its registered office in Warsaw (02-678) at Szturmowa 2 Street, (hereinafter referred to as 'LUX MED') by the healthcare entities whose services I have used or am using, 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 to LMG Försäkrings AB with its registered office in Stockholm (102 51), Sweden, Box 27093, acting through LMG Försäkrings AB S.A., the Branch in Poland with its registered office in Warsaw (02-678) at Szturmowa 2 Street (hereinafter referred to as 'LUX MED') and to LUX MED sp. z o.o. with its registered office in Warsaw, Szturmowa 2 Street, 02-678 Warsaw, acting on commission from LMG, (hereinafter referred to as 'LUX MED') make available 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 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 reinsurance actions relating to reinsurance of the risks assumed by the Insurer under the Insurance Contract.

Representations of the Co-insured:

1. I hereby declare that all of the information provided in the Declaration 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 Healthcare Services (GTC) related to the LUX MED Group Insurance in force on the day of the Insurance Contract I am entering, in a manner which enabled me to read them.
3. I hereby authorise healthcare entities to provide LMG Försäkrings AB, with its registered office in Stockholm (102 51), Sweden, Box 27093, operating through LMG Försäkrings AB S.A., the Branch in Poland with its registered office in Warsaw (02-678) at Szturmowa 2 Street, 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 Försäkrings AB with its registered office in Stockholm (102 51), Sweden, Box 27093, acting through LMG Försäkrings AB S.A., the Branch in Poland with its registered office in Warsaw (02-678) at Szturmowa 2 Street (hereinafter referred to as 'LUX MED') and to LUX MED sp. z o.o. with its registered office in Warsaw, Szturmowa 2 Street, 02-678 Warsaw, acting on commission from LMG, (hereinafter 'LUX MED') by the healthcare entities whose services I have used or am using, 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.
5. I hereby grant my consent to make available to LMG Försäkrings AB with its registered office in Stockholm (102 51), Sweden, Box 27093, acting through LMG Försäkrings AB S.A., the Branch in Poland with its registered office in Warsaw (02-678) at Szturmowa 2 Street (hereinafter referred to as 'LUX MED') and to LUX MED sp. z o.o. with its registered office in Warsaw, Szturmowa 2 Street, 02-678 Warsaw, acting on commission from LMG, (hereinafter referred to as 'LUX MED') make available 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 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 reinsurance actions relating to reinsurance of the risks assumed by the Insurer under the Insurance Contract.

Marketing clauses:

1. I hereby agree to receive from LMG Försäkrings AB S.A. Branch in Poland and other companies in the LUX MED Group marketing communication that is 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) e-mail address (for receiving e-mail messages);
b) telephone number (for receiving text messages, MMS, and incoming phone calls).
2. I hereby consent to have LMG Försäkrings AB S.A. Branch in Poland and other LUX MED Group companies process, for marketing purposes (including through profiling), my personal data obtained when ordering or using these companies' services or which I myself have disclosed on their contact forms. This consent applies to all my personal data, which includes information on the way I use the services of the above-mentioned companies. Put a cross (X) next to the statements you accept.

***The submission of declarations 1-8 in the case of the Main Insured Person and 1-6 in the case of Co-insured is voluntary, but refusal to submit them may render the granting of insurance coverage impossible. The granting of marketing consents is voluntary and does not affect your insurance coverage.**
****In the case of a minor child, their parent/legal guardian should be the signatory.**

	Main Insured Person	1. Co-insured	2. Co-insured	3. Co-insured	4. Co-insured	5. Co-insured
Declarations*	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6
Marketing clauses*	<input type="radio"/> 1a <input type="radio"/> 1b <input type="radio"/> 2	<input type="radio"/> 1a <input type="radio"/> 1b <input type="radio"/> 2	<input type="radio"/> 1a <input type="radio"/> 1b <input type="radio"/> 2	<input type="radio"/> 1a <input type="radio"/> 1b <input type="radio"/> 2	<input type="radio"/> 1a <input type="radio"/> 1b <input type="radio"/> 2	<input type="radio"/> 1a <input type="radio"/> 1b <input type="radio"/> 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 in the GDPR privacy notice enclosed to this Declaration.

LMG FÖRSÄKRINGS AB S.A.
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t: 22 450 45 00, 22 450 50 10
Sąd Rejonowy dla m.st. Warszawy w Warszawie
XIII Wydział Gospodarczy Krajowego Rejestru Sądowego
KRS: 0000399438
NIP: 108 001 14 94, REGON: 145156729
Wysokość kapitału zakładowego: 5 800 000,00 euro

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

Check the marketing clauses to which you consent.

Sign by hand or using a qualified signature.

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.

Enter the current completion date of the declaration.

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.