**STATEMENT** (fill in with capital letters)

Name and Surname:....................................................................................................................................................

PESEL:........................................................................................................................................................................

PASSPORT NUMBER………………………………………………………………………………………………………….

TELEPHONE NUMBER………………………………………………………………………………………………………..

**Legal residence address**

TOWN :……………………………………… POST CODE: …………………………………………………………………

STREET: ………..........................................................................................................................................................

VOIVODESHIP (province)……………………………………………………………………………………………………..

COUNTY(district)........................................................................................................................................................

MUNICIPALITY (commune)………………………………………………………………………………………………......

**Address of residence**

TOWN ……………………………………… POST CODE…………………………………………………………………..

STREET…………………..............................................................................................................................................

VOIVODESHIP (province)……………………………………………………………………………………………………..

COUNTY(district)........................................................................................................................................................

MUNICIPALITY (commune)………………………………………………………………………………………………......

**Ph.D. School**

DEPARTMENT............................................................................................................................................................

YEAR ..........................................................................................................................................................................

**Please** **enroll me in the health insurance plan from (write date)…………………………………………**

**I confirm that I do not have / nor are in the process of applying for :**

• Employment contract

• Civil contract

• Self-employment

• KRUS (Agricultural Social Insurance Fund)

• Pension

• Working spouse

 Please enroll in the health insurance plan thefollowing members of my family:

1......................................................................................pesel....................................................................................

legal residence address:..............................................................................................................................................

2......................................................................................pesel....................................................................................

Legal residence address:.............................................................................................................................................

3......................................................................................pesel....................................................................................

legal residence address:..............................................................................................................................................

**I hereby declare that I will inform the Department of Ph.D. at the UAM about any changes in the aforementioned situations.**

Poznań, date..............................................                                                 ..............................................

Signature