

Toruń, on

.....
(surname) (first name)
.....
PESEL/Passport (foreigners) number personal ID series and number
.....
(faculty)
.....
(year of study, major, full-time/part-time*)

ADDRESS OF PERMANENT RESIDENCE:

.....
(street, house no., flat no.)
.....
(postal code, town/city)
.....
(voivodeship)
.....
(contact phone) (disability code)** (National Health Fund (NFZ) code)

Planned graduation
(year)

DECLARATION OF A STUDENT/DOCTORAL STUDENT OF THE NICOLAUS COPERNICUS
UNIVERSITY

I. I declare that:

1. I am not insured as a family member of an insured person who pays a premium or for whom a premium is paid (such as a parent or a spouse),
2. I am not in an employment relationship, business relationship, I do not run a business covered by social insurance,
3. I am not employed under a mandate agreement,
4. I do not receive retirement and disability benefits under social insurance,
5. I do not receive an athletic scholarship,
6. I do not receive social pension, permanent allowance, permanent compensating allowance or guaranteed periodic allowance under social welfare assistance,
7. I am not entitled to receive maintenance payments,
8. I am not unemployed,
9. I am not a farmer or a working member of a farmer's household within the meaning of the provisions on social insurance for farmers,
10. I am not subject to the obligation of health insurance by virtue of other titles listed in Art. 66 of the Act of 27 August 2004 on health care services financed from public funds,
11. **I have read the Ordinance No. 139** of the Rector of the Nicolaus Copernicus University dated 1 September 2016,
12. and I undertake to check my **University** e-mail account regularly –

.....
(e-mail address)

.....
(legible signature of the student/doctoral student making the declaration)

II. I declare that the following members of my family, who are reported by me, are not otherwise subject to the insurance obligation (due to one of the reasons listed in item I), nor were they reported for health insurance by other family members.

No.	Surname	First name	PESEL number	The degree of kinship	Date of birth		
1.							
2.							
3.							
4.							
No.	Address of residence					Disability code**	Is the person a member of the same household
	Street	House No.	Flat No.	Post Code	City/town		
1.							
2.							
3.							
4.							

.....
(legible signature of the student/doctoral student making the declaration)

III. I declare that:

- the above data are true and that I am aware of the criminal liability under Art. 233 § 1 of the Criminal Code (Journal of Laws of 1997 No. 88, item 553 as amended) for making false statements;
- in the event** of the occurrence of any of the circumstances listed in item I, resulting in the creation of a **different title to health insurance** for me or the family members I have reported, **I will notify the University** of this fact **within 7 days** of its occurrence under pain of liability on this account;
- in the event of a change in the data contained in the application form for health insurance, I will notify the University of this fact within 7 days of the occurrence of the change or obtaining a document confirming the change, under penalty of liability on this account.

.....
(legible signature of the student/doctoral student making the declaration)

IV. I would like to apply for compulsory health insurance coverage for **me / my family members*** from

.....
(legible signature of the student/doctoral student making the declaration)

* cross out as appropriate

** 0 – A person who does not have a certificate of disability,
 1 – A person who has a certificate of mild disability,
 2 – A person who has a certificate of moderate disability,
 3 – A person who has a certificate of severe disability,
 4 – A person who has a disability certificate issued to persons up to age 16.