**REQUEST FOR REGISTRATION OF AN EMPLOYEE WITH THE SOCIAL INSURANCE INSTITUTION (ZUS)**

|  |  |  |  |
| --- | --- | --- | --- |
| Place |  | Date |  |

|  |
| --- |
| **DATA OF THE PERSON REPORTED FOR INSURANCE** |
| **SURNAME** |  |
| **MAIDEN NAME** |  |
| **NAME(S)** |  |
| **CITIZENSHIP** |  |
| **PESEL** |  |  |  |  |  |  |  |  |  |  |  |
| **DATE OF BIRTH***day, month, year* |  |  |  |  |  |  |  |  |
| **PASSPORT***series and No. - refers to foreigners* |  |
| **REGISTRATION ADDRESS** |
|  |  |  |
| *Commune* | *District* | *Voivodeship* |
|  |  |  |
| *City* | *Postal code* | *Street* |
|  |  |  |
| *House no.* | *Apartment no.* |  |
| **RESIDENCE ADDRESS** |
|  |  |  |
| *Commune* | *District* | *Voivodeship* |
|  |  |  |
| *City* | *Postal code* | *Street* |
|  |  |  |
| *House no.* | *Apartment no.* |  |
| **ADDRESS FOR CORRESPONDENCE** |
|  |  |  |
| *Commune* | *District* | *Voivodeship* |
|  |  |  |
| *City* | *Postal code* | *Street* |
|  |  |  |
| *House no.* | *Apartment no.* |
| **I AM RETIRED** | YES | NO | Decision No.: dated: |
| **I AM A PENSIONER** | YES | NO | Decision No.: dated: |
| **DISABILITY DEGREE CODE** |  |

**I request for registration and payment of contributions at ..................................... Regional Branch of the National Health Fund in: ............................................ .**

 *(city)*

|  |
| --- |
| **SPOUSE(S), CHILDREN, OTHER FAMILY MEMBERS LIVING IN A JOINT HOUSEHOLD WITH THE EMPLOYEE***Provide if they are not reported for health insurance elsewhere* |
| **No** | **Surname and name** | **Degree of relationship** | **Date of birth** | **PESEL / NIP (tax no.)** | **Address of residence** | **Degree of disability** | **Does she/he remain in a joint household with the insured?** |
| **1** |  |  |  |  |  |  |  |
| **2** |  |  |  |  |  |  |  |
| **3** |  |  |  |  |  |  |  |
| **4** |  |  |  |  |  |  |  |

**I confirm the above data and undertake to report to the Personnel Affairs Center of the Jagiellonian University - Medical College within 7 days any change that occurs.**

.........................................................

 Employee's signature

**I confirm the above data on the basis of:**

|  |  |  |
| --- | --- | --- |
| **IDENTITY CARD** | series: | no: |
| **OTHER DOCUMENT** |  |

 .........................................................

Signature of PAC Employee

*The above information is provided for the purpose of registration and payment to the Social Insurance Institution in accordance with the Act of October 13, 1998 on the social insurance system (Journal of Laws of 2021, item 423, as amended) and the Act of August 27, 2004 on health care services financed from public funds (Journal of Laws of 2021, item 1285, as amended).*