**Proszę o zgłoszenie do ubezpieczeń zdrowotnych niżej**

**wymienionych członków rodziny**

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1. …………………………….. …………………….PESEL

Imię i nazwisko stopień pokrewieństwa

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8. …………………………….. …………………….PESEL

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Miejscowość i data podpis osoby składającej oświadczenie