FAMILY MEMBERS LIFE 1 *Hospitalization and High Diagnostic Exams*

(digitally fill in the form, sign it and send it via mail to
ITA-FamilyMembersTetraPak@willistowerswatson.com)

The undersigned.....

Company: ☐ Tetra Pak Packaging Solutions Spa

Hiring date:……

Optional Benefit Medical Expenses ◉ yes ○ no

Birth Date …… Place of birth .....

Fiscal code .....

states that:
today my cohabitant family members (intended as the family members included in the family status (="stato di famiglia") or the cohabitant partner or the person civilly united (Law n.76 May 20, 2016 and subsequent amendments), as well as their dependent children (dependent children are insured even if they are not included in the family status) are the following:

Surname and name	M/F	Relation	Fiscal Code	Birth Date	Place of birth

and ask to (flag the right choice)

○ **add**
◉ **remove**

the following family members starting from: .....:

Surname and name	M/F	Relation	Fiscal Code	Birth Date	Place of birth

This statement produces effects and due to this I undertake the responsibility to communicate all the changes of the above-mentioned situation.

Date _____

I undersigned accept art. 13 D.Lgs. 196/2003 about "tutela delle persone e di altri soggetti rispetto al trattamento dei dati personali", and give my consent to the comunication of my personal data and of my family members, needed to receive medical expenses reimbursement to Willis Italia S.p.A., Previass II, RBM Salute. My consent is intended to be used only to get coverage and reimbursement by health insurances .

Employee's consent: _____ MODENA____, ___/___/_____