MSH on behalf of asfe

LIFEPLAN'EXPAT

Application for coverage

BROKER CODE:

YOUR BROKER
Name:
Tel.:

VALIDATE

PLEASE COMPLETE THIS FORM IN CAPITAL LETTERS and return it to us:
- by email to: ***newapplication@msh-intl.com*** having first signed and scanned the entire enrollment form.
- by mail using the contact details shown at the bottom of the last page of this form.

If you require assistance to complete this application for coverage, please contact us on +33 (0)1 44 20 48 77.

PLAN MEMBER INFORMATION

Only persons under the age of 66 may enroll in the plan.

Title: Mr. ☐ Ms. ☐

First name(s):

Last name:

Date of birth: (DD/MM/YYYY) Sex: Male ☐ Female ☐

Nationality (nationality shown on your main passport):

Home country (your country of nationality):

Country of expatriation (the country in which you live for more than 6 months of the year):

Mailing address in your main country of residence (mandatory):

Name and address for premium invoices (if different from the address above):

Telephone number: country code: area code: number:

Email address to receive alerts for reimbursement statements (mandatory, in capital letters):

Email address to receive premium invoices (if different from the email address above, mandatory):

Occupation (mandatory, please specify if you are a student or unemployed):

Industry sector:

Preferred language for contractual documents: French ☐ English ☐

EFFECTIVE DATE OF ENROLLMENT

Please specify the date on which you want your coverage to start (DD/MM/YYYY):
(this must be the 1st or the 15th of the desired month)
Backdated enrollments will not be accepted.
Coverage is subject to acceptance of your application which will be confirmed by the delivery of your certificate of enrollment.

BENEFICIARIES OF THE DEATH/PTD BENEFIT (mandatory)

☐ I name as beneficiary: my spouse from whom I am neither divorced nor separated by a final judgment, failing that my surviving children, in equal shares, failing that my parents in equal shares, or the surviving parent, failing that my other heirs in equal shares.

or

☐ I name as beneficiary (last name – first name – telephone number - address):

. . . . . .

. . . . . .

. . . . . .

SELECTION OF YOUR LIFE & DISABILITY BENEFITS

Please note that the currency chosen for the plan (Euro or US Dollar) must be the same for all benefits selected.

Currency of the plan: Euro ☐ US Dollar ☐

Mandatory benefits: Select your Lump Sum in case of Death/Permanent Total Disability (All Causes)

This lump sum must be between €25,000 (or $30,000) and €1,000,000 (or $1,200,000) in multiples of €25,000 (or $30,000).

Selected amount: ☐☐☐☐☐☐☐

The beneficiary (or beneficiaries) of this lump sum must be named at the bottom of the previous page.

SELECTION OF YOUR OPTIONAL LIFE & DISABILITY BENEFITS
all of these options can be purchased individually

The personal data collected is required to set up your life & disability insurance plan. To find out more about our policy on the protection of personal data, please refer to the section "Personal Data Protection" on page 4.

• **Death/Permanent Total Disability Lump sum to be doubled** in case of accident YES ☐ NO ☐

• **Infirmity lump sum All Causes** (Maximum lump sum paid in the event of certified infirmity with more than 33% disability)

This lump sum can be between €25,000 (or $30,000) and €1,000,000 (or $1,200,000) but cannot be more than the amount of the selected death benefit.

Selected amount: ☐☐☐☐☐☐☐

• **Sick Leave benefit**

In the event of temporary incapacity to work, this benefit allows you to maintain your standard of living by providing you with an allowance calculated according to the following rules. This allowance is based on your gross monthly income (or your gross annual income divided by 12).

The "French-style" Daily Allowance benefit cannot be combined with the "Anglo-Saxon-style" benefits known as "Short-Term Disability" (STD) and/or "Long-Term Disability" (LTD). However, these last two benefits may be purchased together or individually.

French-style Sick Leave benefits (not available if one or more "Anglo-Saxon style" Sick Leave benefits have been purchased)

Daily allowances

Benefit which will be paid at the expiration of a mandatory waiting period (see below) and for a maximum period of 24 months, which will be followed by the payment of a pension if your incapacity to work is recognized as permanent.

Your gross monthly income: ☐☐☐☐☐☐

Three waiting periods are available: 30 days ☐ 60 days ☐ 90 days ☐

Please check the appropriate box. Here the waiting period refers to the period during which you will not yet receive any benefits.

Amount of the daily allowance: amount of between €25 (or $30) and €400 (or $480) in multiples of €25 or $30, limited to the amount of the selected death lump sum divided by 1,000. It cannot exceed 70% of the daily gross income declared for tax purposes (or gross monthly income divided by 30). If the maximum amount of benefit falls between two multiples of €25 or $30, the higher amount will be accepted.

*Example: Mr. M earns €5,000 per month and purchases a death lump sum of €300,000. His maximum daily allowance is calculated as follows: (5,000 / 30) * 0.7 = 116.66, which is within the limit of the death lump sum (€300,000 / 1,000). Mr. M will therefore be able to select a daily allowance of between €25 (minimum allowance) and €125. In the second case, his allowance would provide him with a monthly income of €3,750.*

Selected amount: ☐☐☐☐☐☐

or

Anglo-Saxon-style Sick Leave benefits

Your gross monthly income: ☐☐☐☐☐☐

a. Short-term disability (not available if the Daily Allowance benefit has been purchased)

This benefit provides you with an allowance from the 1st day of temporary incapacity to work due to an accident or hospitalization and from the 7th day in case of illness.

This benefit will stop automatically at the end of one of the following three periods: 30 days ☐ 60 days ☐ 180 days ☐
Please check the appropriate box. The allowance you receive is automatically 70% of your income and is limited to €400/$480.

*Example: Ms. B has a gross income of €7,000/month. Her monthly Short-term disability allowance will be (7,000*0.7) = €4,900 (or €163.33 per day) after 30, 60 or 180 days of sick leave depending on the duration she selected.*

b. Long-term disability (not available if the Daily Allowance benefit has been purchased)

This benefit can take over from Short-term disability benefit, although it is not compulsory. This benefit provides you with an allowance on expiration of one of the periods shown below and up to the 1,080th day.

If Short-term disability benefit has been purchased, this period cannot be less than the one selected for the Short-term disability benefit.

30 days ☐ 60 days ☐ 180 days ☐

Please check the appropriate box. The allowance you receive is automatically 70% of your income and is limited to €400/$480.

*Example: Ms. B has a gross income of €7,000/month. Her monthly Long-term disability allowance will be (7,000*0.7) = €4,900 (or €163.33 per day) after 30, 60 or 180 days of sick leave, depending on the duration she selected.*

PAYMENT OF YOUR PREMIUM

Quarterly amount of your premium:

☐☐☐☐☐.☐☐

Payment currency: Euro ☐ US Dollar ☐

The payment currency must be the same as the plan currency.

TO BE COMPLETED IF THE PAYER IS DIFFERENT FROM THE INSURED MEMBER

For example, a company (payer) which insures an employee (insured member) or a parent (payer) who purchases a plan for their child (insured member). *If the payer is a legal entity, you must download and fill out the form: DOWNLOAD*

First name, last name of the payer:

Billing address of the payer:

Date of birth (DD/MM/YYYY) and place of birth (not applicable to legal entities): , in

Occupation and business sector of the payer:

E-mail address to receive premium invoices:

Relationship between the payer and the insured member:

☐ Employer
☐ Close relative (parent, child, grandparent, grandchild, brother or sister), please specify:
☐ Other, please specify:

FREQUENCY AND METHOD OF PAYMENT

Please select the frequency and method of payment of your premium.

	ANNUAL	BI-ANNUAL	QUARTERLY	MONTHLY
Credit card [1] for the first premium and next installments by credit card via your secure Members' Area	☐	☐	☐	*Not available*
SEPA CORE [2] direct debit from an account in France (*the first installment will have to be paid by credit card, which is why you need to complete the next 2 methods of payment)	☐	☐	☐	☐*
Bank transfer	☐	☐	☐	*Not available*

[1] ***In case of payment by credit card,*** *please fill out this form:*

Type of credit card: Visa ☐ Mastercard ☐ Amex ☐

Cardholder's name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Cardholder's signature:

Card number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiration date (MM/YY): ☐☐ / ☐☐

Validation code: ☐☐☐

(last 3 digits on the back of your card, excluding Amex)

After payment of your first premium, your credit card information will be destroyed for legal reasons.

Credit card authorization form:
I authorize MSH on behalf of ASFE to debit the amount of my first international life and disability insurance premium payment from my bank card, i.e.:

☐☐☐☐.☐☐ Euro ☐ US Dollar ☐

Signed in (town/city and country, excluding USA and countries under international sanctions*):	**Signature of the member**:
Date (DD/MM/YYYY):	

** For any questions on countries under international sanctions, please contact us.*

[(2)] *In case of payment by SEPA CORE direct debit from an account in France, please:*
- fill out the following direct debit authorization,
- provide your bank account details,
- complete the credit card authorization on page 3 for the first payment of your premium.

SEPA CORE DIRECT DEBIT MANDATE

Unique Mandate Reference: UMR (will be sent in your next premium invoice)
By signing this form, you authorize MSH to send instructions to your bank to debit your account on a regular basis (depending on the payment frequency selected), and your bank to debit your account as instructed by MSH.
You are entitled to a refund from your bank under the terms of the agreement you have with them. Any claim for a refund must be submitted within 8 weeks of the date on which your account is debited.
This information is mandatory and required in order for your creditor to set up the SEPA direct debit mandate. In accordance with the data protection regulation applicable in your country, you have a right of access and rectification of your personal data, as well as a right to object to the processing of your personal data for a legitimate reason (if required by the law applicable in your country). To exercise these rights, please refer to the contract with your creditor.

FIRST NAME, LAST NAME AND ADDRESS OF THE ACCOUNT'S HOLDER	CREDITOR INFORMATION
	Name and address of the creditor: MSH 39 rue Mstislav Rostropovitch, 75815 PARIS - Cedex 17 SEPA Creditor Identifier (SCI): FR60ZZZ460359

ACCOUNT HOLDER'S BANK DETAILS

IBAN:

BIC:

Name of your bank:

DATE (DD/MM/YYYY):	MANDATORY SIGNATURE:

PERSONAL DATA PROTECTION

MSH INTERNATIONAL, with its head office located in Season, 39 rue Mstislav Rostropovitch 75815 Paris cedex 17, France, conducts personal data processing actions required for the implementation of your life & disability coverage plan, its management and monitoring and for compliance with regulatory requirements in the field of anti-money laundering and terrorist financing and for the provision of exceptional and temporary information related to crisis events or cases of force majeure (health or political crisis, etc.). In this respect, all of the data collected is mandatory.. In this respect, all of the data collected is mandatory.
The recipients of your personal data are: the risk carrier (insurer), the different entities making up MSH and the service providers involved in the administration of your plan across the world. In this context, your data may be transferred to third countries outside the European Union guaranteeing an appropriate level of protection or subject to the use of adapted safeguards such as the signature of standard data protection clauses adopted by the European Commission, or based on the derogations provided for in Article 49 of Regulation 2016/679, known as General Data Protection Regulation.
Your personal data will be stored for the entire duration of the Plan, as provided for by the applicable laws.
At all times you benefit from a right of access, rectification, or erasure, or restriction or opposition and portability of your personal data as well as the right to organize instructions upon your death. To exercise your rights, please contact the Data Protection Officer by email at dpo@s2hgroup.com or by mail at SIACI SAINT HONORE - Délégué à la Protection des Données - Immeuble Season - 39 rue Mstislav Rostropovitch 75815 Paris Cedex 17, France.
You benefit from the right to file a complaint with a supervisory authority in charge of personal data protection.
You can access our full Policy on the Protection of Personal Data on our website, www.msh-intl.com, under the "Legal notices" section.

INFORMATION NOTE

Please take note of the following important details.

Our analysis and sales offers have been made on the basis of the information, needs and requirements that you communicated and expressed during our meetings and correspondence. Please note that the quality and accuracy of the information communicated by the policyholder in terms of financial information and underwriting objectives directly influence the quality and consistency of our offer.

It is very important that you carefully read the general terms & conditions of your insurance policy, in particular the paragraphs dealing with the exclusions, policy term, waiting periods, definitions of the coverage and applicable measures in case of misrepresentation or non-disclosure.

Should you be dissatisfied in any way, your usual contact person is available to assist you.

You can also contact the Service réclamation (Complaints Department) at 23 allées de l'Europe 92 587 Clichy Cedex, France or the Complaints Department of your nearest regional head office (all contact details are available under "Contact").

In this case, we undertake to provide you with a reply no later than two months after receiving the necessary information related to your complaint, or, failing that, to keep you informed about the progress of your complaint processing.

If you still disagree with the reply or solution provided, you can write to the Insurance Ombudsman as a last resort:

- by mail: La Médiation de l'Assurance, Pôle PLANETE CSCA, TSA 50110, 75441 PARIS CEDEX 09, France
- online: https://www.mediation-assurance.org/Saisir+le+mediateur
- by email: le.mediateur@mediation-assurance.org

We remain available to answer any questions you may have.

MEDICAL FORMALITIES TO BE RETURNED TO US

Depending on your age and the amount of death lump sum purchased, you will be required to complete various medical formalities to enable us to confirm your enrollment. Please refer to the table below to find out which medical formalities you need to return to us, including the information required in each situation as shown in the key below:

Death/Permanent Total Disability Lump sum	€25,000 to €150,000 ($30,000 to $180,000)	€150,001 to €250,000 ($180,001 to $300,000)	€250,001 to €350,000 ($300,001 to $420,000)	€350,001 to €500,000 ($420,001 to $600,000)	€500,001 to €1,000,000 ($600,001 to $1,200,000)
Age 45 or under	1	1	2	4	5
Age 46 to 55	1	2	4	4	5
Age 56 to 65	2	3	4	5	5

Key:

1: Simplified health questionnaire

2: Simplified health questionnaire + Comprehensive health questionnaire

3: Simplified health questionnaire + Comprehensive health questionnaire + Medical Report completed, dated and signed by the examining doctor

4: Simplified health questionnaire + Comprehensive health questionnaire + Medical Report completed, dated and signed by the examining doctor + The following medical tests: Cholesterol, triglycerides, transaminases (SGOT and SGPT), screening for HIV 1 and 2 and marker of acute hepatitis HCV

5: Simplified health questionnaire + Comprehensive health questionnaire + Medical Report completed, dated and signed by the examining doctor + the following medical tests: blood count, platelets, ESR, glucose, cholesterol, HDL, triglycerides, creatinine, gamma GT, transaminases (SGOT and SGPT), screening for HIV 1 and 2, marker of acute hepatitis HCV, PSA test for men ≥ 55 + cardiology examination by a cardiologist including an electrocardiograph with a reading and detailed report from the cardiologist on the consultation and the clinical examination

The documents relating to the medical formalities are available on the following pages.

Examples:

1. *Ms. B is 35 years old and has purchased a death lump sum of €200,000 and €100 of sick leave benefit. She will therefore need to send us the Simplified Health Questionnaire.*
2. *Mr. A is 49 years old and has purchased a death lump sum of €400,000. He will therefore need to send us:*
   - *The Comprehensive Health Questionnaire*
   - *The Medical Report completed, dated and signed by the examining doctor*
   - *The results of following panel of medical tests: cholesterol, triglycerides, transaminases (SGOT and SGPT), screening for HIV 1 and 2 and marker of acute hepatitis HCV.*

These medical formalities can be found on the following pages.

Please ensure you return only the ones which are required for your age and selected level of lump sum, as specified in the table above. If you have any questions, please feel free to contact us at +33 (0) 1 44 20 48 77.

SIMPLIFIED HEALTH QUESTIONNAIRE

First name(s):

Last name:

Date of birth: (DD/MM/YYYY)

Address:

Post/Zip code: Town/City:

Occupation:

VERY IMPORTANT

1. Article L.113-8 of the French Insurance code: Irrespective of the ordinary causes of nullity and subject to the provisions of article L.132-26, the insurance plan is null and void in the event of concealment or intentional misrepresentation on the part of the member when such concealment or misrepresentation changes the subject of the risk or decreases the insurer's assessment of that risk, even if the risk which the member concealed or distorted has no impact on the claim.
2. Read the following questionnaire very carefully: The insurer draws your attention to the importance of this questionnaire and the necessity of answering all of the questions and dating and signing it. IF YOU ANSWER YES to one or more of the questions, please provide all the required details (date, reasons, consequences or aftereffects, type of treatment, duration etc.) on a separate sheet of paper which must also be dated and signed.
3. Confidentiality: Whatever your responses to the health questionnaire are, you may return them in a sealed envelope for the attention of the "Medical advisor". However, if you answered "Yes" to at least one of the questions, you are formally requested to return the health questionnaire in a sealed envelope for the attention of the "Medical advisor".

Height: ☐☐☐ cm Weight: ☐☐☐ kg

Over the last 10 years, have you been hospitalized and/or undergone a surgical procedure, including keyhole surgery (other than C-section, appendectomy or the removal of tonsils, adenoids or the gallbladder)?	NO ☐ YES ☐
Over the last 5 years, have you:	
- sought treatment for disorders of the spine such as slipped disk, lumbago, sciatica etc. or for damage to or rheumatism of joints such as the shoulder, knee, hip etc.?	NO ☐ YES ☐
- sought treatment for mental disorders such as anxiety, depression, fatigue, stress, overwork etc.?	NO ☐ YES ☐
- been prescribed a period of sick leave from work for medical reasons for a period of more than 30 days?	NO ☐ YES ☐
Do you have or have you ever had 100% coverage (with exemption from the patient's contribution to costs/reimbursement at 100% of medical expenses) for medical reasons from a Social Security organization during the last 15 years?	NO ☐ YES ☐
Are you currently on total or partial sick leave from work prescribed for medical reasons (excluding statutory maternity leave)?	NO ☐ YES ☐
Do you require regular medical care and/or medical treatment such as tranquillizers, treatments for cholesterol, diabetes, high blood pressure etc.?	NO ☐ YES ☐
Do you receive a pension, annuity or allowance in respect of incapacity to work or disability or a Disabled Adult's Allowance?	NO ☐ YES ☐
Is it planned (excluding maternity) for you to have any tests over the next 6 months such as laboratory tests, medical imaging, endoscopy etc. or to have a specialist consultation, be admitted to hospital and/or undergo a surgical procedure?	NO ☐ YES ☐

I, the undersigned, certify that I have answered the questions in this form accurately and honestly and have neither declared nor omitted anything that could mislead MSH International and lead to the application of Articles L.113-8 and L.113- 9 of the French Insurance Code.

Your personal data is processed by the insurer in compliance with the GDPR dated June 20, 2018 on the protection of data. Its processing is required for the management of your application and the implementation of your benefits. You have the right to access, rectify, remove and object to this data free of charge by mailing a letter to: Groupama Gan Vie – Service des Relations avec les Consommateurs – Immeuble WP2 – 4, boulevard de Pesaro – 92000 Nanterre, France or by sending an email to: src-collectives@ggvie.fr.

You expressly accept the collection and processing of your health-related data. This data is required for your enrollment and the management of your membership and benefits and is processed in compliance with medical confidentiality. It is intended for the exclusive use of the insurer's medical advisor and their medical department, or for authorized persons (such as medical experts or healthcare professionals).

However, if you have chosen not to return your health questionnaire under confidential cover, the data it contains will also be passed on to the insurer's administration department. You have the right to access, rectify and object to medical data relating to you by mailing a letter, together with a photocopy of ID, to the insurer's medical advisor at the following address: Service Médical Collectives – Immeuble WP2 – 4, boulevard de Pesaro – 92000 Nanterre, France.

Signed in (town/city and country, excluding USA and countries under international sanctions*):	**Signature of the member:**
Date (DD/MM/YYYY):	

** For any questions on countries under international sanctions, please contact us.*

COMPREHENSIVE HEALTH QUESTIONNAIRE

First name(s):

Last name:

Date of birth: (DD/MM/YYYY)

Address:

Post/Zip code: Town/City:

Occupation:

VERY IMPORTANT

1. Article L.113-8 of the French Insurance code: Irrespective of the ordinary causes of nullity and subject to the provisions of article L.132-26, the insurance plan is null and void in the event of concealment or intentional misrepresentation on the part of the member when such concealment or misrepresentation changes the subject of the risk or decreases the insurer's assessment of that risk, even if the risk which the member concealed or distorted has no impact on the claim.
2. Read the following questionnaire very carefully: The insurer draws your attention to the importance of this questionnaire and the necessity of answering all of the questions and dating and signing it. IF YOU ANSWER YES to one or more of the questions, please provide all the required details (date, reasons, consequences or aftereffects, type of treatment, duration etc.) on a separate sheet of paper which must also be dated and signed.
3. Confidentiality: Whatever your responses to the health questionnaire are, you may return them in a sealed envelope for the attention of the "Medical advisor". However, if you answered "Yes" to at least one of the questions, you are formally requested to return the health questionnaire in a sealed envelope for the attention of the "Medical advisor".

Height: ☐☐☐ cm Weight: ☐☐☐ kg

Over the last 10 years, have you:

- been hospitalized and/or undergone a surgical procedure, including keyhole surgery (other than C-section, appendectomy or the removal of tonsils, adenoids or the gallbladder)?	NO ☐ YES ☐	Nature and date(s) of the hospitalization(s)/surgical procedure(s):
- sought treatment for disorders of the spine such as slipped disk, lumbago, sciatica etc. or for damage to or rheumatism of joints such as the shoulder, knee, hip etc.?	NO ☐ YES ☐	Please provide details: Date(s):
- sought treatment for mental disorders such as anxiety, depression, fatigue, stress, overwork etc.?	NO ☐ YES ☐	Please provide details: Date(s):

Over the last 5 years, have you:

- sought treatment for a heart murmur?	NO ☐ YES ☐	Please provide details: Date(s):
- sought treatment for respiratory disorders such asthma, chronic bronchitis etc.?	NO ☐ YES ☐	Please provide details: Date(s):
- suffered from an illness which led to you being prescribed a period of sick leave for medical reasons and/or a medical treatment (excluding statutory maternity leave) lasting more than 30 days?	NO ☐ YES ☐	Which illness? Duration of sick leave: Type of medical treatment: Date(s):
- been involved in an accident which led to you being prescribed a period of sick leave for health reasons and/or a medical treatment lasting more than 30 days?	NO ☐ YES ☐	Date of the accident: Nature of the injuries: Duration of sick leave: Are you still suffering aftereffects? NO ☐ YES ☐ Please provide details: Type of medical treatment:

- had treatment using laser, radiotherapy or chemotherapy?	NO ☐ YES ☐	Please provide details: Date(s): Duration(s):
Have you been screened for one of the human immunodeficiency viruses (HIV), hepatitis B (HBV) and hepatitis C (HCV) where one of the results was positive?	NO ☐ YES ☐	Which one(s)? On what date(s)?
Do you have or have you ever had 100% coverage (with exemption from the patient's contribution to costs/ reimbursement at 100% of medical expenses) for medical reasons from a Social Security organization during the last 15 years?	NO ☐ YES ☐	Why? Date(s): Duration(s):
Over the last 12 months, have you been prescribed more than 3 periods of sick leave of any duration and/or medical examinations such as radiology, cardiology, laboratory tests, etc. other than for routine screening?	NO ☐ YES ☐	Which ones? Why? Dates/Durations / Results (to be enclosed if possible):
Are you currently on total or partial sick leave from work prescribed for medical reasons (excluding statutory maternity leave)?	NO ☐ YES ☐	For what reason? From what date? Scheduled date of return to work:
Are you aware that you are suffering from any illnesses and/or disorders?	NO ☐ YES ☐	Please provide details: From which date:
Do you require regular medical care and/or medical treatment such as tranquillizers, treatments for cholesterol, diabetes, high blood pressure etc.?	NO ☐ YES ☐	For what reason? Type of medical care and/or treatment: From what date?
Do you receive:		
- a pension, annuity or allowance in respect of incapacity to work or disability?	NO ☐ YES ☐	From what date? Why? At what rate or in what category? Which organization provides the benefit?
- a Disabled Adult's Allowance?	NO ☐ YES ☐	From what date? Why? At what rate?
Do you suffer from a malformation and/or have you had a limb amputated?	NO ☐ YES ☐	Please provide details: Date(s):
Do you suffer from a hearing and/or vision disorder (other than short-sightedness, long-sightedness or astigmatism)?	NO ☐ YES ☐	Please provide details: Causes(s):
Is it planned (excluding maternity) over the next 12 months for you to:		
- have any examinations such as laboratory tests, medical imaging, endoscopy etc. other than for the purposes of routine screening?	NO ☐ YES ☐	Nature of the tests: Date(s):
- have a specialist consultation?	NO ☐ YES ☐	Why? Date(s):
- undergo any medical treatments and/or surgical procedures (excluding health check-ups)?	NO ☐ YES ☐	Type of medical treatment: Type of surgical procedure: Date(s): Why?

I, the undersigned, certify that I have answered the questions in this form accurately and honestly and have neither declared nor omitted anything that could mislead MSH International and lead to the application of Articles L.113-8 and L.113- 9 of the French Insurance Code.

Your personal data is processed by the insurer in compliance with the GDPR dated June 20, 2018 on the protection of data. Its processing is required for the management of your application and the implementation of your benefits. You have the right to access, rectify, remove and object to this data free of charge by mailing a letter to: Groupama Gan Vie – Service des Relations avec les Consommateurs – Immeuble WP2 – 4, boulevard de Pesaro – 92000 Nanterre, France or by sending an email to: src-collectives@ggvie.fr.

You expressly accept the collection and processing of your health-related data. This data is required for your enrollment and the management of your membership and benefits and is processed in compliance with medical confidentiality. It is intended for the exclusive use of the insurer's medical advisor and their medical department or for authorized persons (such as medical experts or healthcare professionals).

However, if you have chosen not to return your health questionnaire under confidential cover, the data it contains will also be passed on to the insurer's administration department. You have the right to access, rectify and object to medical data relating to you by mailing a letter, together with a photocopy of ID, to the insurer's medical advisor at the following address: Service Médical Collectives – Immeuble WP2 – 4, boulevard de Pesaro – 92000 Nanterre, France.

Signed in (town/city and country, excluding USA and countries under international sanctions*): **Date** (DD/MM/YYYY):	**Signature of the member:**

** For any questions on countries under international sanctions, please contact us.*

MEDICAL REPORT

These statements must include answers to all questions (scoring out and "nothing to report" are not deemed to be answers) and must be dated and signed, failing which the insurer will not be able to provide coverage.
Very important: Article L.113-8 of the French insurance code: Irrespective of the ordinary causes of nullity and subject to the provisions of article L.132-26, the insurance plan is null and void in the event of concealment or intentional misrepresentation on the part of the member when such concealment or misrepresentation changes the subject of the risk or decreases the insurer's assessment of that risk, even if the risk which the member concealed or distorted has no impact on the claim.

STATEMENTS OF THE APPLICANT FOR THE INSURANCE, COLLECTED AND TRANSCRIBED BY THE DOCTOR

First name(s):

Last name:

Date of birth: (DD/MM/YYYY) Place of birth:

Marital status:

Address:

Post/Zip Code: Town/City:

Current occupation:

Plan ref. number (if known):

QUESTIONS

Are you currently on total or partial sick leave from work prescribed for medical reasons (excluding statutory maternity leave)?	NO ☐ YES ☐	From what date? Cause:
Over the last 5 years, have you been prescribed a period of total or partial sick leave for health reasons of more than 3 weeks?	NO ☐ YES ☐	Date(s): Cause(s): Date(s) of return to work:
Do you receive a pension, annuity or allowance in respect of incapacity to work or disability?	NO ☐ YES ☐	What rate or category? Date of award: Cause: In what capacity? General scheme ☐ Occupational illness ☐ Military ☐ Work-related accident ☐
Do you have an infirmity or a disability?	NO ☐ YES ☐	Please provide details: Cause:
Do you have or have you ever had 100% coverage (with exemption from the patient's contribution to costs/reimbursement at 100% of medical expenses) for medical reasons from a Social Security organization (Social Security, "Mutualité Sociale Agricole" etc.)?	NO ☐ YES ☐	For what reason? Date of award of 1st exemption:
Have you been involved in any accidents?	NO ☐ YES ☐	Date(s): Nature and location of any injuries: Are you still suffering aftereffects? Please provide details:
Have you ever been admitted to hospital?	NO ☐ YES ☐	Date(s): Cause(s):

Have you ever undergone a surgical procedure including with a local anesthetic or keyhole surgery (excluding dental surgery)?	NO ☐ YES ☐	Please provide details: Why? Date(s):
Have you ever been treated using radiotherapy, laser or chemotherapy?	NO ☐ YES ☐	Date(s): Cause(s): Treatment:
Over the last 12 months, have you:		
- been prescribed more than 3 periods of sick leave from work of any duration?	NO ☐ YES ☐	Please provide details: Date(s):
- had any medical examinations, other than routine screening, such as Doppler, ECG, PFT, blood tests, endoscopy, medical imaging, radiography, scans etc.?	NO ☐ YES ☐	Date(s): Type: Cause(s): Results:
Avez-vous suivi des traitements médicaux de plus de 30 jours au cours des 2 dernières années ou suivez-vous un traitement médical actuellement ?	NO ☐ YES ☐	Date(s): Type: Cause(s):
Have you consulted a doctor over the last 3 months?	NO ☐ YES ☐	Date(s): Cause(s):
Do you drink alcohol (aperitifs, beer, liqueurs, and wine)?	NO ☐ YES ☐	Please provide details: wine ☐ aperitifs ☐ other ☐ beer ☐ liqueurs ☐ Quantity per day:
Do you smoke?	NO ☐ YES ☐	Since when? Number of cigarettes/day: Number of cigars/day: Number of pipes/day:
Do you use e-cigarettes, e-cigars, e-pipes etc.?	NO ☐ YES ☐	
Have you ever smoked?	NO ☐ YES ☐	Quantity (/day): Number of years: Date of stopping: Reason:
Have you been screened for one of the human immunodeficiency viruses (HIV), hepatitis B (HBV) and hepatitis C (HCV) where one of the results was positive?	NO ☐ YES ☐	Which one(s)? On what date(s)?
To your knowledge, in the next 6 months, will you require to consult a specialist, undergo medical tests, be admitted to hospital or undergo a surgical procedure?	NO ☐ YES ☐	Why? Date(s): Nature of tests: Type of surgical procedure:

HAVE YOU EVER SUFFERED OR ARE YOU CURRENTLY SUFFERING FROM:

Respiratory or lung disorders such as allergies, asthma, bronchitis, pulmonary embolism, emphysema, pleurisy, pneumonia, tuberculosis etc.?	NO ☐ YES ☐	Please provide details: Date of first symptoms: Number of attacks per year:
Neurological, cerebral or neuromuscular disorders such as aneurysm, stroke, epilepsy, fibromyalgia, multiple sclerosis, meningitis, muscular dystrophy, paralysis, even if temporary etc.?	NO ☐ YES ☐	Please provide details: Date of first symptoms: For epilepsy, number of attacks per year:
Mental disorders such as anxiety, depression, fatigue, insomnia, stress, overwork, behavioral problems etc.?	NO ☐ YES ☐	Please provide details: Treatment: Duration: Date:
Disorders of the heart or blood vessels such as arteritis, chest pain, hypertension, heart attack, coronary heart disease, malformation, edema, palpitations, phlebitis, murmur, heart rhythm disorders etc.?	NO ☐ YES ☐	Please provide details: Date(s):
Digestive or liver disorders such as cirrhosis, irritable bowel syndrome, constipation, Crohn's disease, diarrhea, diverticula, hiatal hernia, hepatitis, heartburn, pancreatitis, parasitic disease, polyps, ulcerative colitis, rectal bleeding, ulcers etc.?	NO ☐ YES ☐	Please provide details: Date(s):
Kidney or urinary tract disorders such as albuminuria, stones, renal colic, dialysis, hematuria, renal cysts, nephritis etc.?	NO ☐ YES ☐	Please provide details: Date(s):
Inflammatory rheumatic disorders such as spondylitis, rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis etc.?	NO ☐ YES ☐	Please provide details: Date(s):
Musculoskeletal disorders (spine or other joints) such as algodystrophy, osteoarthritis, slipped disk, lower back pain, osteoporosis, prostheses, ruptured ligament, sciatica, scoliosis, vertebral compression etc.?	NO ☐ YES ☐	Please provide details: Date(s):
Endocrine or metabolic disorders such as thyroid disease, cholesterol diabetes, dyslipidemia, gout etc.?	NO ☐ YES ☐	Please provide details: Date(s):
Blood or lymphatic disorders such as adenopathy, anemia, hemochromatose, hemophilia, leukemia, polycythemia, splenomegaly, bleeding disorders etc.?	NO ☐ YES ☐	Please provide details: Date(s):
Skin conditions such as eczema, herpes, cysts, lupus, mycosis, birthmarks, psoriasis, purpura, shingles etc.?	NO ☐ YES ☐	Please provide details: Date(s):
ENT or eye disorders such as cataracts, glaucoma, laryngitis, ear infections, retinopathy, sinusitis, dizziness etc.?	NO ☐ YES ☐	Please provide details: Date(s):

QUESTIONS FOR FEMALE APPLICANTS ONLY

Have you ever suffered or are you currently suffering from a disorder of the genitals and/or breast?	NO ☐ YES ☐	Please provide details: Date of last consultation:
Have you ever had a mammogram or a pelvic ultrasound?	NO ☐ YES ☐	Mammogram ☐ Ultrasound ☐ Why? Date(s): Results (please enclose):
Are you pregnant?	NO ☐ YES ☐	Normal pregnancy: NO ☐ YES ☐ How many months? C-section planned: NO ☐ YES ☐

Your personal data is processed in compliance with the GDPR dated June 20, 2018 on the protection of data. You expressly accept the collection and processing of your data required for the management of your membership and benefits.

This data is processed in compliance with medical confidentiality. It is intended for the exclusive use of the insurer's medical advisor and their medical department. You have the right to access, rectify and object to medical data relating to you by mailing a letter, together with a photocopy of ID, to the insurer's medical advisor at the following address: Service Médical Collectives – Immeuble WP2 – 4, boulevard de Pesaro – 92000 Nanterre, France.

I, the undersigned, Doctor _____

- certify that I have read all of the questions from this questionnaire to the person applying for the insurance and have accurately transcribed opposite each question the answer which they gave to it.
- certify that M _____ signed the questionnaire in my presence.

Signed in: **Date** (DD/MM/YYYY):	**Signature and stamp of the examining doctor:**

I, the undersigned, M _____

certify that the answers to this questionnaire have been transcribed in my presence and are exactly those which I gave to the questions.

I understand that my accurate and honest statements form the basis of my membership of the plan.

Signed in (town/city and country, excluding USA and countries under international sanctions*): **Date** (DD/MM/YYYY):	**Signature of the person applying for the insurance:**

** For any questions on countries under international sanctions, please contact us.*

MEDICAL EXAMINATION

Please do not provide the applicant with any opinion which may prejudge the decision of the insurer.

GENERAL APPEARANCE

Height (cm):	Weight (kg):	
Weight loss or gain over the last year?	NO ☐ YES ☐	Loss (kg): Gain (kg): Cause:
Chest measurement:	Inhaling:	Exhaling:
Waist and hip measurements:	Waist:	Hips:
Skin lesions such as birthmarks, suspicious moles or scars	NO ☐ YES ☐	Details:
Signs of alcoholism or other substance abuse?	NO ☐ YES ☐	Please provide details:

NERVOUS SYSTEM AND MUSCLES

Are there any signs of disorders of the nervous system or myopathy?	NO ☐ YES ☐	Please provide details:

MENTAL HEALTH

Did you detect any behavioral, thought or mood disorders or any signs suggesting a psychiatric or neuropsychic disorder?	NO ☐ YES ☐	Please provide details:

SENSORY ORGANS

Are there any disorders or impairment of vision?	NO ☐ YES ☐	Please provide details: Uncorrected: - R: - L: Corrected: - R with diopters: - L with diopters:
Impaired hearing?	NO ☐ YES ☐	In one or both ears? Total or partial?
Other disorders of the ear?	NO ☐ YES ☐	Please provide details:

RESPIRATORY SYSTEM

Did your examination reveal any abnormalities?	NO ☐ YES ☐	Please provide details:

CARDIO VASCULAR EXAMINATION

Did auscultation reveal any signs of heart abnormality?	NO ☐ YES ☐	Please provide details:
Did auscultation reveal any signs of abnormality of the arterial tree (carotid artery, iliofemoral axis)?	NO ☐ YES ☐	Please provide details:
Was the heartbeat irregular?	NO ☐ YES ☐	Please provide details:
Were there any abnormalities of the peripheral pulses?	NO ☐ YES ☐	Please provide details:
Disorders of the venous system, edema or trophic disorder?	NO ☐ YES ☐	Please provide details:
Blood pressure:	Right systolic: Left systolic:	Right diastolic: Left diastolic:
Is blood pressure controlled?	NO ☐ YES ☐	Type of treatment:
If you detected high blood pressure, please test again at rest:	Right systolic: Left systolic:	Right diastolic: Left diastolic:
Pulse rate (/min):		

DIGESTIVE TRACT AND ACCESSORY ORGANS		
Did you detect any abnormalities of the mouth and throat?	NO ☐ YES ☐	Please provide details:
Did palpation of the abdomen reveal any signs of abnormality?	NO ☐ YES ☐	Please provide details:
Evidence of enlarged liver?	NO ☐ YES ☐	By how many cm? Consistency:
Evidence of enlarged spleen?	NO ☐ YES ☐	Palpable over (cm):
Evidence of hernia or eventration?	NO ☐ YES ☐	Description:
CONDITION OF BONES AND JOINTS		
Are there any abnormalities of the bones, joints, spine (malformation, Lasegue, mobility, inflammatory symptoms etc.)?	NO ☐ YES ☐	Please provide details:
ENDOCRINE GLANDS		
Any signs of dysfunction?	NO ☐ YES ☐	Please provide details:
Abnormalities discernable by palpation?	NO ☐ YES ☐	Please provide details:
LYMPH NODES		
Abnormalities discernable by palpation?	NO ☐ YES ☐	Please provide details:
GENITO-URINARY SYSTEM		
Results of urine test carried out by you using a test strip. (Please discard any samples brought to the office by the patient)	Proteins: NO ☐ YES ☐	Sugar: NO ☐ YES ☐ Leukocytes: NO ☐ YES ☐ Blood: NO ☐ YES ☐
Abnormalities of the kidneys discernable by palpation?	NO ☐ YES ☐	Please provide details:
Any abnormalities of the breasts or testicles?	NO ☐ YES ☐	Please provide details:
In your role as Examining doctor, do you know the person being examined?	NO ☐ YES ☐	If yes, in what capacity? If no, identity check is mandatory ID card ☐ Passport ☐
Name and address of Treating doctor:		

Additional remarks (optional):

Signed in (town/city and country, excluding USA and countries under international sanctions*): **Date** (DD/MM/YYYY):	**Signature and stamp of Examining doctor:**

** For any questions on countries under international sanctions, please contact us.*

APPLICATION FOR COVERAGE

I HEREBY APPLY for membership of ASFE (Association of Services for Expatriates), an association governed by the French law of 1901 with its registered office in Season, 39 rue Mstislav Rostropovitch 75815 PARIS Cedex 17, FRANCE, as well as the insurance agreements entered into by the association with the following insurance companies:

- GROUPAMA GAN VIE, for LIFEPLAN'EXPAT Life and Disability benefits

I ACKNOWLEDGE the following:

- I have noted the advice provided by MSH INTERNATIONAL and wish to follow it. MSH INTERNATIONAL is a French insurance broker (registered with ORIAS under number 07 002 751) which designs and manages the entire range of insurance on behalf of ASFE including the LIFEPLAN'EXPAT policy.
- I have read and accepted the provisions of the terms and conditions of the LIFEPLAN'EXPAT policy, serving as the information booklet, have retained a copy of it and accept the terms of this application which serves as the schedule. I am aware of my right to cancel.
- I am aware that my telephone calls to the MSH INTERNATIONAL administration teams may be recorded for the requirements of internal administration and in order to improve their services. I may access recordings of my calls by writing to MSH INTERNATIONAL - Gestion ASFE - 23 allées de l'Europe - 92587 Clichy Cedex - France enclosing ID. Each recording is kept for a period of 90 days.
- Membership of ASFE does not exempt me from paying contributions to any mandatory scheme to which I may belong.
- I am aware that no payments can be made directly or indirectly to a country which is subject to sanctions imposed, for example, by the United Nations, the Office of Foreign Assets Control (OFAC) of the US Treasury or the European Union.
- I have been informed that the information collected is intended to formally identify me in order to provide me with access to a secure area or to gather details to enable MSH INTERNATIONAL to provide me with solutions and answers. This information is intended solely for MSH INTERNATIONAL and may be processed in order to comply with its legal obligations and for the execution, promotion, administration and implementation of the insurance policies. Under the GDPR dated June 20, 2018 on data protection, you have the right to access, amend, rectify and object to information concerning you by writing to: MSH INTERNATIONAL - Direction juridique - Season, 39 rue Mstislav Rostropovitch - 75815 Paris Cedex 17 - France enclosing a copy of a signed identity document.
- I have received all the information related to the processing of personal data and I have expressly agreed that, if I live outside the European Union and in order to benefit from international Life and Disability benefits coverage, my data may be transferred to providers located in third countries outside the European Union guaranteeing a level of protection different from the one provided by the GDPR.
- I have been informed that if my membership application is based on scanned documents, it is my responsibility to keep the originals throughout the entire life of the plan as I may be requested to produce them for audit purposes at any time during this period. If I cannot provide the original documents requested, benefits will be forfeited.

☐ I EXPRESSLY AGREE that to benefit from life & disability coverage under my plan, my data may be transferred to third countries outside the European Union guaranteeing an appropriate level of protection or subject to the use of adapted safeguards such as the signature of standard data protection clauses adopted by the European Commission, or based on the derogations provided for in Article 49 of Regulation 2016/679, known as General Data Protection Regulation.

I CERTIFY that I have answered the questions in this application form accurately and honestly and have neither declared nor omitted anything that could mislead MSH INTERNATIONAL and lead to the application of Articles L.113-8 and L.113- 9 of the French Insurance Code.

Signed in (town/city and country, excluding USA and countries under international sanctions*):	**Signature of the member:**
Date (DD/MM/YYYY):	

** For any questions on countries under international sanctions, please contact us.*

COMPLETION OF YOUR APPLICATION FOR COVERAGE

To complete your application, you need to email or mail us the following:

- The enrollment form filled out and signed,
- The medical questionnaire included in this document, filled out and signed, together with the additional medical information if you answered yes to any questions. The primary insured member, and each of their dependents if any, must fill out a medical questionnaire,
- A copy of a valid identity document with a photo (ID card or passport) for the primary insured member and their dependents, and the payer of the premiums (if different from the insured member),
- A bank account slip or the account's bank details to receive the reimbursement of your medical expenses,
- In case of payment by SEPA direct debit, please provide you bank account slip,
- A certificate from your previous healthcare insurance provider issued less than a month ago and a summary of benefits in order to possibly waive waiting periods,
- A school/university attendance certificate for your children aged between 18 and 25.

If the payer is a legal entity:

- Identification document of the legal entity issued less than 3 months ago (French K-bis or company registration certificate),
- The completed client information form.

You can pay your premium by:

- The SEPA CORE direct debit mandate completed and signed (from a French or Monaco account only),

or

- The credit card authorization completed and signed,

or

- Bank transfer.

After payment of your premium, you will receive a welcome e-mail including:

- A personalized card showing all our contact details.
- Your login details allowing you to access all our on-line services available at www.msh-intl.com in your Members' Area.
- Your member's guide, including the general terms and conditions of your plan and all the necessary information about how to use the services under your plan.

ENROLLMENT BY EMAIL:

Fill out this application for coverage form and send it together with the abovementioned supporting documents to: newapplication@msh-intl.com

ENROLLMENT BY MAIL:

MSH - Service Adhésions
23 allées de l'Europe - 92587 Clichy Cedex - France

PLEASE NOTE THAT INCOMPLETE APPLICATION WILL NOT BE PROCESSED.

A QUESTION?

ASFE – MSH: a French insurance broker and simplified joint stock company (SAS) with a capital of €2,500,000 and its registered office located at Immeuble Season – 39 rue Mstislav Rostropovitch 75815 Paris cedex 17. It is registered in the French "Registre du Commerce et des Sociétés de Paris" under number 352 807 549 RCS, ORIAS no. 07 002 751 and intra-Community VAT identification number FR 78 352 807 549.

MSH on behalf of asfe