START' EXPAT
ENROLLMENT FORM

I1267

MSH INTERNATIONAL
SIACI SAINT HONORE GROUP

on behalf of asfe MONCEY ASSURANCES & CONSEILS

PLEASE COMPLETE THIS FORM IN BLOCK CAPITALS, and send it to us duly completed and signed along with the complementary documents requested:
By email to: admineurope@asfe-expat.com
(having first signed and scanned the entire enrollment form, while keeping the original copy)
By mail, see address at the end of this form.

1 APPLICANT DETAILS

Only people aged between 16 and 65 can subscribe to the plan.

Title: Ms ☐ Miss ☐ Mr. ☐

First name(s):

Last name:

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

Nationality:

Occupation (for working pople; please specify if your are a student):

Country of expatriation (several countries may be indicated):

Telephone No.:

Email:

Mailing address in your main country of residence:

Coverage period: 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5 months ☐ 6 months ☐
7 months ☐ 8 months ☐ 9 months ☐ 10 months ☐ 11 months ☐ 12 months ☐

Effective date of coverage requested (subject to the acceptance of your application): / /

Payment: By check ☐ By credit card debit authorization ☐

2 YOUR BENEFICIARY CLAUSE IN THE EVENT OF DEATH (DEATH BENEFIT)

☐ I hereby designate as my beneficiary my living spouse unless legally separated or divorced, otherwise my living children in equal shares among them, otherwise my father and mother in equal shares among them or the survivor of them, otherwise my other heirs in equal shares among them.

☐ I hereby designate as my beneficiary(-ies):

In (city/country, excluding USA)**:**	**Insured member's signature or the legal guardian of child under 18** (in this case, please indicate your relationship along with your surname and name) Preceded by "**Read and approved**":
Date (DD/MM/YYYY)**:** / /	

3 MEDICAL QUESTIONNAIRE

Please write in capital letters.

Title: Ms ☐ Miss ☐ Mr. ☐

First name(s):

Last name:

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

Nationality: **Height** (cm): **Weight** (kg):

IF YOU ANSWER YES TO ANY OF THE QUESTIONS BELOW:

Please provide all details deemed useful (dates, medical grounds, carry-over effects, therapy, duration, etc...) on an additional page that you will date, sign and send along with your application in a sealed envelope for medical confidentiality reasons, for the attention of the Consulting Physician.

Over the past 10 years, have you been hospitalized or undergone surgery (other than removal of the appendage, amygdala, adenoids and wisdom teeth)?	YES ☐ NO ☐
Have you been, or are your currently under medical supervision (therapy, medical care, prescribed medication...)?	YES ☐ NO ☐
Have you ever suffered from an illness condition or accident that required medical supervision for more than 30 consecutive days?	YES ☐ NO ☐
Are you scheduled to undergo a medical procedure or surgery and/or a medical examination and/or a medical treatment of any kind (psychology, psychiatry, physiotherapy, radiotherapy, speech therapy, chemotherapy, dental treatment, drug treatment, etc...) in the next 12 months?	YES ☐ NO ☐
Have any of your medical or viral test yielded abnormal results?	YES ☐ NO ☐

I hereby testify that the foregoing declarations are accurate, complete and fair. I have been informed and I accept that any intentional withholding of significant information or proven false declaration that might mislead the Association's insurers may lead to the cancellation of the insurance cover and to the reduction of benefits in accordance with the provisions of Articles L. 113-8 and L 113-9 of the French Insurance Code (Code des Assurances).

In (city/country, excluding USA):	**Insured member's signature or the legal guardian of child under 18** (in this case, please indicate your relationship along with your surname and name) Preceded by "**Read and approved**":
Date (DD/MM/YYYY): / /	

4 SIGNATURE AGREEMENT OF THE ENROLLMENT FORM

I HEREBY REQUEST coverage with ASFE (Association of Services for Expatriates), an association governed by the French law of 1901 on associations, which registered office is located 18 rue de Courcelles 75008 PARIS, France, and also request to be covered under the insurance agreements underwritten by ASFE with the following insurance companies:

- AXA FRANCE VIE, fors Healthcare coverage
- EUROP ASSISTANCE, for the Medical Assistance & Repatriation coverage, Death & Disability coverage, Third-Party Liability coverage and Rental Civil Liability coverage

I HEREBY ACKNOWLEDGE THE FOLLOWING:

- I understand the advice given by MSH INTERNATIONAL and agree to follow it. MSH INTERNATIONAL is a French brokerage company (registered with the ORIAS under No. 07 002 75) which designs and manages ASFE's entire range of insurance plans on its behalf, including the START'EXPAT plan.
- I have read and agree to the provisions of the general terms & conditions of START'EXPAT 2016/2017 that constitute an information guide, from which I have kept a copy, I agree to the specific terms and conditions of this application file. I acknowledge that I have read about my opting-out right.
- I have been informed that my telephone conversations with the administration teams of MSH INTERNATIONAL may be recorded for internal management purposes and with a view to improving services. I may access these records by writing to MSH INTERNATIONAL – Gestion ASFE – 82 rue Villeneuve, 92587 Clichy Cedex France and attaching a document of identification to my request. Each record is kept for a 90-day period.
- I hereby acknowledge that enrollment to ASFE does not exempt me from any premium payable under any mandatory scheme to which I may be eligible.
- I have been informed that no payment will be made, whether directly or indirectly, to countries subject to sanctions, as provided, for example, by the United Nations, the Office of Foreign Assets Control (OFAC) of the US Department of the Treasury or the European Union.
- I understand that the information collected is used either for identification purposes to allow me secure access to a website, or to collect information so MSH INTERNATIONAL can offer me customized solutions and answers. This information is exclusively intended for MSH INTERNATIONAL and is subject to automated processing used for compliance with legal requirements and for the purposes of signing, promoting, administering and fulfilling the insurance contracts. As provided by the French law of January 6, 1978 on Date Protection (Loi Informatique et Libertés), amended in 2004, I acknowledge the right to request, access rectify and delete any personal information held pertaining to myself. This right may be exercised by writing to: MSH INTERNATIONAL – Direction juridique – 18 rue de Courcelles – 75384 PARIS Cedex 08, FRANCE, together with a copy of signed document of identification.

I HEREBY AUTHORIZE MSH INTERNATIONAL to receive on my behalf reimbursement statements for hospitalization expenses paid for me by direct payment agreement.

I HEREBY TESTIFY that the foregoing declarations are accurate complete and faire. I have been informed and I accept that any intentional withholding of significant information or proven false declaration that might mislead MSH INTERNATIONAL may result in the cancellation of the insurance cover and to the reduction of benefits in accordance with the provisions of Articles L. 113-8 and L. 113-9 of the French Insurance Code (Code des Assurances).

In (city/country, excluding USA):	Insured member's signature or the legal guardian of child under 18 (in this case, please indicate your relationship along with your surname and name) Preceded by "**Read and approved**":
Date (DD/MM/YYYY): / /	

5 CREDIT CARD AUTHORIZATION FORM

I hereby authorize MSH INTERNATIONAL / ASFE to debit my credit card for the amount of my insurance, premium, i.e:

Cardholder's details:

Type of credit card: Visa ☐ Mastercard ☐ Amex ☐

Card number:

Expiration date: / / (DD/MM/YYYY)	**Card Validation Code:** (last three digits on the back of your card, excluding Amex)

In (city/country, excluding USA):	Insured member's signature or the legal guardian of child under 18 (in this case, please indicate your relationship along with your surname and name) Preceded by "**Read and approved**":
Date (DD/MM/YYYY): / /	

7 INFORMATION NOTE

Please be advised of the following important information:

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 tex 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 82, rue de Villeneuve 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 the investigation into your complaint.

If you still disagree with the reply or solution provided, you can write to the Insurance Mediator as a last resort: La Médiation de l'Assurance, TSA 50110 - 75441 Paris Cedex 09, France.

The information collected may be subject to automated processing used for the purposes of administering and fulfilling the contracts offered by our company.

As provided by the French law of January 6 1978 on Data Protection (Loi Informatique et Libertés), amended in 2004, you have the right to access, rectify and delete any personal information that we have on file pertaining to you. You may exercise this right by writing to (with a copy of a signed document of identification: ASFE - MSH INTERNATIONAL - Direction juridique - 18 rue de Courcelles - 75384 PARIS Cedex 08.

10 COMPLETION OF YOUR ENROLLMENT FORM

To complete your enrollment, you need to send us:

- **The enrollment form** completed and signed
- **The medical questionnaire** completed and signed, along with the additional medical details (on an additional page that you will date and sign) if you answered yes to any questions in the medical questionnaire
- **A copy of your identity card or passport**
- **A bank account slip** for your reimbursements from ASFE
- **The payment of your premium** (see below)

Please attach the following to your enrollment file:

- **A check payable** to ASFE

ou

- **The credit card authorization form** completed and signed for the amount corresponding to your premium for the chosen duration of stay

You will receive a Welcome Package when you join the plan in which you will find your member's guide, including:

- **A practical guide** to help you through your healthcare procedures and to provide you with clear and useful answers to the questions you are likely to have,
- **Your general terms and conditions**.

PLEASE SEND YOUR ENROLLMENT FORM AND ALL REQUIRED DOCUMENTS:

By email:

Signing and scanning your complete enrollment form (while keeping the original copy) to:
admineurope@asfe-expat.com

By mail:

ASFE - Service Adhésions
82, rue Villeneuve
92587 CLICHY Cedex - France

AN INCOMPLAETE ENROLLMENT FORM WILL NOT BE PROCESSED

MSH INTERNATIONAL on behalf of asfe MONCEY ASSURANCES & CONSEILS

SIACI SAINT HONORE GROUP