FIRST' EXPAT+
APPLICATION FORM

I1267

MSH INTERNATIONAL
SIACI SAINT HONORE GROUP

on behalf of asfe MONCEY ASSURANCES & CONSEILS

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.

1 APPLICANT DETAILS

Only persons under the age of 66 (or under the age of 71 if they are still in paid employment) may enroll in the plan.

Title: Mr ☐ Ms ☐

First name(s):

Last name:

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

Nationality (country for which you own a valid passport):

Home country (either your nationality country, or the country you would want to be repatriated to):

Country of expatriation (the country where you and your dependents (if applicable) 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 above address):

Phone number: country code: area code: number:

Email address (to receive email alerts for reimbursement statements):

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

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

Business sector:

Preferred language for contractual documents: French ☐ English ☐

2 DEPENDENTS TO BE COVERED UNDER THIS PLAN

Dependents can include your spouse/partner and any children financially dependent on the applicant up to the day before their 20th birthday, or up to the day before their 25th birthday if in full time education. Where the child is 18 or older, please attach a letter from the college/university confirming student status or a copy of the student's ID. If there is insufficient space for all dependents, please use another Application Form.

	DEPENDENT 1	DEPENDENT 2	DEPENDENT 3	DEPENDENT 4
Relationship to applicant	Spouse ☐ Child ☐	Child ☐	Child ☐	Child ☐
First name				
Last name				
Date of birth (DD/MM/YYYY)	/ /	/ /	/ /	/ /
Sex	M ☐ F ☐	M ☐ F ☐	M ☐ F ☐	M ☐ F ☐
Nationality				
Home country				
Country of expatriation				
Occupation (mandatory, please specify if your are a student)				
Business sector				

3 COMMENCEMENT OF COVER

Please indicate the date you require cover from (DD/MM/YYYY): / /
(must be the 1st or the 15th of any month)

Backdated enrollments will not be accepted.
Cover is conditional upon acceptance of your application, which is only confirmed when an Insurance Certificate is issued to you.

4 PLAN DETAILS

Please note that the currency/level of coverage/ benefits/ deductible will apply to all plan members.

Currency of the plan: Euro ☐ (Zones 1 to 4) US Dollar ☐ (All zones)

Select your level of healthcare coverage:

Quartz plan ☐ Pearl plan ☐ Sapphire plan ☐ Diamond plan ☐

Select your healthcare benefits:

☐ **HEALTH**: Inpatient care + Outpatient care*
☐ **HEALTH+**: Inpatient care + Outpatient care* + Vision + Dental
☐ **HEALTH+ CHILD**: Inpatient care + Outpatient care* + Vision + Dental + Maternity

* Inpatient care + Outpatient care* include Legal assistance and Civil liability

Select your deductible:

Please note that this deductible will apply to your inpatient and outpatient care covered by your plan. The currency of your deductible must be the same than the one you selected for the plan.
Please note that depending on the coverage zone and the level of coverage you selected, not all the deductibles will be available.

€: no deductible ☐	€350 ☐	€750 ☐	€2,000 ☐	€4,000 ☐
$: no deductible ☐	$500 ☐	$1,000 ☐	$2,500 ☐	$5,000 ☐

Select your coverage zone (your country of expatriation determines the minimum coverage zone):

The benefits apply in the **Selected coverage zone** and in lower **Coverage zones** (for example, if the **Selected coverage zone** is zone 3, the benefits will apply in zones 3, 2 and 1).
However, you may opt for a coverage zone which is higher than that corresponding to your country of expatriation.

☐ **Zone 5**: USA + Zones 1, 2, 3, 4

☐ **Zone 4**: Bahamas, Brazil, China, Hong Kong, Jersey, St. Barthelemy, St. Martin, Singapore, Switzerland, and United Kingdom + Zones 1, 2 and 3

☐ **Zone 3**: Australia, Austria, Canada, French Polynesia, Greece, Ireland, Israel, Italy, Japan, Monaco, New Zealand, Portugal, Qatar, Russia, Saint Pierre and Miquelon, Spain, Taiwan, Turkey, United Arab Emirates, and Vanuatu + Zones 1 and 2

☐ **Zone 2**: Andorra, Angola, Argentina, Azerbaijan, Bahrain, Barbados, Belarus, Belgium, Bolivia, Bosnia and Herzegovina, Bulgaria, Chile, Colombia, Costa Rica, Croatia, Cyprus, Czech Republic, Denmark, Djibouti, Dominican Republic, Ecuador, Finland, France, Georgia, Germany, Guatemala, Hungary, Iceland, Kazakhstan, Kuwait, Latvia, Lebanon, Liechtenstein, Luxembourg, Malaysia, Mexico, Mozambique, Netherlands, Nigeria, Norway, Oman, Panama, Peru, Saudi Arabia, Slovakia, South Africa, Sweden, Thailand, Ukraine, Uruguay, Venezuela, Vietnam and Wallis and Futuna + Zone 1

☐ **Zone 1**: Worldwide excluding countries from Zones 2 to 5

For clarity purposes, some islands and territories are not included in the list of countries. If your country of expatriation is not shown, please contact us.

5 SELECT YOUR OPTION: ASSISTANCE AND MEDICAL REPATRIATION

YES ☐ NO ☐

6 PAYMENT DETAILS

Quarterly premium: ☐☐☐☐,☐☐

Currency: Euro ☐ (Zones 1 to 4) US Dollar ☐ (All zones)

The currency must be the same than the one you selected in paragraph 4.

FREQUENCY AND METHOD OF PAYMENT

Please select the frequency and method of payment best suited to your situation:

	ANNUAL	BI-ANNUAL	QUARTERLY	MONTHLY
By direct debit on a French bank account **(the first installment will have to be paid by credit card, which is why you need to complete the next 2 methods of payment)**	☐	☐	☐	☐
Credit card* for the first payment and all future payments through your online Members' Area	☐	☐	☐	Not available
Check made payable to ASFE	☐	☐	☐	Not available

In (city/country, excluding USA):

Date (DD/MM/YYYY): / /

Insured member's signature, or the legal guardian of child under 18
(in this case, please indicate your relationship (parent, guardian...) along with your first name and name preceded by "read and approved"):

* **In case of payment through Credit Card, please fill out this form:**

Type of credit card: Visa ☐ Mastercard ☐ Amex ☐

Cardholders'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 term, the credit card information will be destroyed for legal reasons.

Credit card authorization form:

I hereby authorize MSH INTERNATIONAL on behalf of ASFE to debit my credit card for the amount of my quarterly insurance premium, ie:

☐☐☐☐,☐☐ Euro ☐ (Zones 1 to 4) Dollar US ☐ (All zones)

In (city/country, excluding USA):

Date (DD/MM/YYYY): / /

Insured member's signature, or the legal guardian of child under 18
(in this case, please indicate your relationship (parent, guardian...) along with your first name and name preceded by "read and approved"):

** In case of payment through direct debit on a French bank account, please fill out the following SEPA CORE direct debit mandate, and enclose your “Relevé d’identité bancaire”. You also need to fill out the credit card authorization form on page 3:

ASFE SEPA CORE DIRECT DEBIT MANDATE

Unique Mandate Reference: UMR (will be sent in your next premium invoice)

By signing this mandate form, you authorize MSH INTERNATIONAL to send instructions to your bank to debit your account and your bank to debit your account in accordance with the instructions from MSH INTERNATIONAL. As part of your rights, you are entitled to a refund from your bank under the terms and conditions of your agreement with your bank. A refund must be claimed within 8 weeks starting from the date on which your account was debited.

This information is mandatory and necessary to your creditor for the implementation of SEPA Direct Debit. 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 INTERNATIONAL Immeuble Season - 39 rue Mstislav Rostropovitch 75815 Paris cedex 17 SEPA CREDITOR IDENTIFIER (CI): FR60ZZZ460359

ACCOUNT HOLDER'S BANK DETAILS

IBAN

BIC

NAME OF YOUR BANK:

DATE (DD/MM/YYYY)	MANDATORY SIGNATURE

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 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 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: ASFE - MSH INTERNATIONAL - Direction juridique - Immeuble Season - 39 rue Mstislav Rostropovitch - 75815 Paris cedex 17, together with a copy of a signed document of identification.

Please do not hesitate to contact us should you have any questions or concerns.

8 MEDICAL QUESTIONNAIRE

If you answer yes to any of these questions for you or one of your dependents, please provide all details deemed useful (dates, medical grounds, carry-over effects, nature of therapy, duration, etc.) on an additional page that you must date and sign. For confidentiality reasons, please put it in a closed envelope for the attention of the "Consulting Physician".

According to your answers to this questionnaire and the analysis of our Consulting Physician, we can either refuse your enrollment or accept it with some restriction of benefits or with a loaded premium, as mentioned in the General Terms and Conditions of your plan.

Each member must fill out and sign a Medical Questionnaire (the legal representative must sign if the child is aged under 18). If you need to fill out more than one medical questionnaire, please make a photocopy.

QUESTIONS	
Indicate whether you are...	INSURED MEMBER ☐ SPOUSE ☐ CHILD ☐
Last name	
First name	
Height (cm)	
Weight (kg)	

ALL QUESTIONS MUST BE ANSWERED. PLEASE ADD ALL REQUESTED DETAILS WHERE NECESSARY.

1	Are you currently on sick leave?	YES ☐ NO ☐
2	Over the past three years, have you ever been on sick leave for more than 10 consecutive days?	YES ☐ NO ☐
3	Over the past 10 years, have you ever been hospitalized (in a hospital, clinic, spa facility...) for: - Surgery interventions	YES ☐ NO ☐
	- Follow-up care / medical treatments	YES ☐ NO ☐
4	Over the past 10 years, have you ever suffered from an illness or condition that required medical supervision (therapy, medical care, medical follow-up care...) for more than 15 consecutive days?	YES ☐ NO ☐
5	Are you currently under medical supervision (therapy, medical care, medical follow-up care...) and/or are you taking prescribed medication (other than contraceptives)?	YES ☐ NO ☐
6	Before enrolling in this plan, were you entitled to 100% French Social Security coverage on medical grounds? If so, please mention the pathology.	YES ☐ NO ☐
	Are you scheduled, within the next 12 months, to undergo: - A medical or surgery intervention?	YES ☐ NO ☐
7	- A medical examination (radiology, laboratory tests, MRI, scans, GP's or specialist visits...)?	YES ☐ NO ☐
	- A medical procedure of any kind (psychology, psychiatry, physiotherapy, radiotherapy, speech therapy, chemotherapy, dental treatment, drug treatment, etc.)	YES ☐ NO ☐
8	Over the past five years, have any of your medical or viral tests yielded abnormal results?	YES ☐ NO ☐

QUESTIONS (suite)	
9 Have any of your parents, brothers or sisters (living or deceased) suffered from diabetes, heart disease, high blood pressure or cholesterol, cancer, kidney disease, polyposis of the colon, or any other hereditary disorder before the age of 65?	YES ☐ NO ☐
10 Do you: - smoke more than 10 cigarettes a day?	YES ☐ NO ☐
- drink more than 2 glasses of wine (or equivalent) a day?	YES ☐ NO ☐
11 Are you or have you been a drug user (marijuana, hashish, etc.)? If you have quit, since when?	YES ☐ NO ☐ / /
12 Have you ever had psychotherapy or consulted a psychiatrist? If yes, when?	YES ☐ NO ☐ / /

If you answer "yes" to any of these questions for you or one of your dependents, please provide all details deemed useful (dates, medical grounds, carry-over effects, nature of therapy, duration, etc.) mentioning the number of the question(s) you answered "Yes" to. If you need more space, please fill out another page that you will have to date and sign.

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 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):

Date (DD/MM/YYYY): / /

Insured member's signature, or the legal guardian of child under 18
(in this case, please indicate your relationship (parent, guardian...) along with your first name and name preceded by "**read and approved**"):

9 SIGNATURE 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 Immeuble Season - 39 rue Mstislav Rostropovitch - 75815 Paris cedex 17, France and also request to be covered under the insurance agreements underwritten by ASFE with the following insurance companies:

- **GROUPAMA GAN VIE,**
  acting on behalf of GROUPAMA GAN VIE, for Healthcare coverage FIRST'EXPAT+
- **EUROP ASSISTANCE**
  for the Medical Assistance & Repatriation coverage FIRST'EXPAT +
- **CIVIS - AREAS** for Legal Protection coverage FIRST'EXPAT+
- **CHUBB** for Third-Party Liability Coverage

I HEREBY ACKNOWLEDGE:

- 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. 07 002 751) which designs and manages ASFE's entire range of insurance plans on its behalf, including the FIRST'EXPAT plan.
- I have read and agree to the provisions of the general terms & conditions of FIRST'EXPAT that constitute an information guide, from which I have kept a copy, and I agree to the specific terms and conditions of this enrollment form. 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 Data 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 - Immeuble Season, 39 rue Mstislav Rostropovitch, 75815 Paris cedex 17, France, together with a copy of a signed document of identification.
- I understand that if I subscribe by email sending my signed and scanned enrollment file, I will have to keep the original enrollment file during all the duration of my membership at MSH INTERNATIONAL. I acknowledge that the original enrollment form can be asked for at any time. If I cannot provide it when asked, a lapse of coverage will apply.

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 fair. 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 (parent, guardian...) along with your first name and name preceded by "**read and approved**"):
Date (DD/MM/YYYY): / /	

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 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 healthcare reimbursements from ASFE,
- **a certificate from your previous healthcare insurance** and a summary of benefits in order to possibly waive waiting periods,
- **a school/university attendance certificate** for your children aged 20 to 25.

And for payment of your premium:

- **The direct debit authorization** (for French accounts only) completed and signed,

or

- **the credit card authorization** completed and signed

or

- **a check payable** to ASFE

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.asfe-expat.com in your Members' Area,
- **your member's guide**, including your general terms and conditions and a practical booklet to help you through your healthcare procedures and to provide you with clear and useful answers to the questions you are likely to have.

PLEASE SEND YOUR ENROLLMENT FORM AND ALL REQUIRED DOCUMENTS:

By email:

Signing and scanning your complete enrollment form at: newapplication@msh-intl.com

By mail:

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

INCOMPLETE ENROLLMENT FORMS WILL NOT BE PROCESSED

MSH INTERNATIONAL on behalf of asfe

SIACI SAINT HONORE GROUP