MSH

FIRST'EXPAT+
Application for coverage

BROKER CODE:
I1267

YOUR BROKER
Name: Moncey Assurances
Tel.: +33153163160

VALIDATE

PLEASE COMPLETE THIS FORM IN CAPITAL LETTERS, and return it to us:
- by email: at ***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 **33153163160**

PLAN MEMBER INFORMATION

Available to everyone up to and including age 70, except for the HOSPI package: up to and including age 60.

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 (either your country of nationality, or the country you would wish to be repatriated to):

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, this address will be used for communications related to the plan):

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 (mandatory, please do not fill in this field if you are a student or unemployed):

Preferred language for contractual documents: French ☐ English ☐

DEPENDENTS TO BE COVERED UNDER THE PLAN

Dependents include your spouse or dependent children under the age of 18, as well as children in full time education aged under 26.
In this case, dependent children over the age of 18 must provide proof of their student status at the beginning of each school year. If there is insufficient space for all dependents, please use a copy of this application for coverage form.
Please inform your dependents of our provisions relating to the protection of their personal data, and in particular of their rights of access, rectification, or erasure, or restriction or opposition and portability of their personal data.

	DEPENDENT 1	DEPENDENT 2	DEPENDENT 3	DEPENDENT 4
Relationship to plan member	Spouse ☐ Child ☐	Child ☐	Child ☐	Child ☐
First name(s)				
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 student or unemployed)				
Industry sector (mandatory, please do not fill in this field if student or unemployed)				

EFFECTIVE DATE OF MEMBERSHIP OF THE PLAN

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 requested 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.

SELECT YOUR LEVEL OF HEALTHCARE COVERAGE AND ASSOCIATED OPTIONS

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

Currency of the plan:

Euro ☐ (zones 1 to 4) US Dollar ☐ (zones 1 to 5)

Select your healthcare package:

Quartz plan ☐ Pearl plan ☐ Sapphire plan ☐ Diamond plan ☐
not applicable to the USA - zone 5

Select your healthcare benefits:

☐ HOSPI**: Hospitalization + Medical Evacuation (not applicable to the USA - zone 5)

☐ HEALTH: Hospitalization + Medical Evacuation + Routine healthcare*

☐ HEALTH+: Hospitalization + Medical Evacuation + Routine healthcare* + Vision + Dental

☐ HEALTH+CHILD: Hospitalization + Medical Evacuation + Routine healthcare* + Vision + Dental + Maternity

** The **Routine healthcare** coverage automatically includes Legal assistance + Personal third-party liability*
***HOSPI: enrollment up to 60 years included. Other packages: up to 70 years included*

Select your Repatriation Assistance option:

The Medical Evacuation benefit is included as standard with the plan.

If you would like to purchase the repatriation option, please specify: YES ☐ NO ☐

Select your deductible:

This deductible will apply to all your hospitalization care and routine healthcare covered by the Health package.

The currency of your deductible must be the same as the one you selected for the plan.

Please note that depending on the coverage zone and the level of healthcare coverage you selected, not all the deductibles will be available.

No deductible ☐ €350 / $500 ☐ €750 / $1,000 ☐ €2,000 / $2,500 ☐ €4,000 / $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.

If you would like to opt for a higher coverage zone, please indicate it here and specify the country:

☐ zone 5: USA + *zones 1, 2, 3 and 4*

☐ zone 4: Bahamas, Brazil, China, Hong Kong, Jersey, Mexico, 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, 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, Georgia, Germany, Guatemala, Hungary, Iceland, Kazakhstan, Kuwait, Latvia, Lebanon, Liechtenstein, Luxembourg, Malaysia, Monaco, 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 (including France) 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.

We inform you that some of the countries listed above outside the European Union, to which your data may be transferred if you are living in one of them, may guarantee a level of protection different from the one provided for by the GDPR.

☐ **I expressly agree** that, to benefit from the healthcare 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.

PAYMENT OF YOUR PREMIUM

Quarterly amount of your premium: ☐☐☐☐☐.☐☐

Currency: Euro ☐ (zones 1 to 4) US Dollar ☐ (zones 1 to 5)
The currency of payment must be the same as the currency of the plan.

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. *Important: regardless of the frequency and method of payment chosen, a minimum of 3 months of premiums must be paid by credit card or bank transfer upon enrollment.*

	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 direct debit[2] from an account in France or in Monaco (the first installment will have to be paid by credit card, **please fill out the SEPA mandate and the direct debit by credit card authorization).** **Important: Your first payment must correspond to three months of premiums. The monthly debit will start to apply as of the 4th month of premium*	☐	☐	☐	☐*
Bank transfer	☐	☐	☐	*Not available*
Country in which the payer's bank account is				

Signed in (town/city and country, excluding USA and countries under international sanctions**):

Date (DD/MM/YYYY):

Signature of the member or legal representative of a minor child (in this case, please indicate the capacity in which you are signing (parent, guardian, etc.) and your first and last names):

Sign here INITIAL HERE

[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 capacity (please indicate your capacity: parent, guardian, etc.):

Card number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiration date (MM/YY): ☐☐ / ☐☐

Validation code (mandatory): ☐☐☐☐ *(last 3 digits on the back of your card, or the four-digit number for AMEX cards. For American Express cards, the validation code is shown on the front of your card.)*

After payment of your first installment by credit card, this 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 health insurance premium payment from my bank card, i.e.:

☐☐☐☐☐.☐☐ Euro ☐ (zones 1 to 4) US Dollar ☐ (zones 1 to 5)

Signed in (town/city and country, excluding USA and countries under international sanctions**):

Date (DD/MM/YYYY):

Cardholder's signature:

Sign here INITIAL HERE

** *For any questions on countries under international sanctions, please contact:* **Moncey Assurances**

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

SEPA CORE DIRECT DEBIT MANDATE - BANK ACCOUNT SLIP TO BE PROVIDED

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 HOLDER

CREDITOR INFORMATION

Name and address of the creditor:

MSH
Immeuble Season - 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):

SIGNATURE REQUIRED:

Sign here

INITIAL HERE

MANDATORY: REIMBURSEMENT CONDITIONS

I want my reimbursements to be paid:

☐ to the same bank account as the one indicated for the direct debit of my premiums
☐ to a bank account different from the one used for the direct debit of my premiums (please provide your bank account slip).

FIRST NAME, LAST NAME AND ADDRESS

DEBTOR'S BANK DETAILS

IBAN:

BIC:

Name of your bank:

DATE (DD/MM/YYYY):

SIGNATURE REQUIRED:

Sign here

INITIAL HERE

MEDICAL QUESTIONNAIRE

If you answer yes to any of the questions below for you or one of your dependents, please provide all details deemed useful (date, reason, consequences and after effects, type of treatment, duration, etc.) at the back of this form after completing and signing it. For confidentiality reasons, please send this additional information in a closed envelope for the attention of the "Medical Advisor".

Depending on the details provided and further to a review by our medical advisor, we may be required to reject the application for coverage or accept it subject to restrictions on benefits or an increase in your premium as stated in the terms and conditions of the plan.

Each future member must fill out and sign a Medical Questionnaire (the legal representative must sign if the child is aged under 18). Please provide one medical questionnaire per member (photocopy or PDF form).

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 last 3 years, have you ever been on sick leave for more than 10 days?	YES ☐ NO ☐
3.	Over the last 10 years, have you ever been admitted to hospital and/or undergone surgery, including by endoscopy (other than childbirth, benign appendectomy, wisdom teeth, tonsil or adenoid removal during childhood, uncomplicated fractures which occurred more than a year ago, etc.)?	YES ☐ NO ☐
4.	Over the last 10 years, have you ever suffered from an illness, condition or injury that required medical supervision (treatment, regular medical care, etc.) for more than 15 days?	YES ☐ NO ☐
5.	Are you currently under medical supervision (treatment, medical care, medical follow-up care, etc.) 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 due to a chronic disease? If so, please mention the pathology:	YES ☐ NO ☐
7.	Are you scheduled, within the next 12 months, to undergo (excluding maternity and preventive tests):	
a.	- a medical or surgical procedure?	YES ☐ NO ☐
b.	- a medical examination (radiology, laboratory tests, MRI, scans, consultations, etc.)?	YES ☐ NO ☐
c.	- a medical treatment of any kind (psychology, physical therapy, radiotherapy, speech therapy, chemotherapy, dental treatment, drug treatment, etc.)?	YES ☐ NO ☐
8.	Over the last 5 years, have any of your biological and/or serological tests returned abnormal results?	YES ☐ NO ☐
9.	Have any of your parents, brothers or sisters (living or deceased) suffered from heart disease, high cholesterol, cancer, kidney disease, polyposis of the colon, or any other hereditary disorder before the age of 65?	YES ☐ NO ☐

Indicate whether you are…	INSURED MEMBER ☐	SPOUSE ☐	CHILD ☐
Last name			
First name			

10.	Do you:	
a.	- smoke more than 10 cigarettes a day?	YES ☐ NO ☐
b.	- drink more than 2 glasses of wine (or equivalent) a day?	YES ☐ NO ☐
11.	Have you ever had psychotherapy or consulted a psychiatrist? If yes, when?	YES ☐ NO ☐

If you answer yes to any of the questions above for you or one of your dependents, please provide all details deemed useful (date, reason, consequences and after effects, type of treatment, duration, etc.) mentioning the number of the question(s) you answered "YES" to. If you need more space, please indicate all necessary additional details on a separate sheet of paper.

I, the undersigned, 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 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 or legal representative of a minor child** (in this case, please indicate the capacity in which you are signing (parent, guardian, etc.) and your first and last names):
Date (DD/MM/YYYY):	Sign here **INITIAL HERE**

** For any questions on countries under international sanctions, please contact:* **Moncey Assurances**

PERSONAL DATA PROTECTION

MSH, 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 healthcare coverage plan, its management and monitoring and for compliance with regulatory requirements in the field of anti-money laundering and counter 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.

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 DIOT-SIACI - 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 penalties 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 92587 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 PLANÈTE 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.

SIGNATURE OF THE 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 at 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 Medical Expenses and Life & Disability benefits under the FIRST'EXPAT+ plan
- EUROP ASSISTANCE, for Medical Evacuation and Medical Assistance / Repatriation benefits under the FIRST'EXPAT+ plan
- CIVIS - AREAS, for Legal Assistance benefits under the FIRST'EXPAT+ plan
- CHUBB, for Third-Party Liability benefits under the FIRST'EXPAT+ plan

I ACKNOWLEDGE the following:

- I have taken note of the advice provided by MSH and wish to follow it. MSH is a French insurance broker (registered with ORIAS under number 07 002 751) which designs and manages the entire range of ASFE insurance products on its behalf, including the FIRST'EXPAT+ plan.
- I have read and accepted the provisions of the information booklet of the FIRST'EXPAT+ plan, serving as the terms and conditions, 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 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 - 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 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 healthcare coverage, my data may be transferred to healthcare 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 have informed my dependents under the plan of their rights regarding the protection of their personal data.

☐ **I AUTHORIZE MSH to receive on my behalf my reimbursement statements in respect of hospitalization expenses for which I used the direct billing service.**

I CERTIFY that I have answered the questions in this application accurately and honestly and have neither declared nor omitted anything that could mislead MSH 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 or legal representative of a minor child** (in this case, please indicate the capacity in which you are signing (parent, guardian, etc.) and your first and last names):
Date (DD/MM/YYYY):	

* *For any questions on countries under international sanctions, please contact:* **Moncey Assurances**

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?

+33153163160

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