Indigo Expat – Application Form

Indigo Expat Junior
Application Form – Private insurance

Please read the following carefully, completing all relevant information in **BLOCK CAPITALS** and ticking ☑ the relevant boxes to subscribe to Indigo Expat Junior.

☐ New application

☐ Change on existing policy

If you are adding a new dependant, please state your existing Policy Number _____

You must notify us of any change of contact details so we can ensure that correspondence reaches you. The underwriting department will consider applicants for cover up to the day of their 29th birthday. The contract can be renewed a maximum of 2 times, and covers up to the 30th birthday maximum.

1. Applicant's details

☐ M. ☐ Mrs Surname _____

First name _____ Date of birth (dd/mm/yy) ____ / ____ / ____

Family status ☐ Maried ☐ Divorced ☐ Widow ☐ Single ☐ Partner

Nationality (you have a valid passport) _____

Address in principal country of residence _____

City and zip code _____ Country _____

Home country _____ Country of expatriation _____

Primary phone number _____ (country code) _____ (area code) _____

Secondary phone number _____ (country code) _____ (area code) _____

Email address (claims administration) _____

Email address (invoicing, if different) _____

You are
☐ Student
☐ Employee –precise : _____
☐ Self employed – precise : _____
☐ Without professional activities – precise : _____
☐ Other situation (Working Holiday, …) – precise : _____

Language in which you wish to receive your policy documentation ☐ French ☐ English

Please indicate if you subscribed to any current domestic or international health insurance:

Name of Insurer _____

Policy number _____ Start date (dd/mm/yy) ____ / ____ / ____

2. Dependant to be covered under the contract

Dependant can include your spouse/partner. We will consider adult dependants for cover up to the day of their 29th birthday.

	Spouse
Surname	
First name	
Date of birth (dd/mm/yy)	____ / ____ / ____
Gender	☐ M ☐ F
Nationality	
Home country	
Country of residence / expatriation (where you live at least 6 months during the year)	
Occupation (mandatory, please state if student or without activities)	

3. Commencement of cover

Please indicate the date you require cover from
This date must be later than the date of receipt of your application form ____ / ____ / ____
Cover is conditional upon acceptance of your application, which is only confirmed when an Insurance Certificate is issued to you.

4. Plan details

Please select the type of intervention chosen for the Indigo Expat Junior coverage. This choice is applicable to all members.

Selected plan ☐ Indigo Expat Junior **1st Euro** ☐ Indigo Expat Junior on **Top-Up to CFE** (JeunExpat or MondExpat plans)

☑ We have created a bundled package specifically for individual clients which includes assistance and repatriation, personal liability and accidental death. Please note that these benefits are not available for sale separately.

Zone de couverture

☐ Zone 2: Angola, Argentina, Australia, Azerbaijan, Bahrain, Bolivia, Canada, Chile, Colombia, Costa Rica, Djibouti, Dominican Republic, Ecuador, Gibraltar, Georgia, Guatemala, Indonesia, Ireland, Iceland, Israel, Italy, Japan, Kazakhstan, Kuwait, Malaysia, Mexico, Moldova, Monaco, Mozambique, New Zealand, Nigeria, Oman, Panama, Peru, Qatar, Saudi Arabia, Seychelles, South Africa, South Korea, Thailand, Uruguay, Vanuatu, Vatican + Zone 1,

☐ Zone 1: Worldwide excluding countries listed in Zones 2.

NB: the following countries of expatriation are excluded: Bahamas, Barbados, Belarus, Brazil, China, Faroe Islands, Hong Kong, Lebanon, Morocco, Polynesia, Russia, Saint Barthélémy, Saint Martin, Saint Pierre et Miquelon, Singapore, Switzerland, Taiwan, United Arab Emirates, United Kingdom, United States of America, Venezuela, Wallis and Futuna.

5. Premium and payment details

Calculate and indicate your <u>quarterly premium</u> (i.e. annual premium divided by 4) _____ Euro

Quarterly fees to join ACME Association (annual fees of 24 Euro) _____ 6,00 Euro

If Insurance Premium Tax or other government levies apply, these will be stated on your insurance certificate and/or your invoice, send by ExpaTPA.

Payment frequency and method

Please tick ☑ to indicate you preferred payment frequency and method:

	Annual	Half yearly	Quarterly
Direct Debit * on a bank account located in the EU	☐	☐	☐
Credit card* for the first payment, and all future payments through your online Member's Area	☐	☐	☐
Bank transfer	☐	☐	☐

In (city/country) _____

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 an EU bank account, please fill out the following SEPA CORE direct debit mandate, and enclose your bank details ("Relevé d'Identité Bancaires"):**

SEPA CORE DIRECT MANDATE

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

By signing this mandate form, you authorize ExpaTPA to send instructions to your bank to debit your account and your bank to debit your account in accordance with the instructions from ExpaTPA. 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: EXPATPA 142 rue de Rivoli 75001 Paris Identifiant du Créancier SEPA (ICS) : FR32ZZZ871173

ACCOUNT'S HOLDER BANK DETAILS

IBAN : _____

BIC : _____

NAME OF YOUR BANK : _____

DATE (DD/MM/YYYY)

Date (dd/mm/yyyy) ____ / ____ / ____

MANDATORY SIGNATURE

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")

6. 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.
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.
Please do not hesitate to contact us should you have any questions or concerns.

7. Signature of the Application Form

I HEREBY REQUEST coverage with ACME (Association Cooperation, Mobility & Expatriation), an association governed by the French law of 1901 on associations, which registered office is located 9, rue du 4 Septembre 75002 PARIS, also request to be covered under the insurance agreements underwritten by ACME with the following insurance companies:

• MFPREVOYANCE, under a delegation of subscription granted to MGEN International Benefits, for healthcare coverage (contract n°G0507 for medical benefits on a 1st Euro basis and contract n°G0508 for those on Top-Up to CFE),

• TOKIO MARINE Europe S.A. (TOKIO MARINE HCC)
for assistance and repatriation, personal liability and accidental death coverage (contract n°FR025648TT),

I HEREBY ACKNOWLEDGE:

- I understand that Assurances et Conseils Moncey is a French brokerage company (registered with the ORIAS under n°07 005 355) which designs and manages, on the behalf of ACME, the entire range of Indigo Expat products.
- I have read and agree with the Indigo Expat's Notices of Information (including IPID), 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 ExpaTPA may be recorded for internal management purposes and with a view to improving services. I may access these records by writing to ExpaTPA – 142, rue de Rivoli, 75001 Paris, 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 ACME 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 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. 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 ExpaTPA 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 ExpaTPA 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) _____

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")

8. Completion of your Application Form

To complete your enrolment, please send us:

- **The Application Form** duly completed and signed
- **The Medical Questionnaire** duly completed and signed, for each member
- **A copy of your National ID Card** and/or your passport, for each member
- **Your Bank details** including your IBAN (for your healthcare reimbursements)
- **A copy of your CFE certificate** (mentioning the subscribed plan, the start date of your rights and all members) if you apply for a coverage on Top-Up to CFE

INCOMPLETE APPLICATION FORM AND FILES WILL NOT BE PROCESSED

PLEASE SEND YOUR APPLICATION FORM AND ALL REQUIRED DOCUMENTS:

By Mail to

Moncey Assurances / Indigo Expat
63 rue de Provence
75009 Paris, France

Email

Scan and email to:

backoffice@moncey-assurances.com

Personal Data protection

According to the Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of individuals concerning the processing of personal data and the free movement of such data (known as the "General Data Protection Regulation") and the amended "Informatique et Libertés" Act of 6 January 1978, and for the management of the insurance contract, the personal data of the Insured Person may be transferred to the Insurer and to its delegates, service providers, subcontractors or reinsurers. The purpose of the data processing is the conclusion, management and execution of insurance contracts, the elaboration of statistics and actuarial studies, the exercise of recourse and the management of claims and litigation, the execution of legal, regulatory and administrative provisions in force, in particular the fight against money laundering, against the financing of terrorism and against fraud, and operations relating to customer management. Within the strict framework of the above mentioned purposes, the recipients of this data are the duly authorized personnel of the Insurer, its delegates, its service providers, its subcontractors or its respective reinsurers and, where applicable, the social organizations and insurance intermediaries. This data will be kept throughout the contract's life, until the expiry of both the legal limitation periods and the periods provided for by the retention obligations imposed by the regulations.

You have the right to access, rectify and delete your personal data. Where consent is required for processing, you have the right to withdraw it. Under certain regulatory conditions, you have the right to request the limitation of processing or to object to it. You may also request the portability of the data you provided when necessary for the contract or when your consent was required.

Any request to exercise their rights can be addressed to the Data Protection Officer of CNP Assurances for MFPrévoyance - Data Protection Officer, 4 Place Raoul Dautry, 75716 PARIS CEDEX - dpo@cnp.fr or Data Protection Officer of Groupe VYV, Tour Montparnasse - 33, avenue du Maine - BP 245 - 75755 Paris Cedex 15 - dpo@groupe-vyv.fr. The Member has the right to lodge a complaint with the Commission Nationale de l'Informatique et des Libertés [CNIL] located at 3, Place de Fontenoy - TSA 80715 - 75334 Paris Cedex 07 - France.

Cancellation right in case of distance selling

Distance selling provisions apply if the policy is concluded via one or more distance selling techniques, particularly sale via correspondence or via the internet. In accordance with article L 112-2-1 of the French Insurance Code, a cancellation period of 14 calendar days applies in the case of distance selling. This period begins on the date the policy is concluded or from the date the applicant receives the policy conditions and information mentioned in article L.222-6 of the French Consumer Code (if this is after the date the policy is concluded). The date of conclusion of the policy corresponds to the membership start date.

Contract subscribed through Assurances et Conseils Moncey to VYV IB, on the behalf of MFPrévoyance, registered in accordance with the rules of the French insurance Code, subject to the supervision of ACPR 4 Place de Budapest 75436 Paris Cedex 09.

Association ACME

Information about Association law 1901 ACME is available on this page (in French): https://indigo-expat.com/infos/savoir-partir-expatriation/association-cooperation-mobility-expatriation-acme/

Note from the translator: Translation from an original document in French. In case of any discrepancies or misinterpretations resulting from the translation process, the original document in French will always prevail. The translator is not responsible for the contents of this document.

ASSOCIATION COOPERATION, MOBILITY & EXPATRIATION (ACME), Association régie par la Loi du 1er Juillet 1901 et par décret du 16 Aout 1901.
Adresse : 9 rue du 4 Septembre 75002 Paris.

You Insurance Broker
ASSURANCES ET CONSEILS MONCEY
Orias 07 005 355
Tel: +33 (0)1 53 16 31 60
FRANCE

Indigo Expat Junior

Medical Questionnaire (pls scan and send it separately)

Pre-existing conditions are medical conditions or any related conditions for which one or more symptoms have been displayed at some point during your lifetime, irrespective of whether any medical treatment or advice was sought. Any such condition or related condition, about which you or your dependants could reasonably have been assumed to have known, will be deemed to be pre-existing. Pre-existing conditions are covered under the policy, unless otherwise advised by us in writing. Conditions arising between completing the Application Form and the start date of the policy will equally be deemed to be pre-existing. Such pre-existing conditions will also be subject to medical underwriting and if not disclosed, they will not be covered.

Therefore, it is necessary that you advise us of any material changes to the information provided, between submission of this application and acceptance by us. You are hereby obliged on request to provide any further information that we might require. Full and accurate completion of this Application Form and disclosure of all relevant information is a condition precedent to cover. If you are an existing client, please also include details of any conditions for which you have claimed for since joining.

Please answer the following questions on the basis of your own and your dependants (if applicable) complete medical past. **All material facts (facts likely to influence the insurer's assessment and acceptance of this application) must be disclosed**. Failure to do so may invalidate the policy. **If you are in any doubt as to whether a fact is material, then it should be disclosed**. **This Health Declaration is valid for two months from the date of completion and the form being signed by the applicant.**

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. If you need to fill out more than one medical questionnaire, please make a photocopy.**

QUESTIONS

You are	☐ Insured Member	☐ Spouse
Surname		
Name		
What is your height,		
usual blood pressure at rest,		
Weight.		

PLEASE ANSWER ALL QUESTIONS AND PRECISE WHEN REQUIRED

1	Are you currently on sick leave?	☐ Yes	☐ No
2	In the past 3 years, have you had more than 10 days of medical leave?	☐ Yes	☐ No
3	In the course of the 10 past years, have you been hospitalized (clinic, hospital, thermal centre…) for one or several:		
	- surgical interventions?	☐ Yes	☐ No
	- medical follow-ups / treatments?	☐ Yes	☐ No
4	In the course of the 10 past years, have you affected by illnesses, illnesses and accidents which have led to medical surveillance (treatment, medical care, regular medical follow-up, tec.) for more than 15 days?	☐ Yes	☐ No
5	Are you currently under medical supervision (treatment, medical care, regular medical monitoring, etc.) and/or are you taking medication prescribed by a doctor (other than contraceptives)?	☐ Yes	☐ No

6	Before submitting your Application Form, did you benefit from 100% medical coverage by social security in the context of a Long-Term Affection? If so, please specify the pathology. In the next 12 months, should you undergo: - medical or surgical intervention?	☐ Yes ☐ No ☐ Yes ☐ No
7	- a medical examination (radiology, laboratory examination, MRI, scanner, consultation, etc.)? - a medical treatment of any kind (psychology, physiotherapy, radiotherapy, speech therapy, chemotherapy, dental treatment, medication, etc.)?	☐ Yes ☐ No ☐ Yes ☐ No
8	In the past 5 years, have you undergone any biological and/or serological tests which turned out to be abnormal?	☐ Yes ☐ No
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? - drink more than 2 glasses of wine (or equivalent) a day?	 ☐ Yes ☐ No ☐ 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 undergone psychotherapy or seen a psychiatrist? If so, when?	☐ Yes ☐ No __/__/__

If you answer “yes” to any of these questions for you or one of your dependants, 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 ExpaTPA 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) _____

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”)