Indigo Expat – Application Form

Indigo Expat WeCare
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 WeCare.

☐ New application

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

☐ Change on existing policy _____

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 before their 69th birthday.

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 : _____

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. Dependants to be covered under the contract

Dependants can include your spouse/partner and any children financially dependent on the applicant up to the day before their 18th birthday, or up to the day before their 24th birthday if in full-time education. Where the child is 18 years of age or older, please attach a letter from college/university confirming student status or a copy of the student's ID. We will consider adult dependants for cover up to the day before their 70th birthday. If there is insufficient space in the table below for all your dependants, please use another Application Form.

	Spouse	**Child 1**	**Child 2**	**Child 3**	**Child 4**
Surname					
First name					
Date of birth (dd/mm/yy)	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Gender	☐ M ☐ F	☐ M ☐ F	☐ M ☐ F	☐ M ☐ F	☐ M ☐ F
Nationality					
Home country					
Country of residence / expatriation (where you live at least 6 months during the year)					
Occupation (mandatory, please state i student or without activities)					

3. Commencement of cover

Please indicate the date you require cover from
This date is **the 1st or the 15th of the month** following the reception 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

Indigo Expat WeCare intervenes on a first euro basis, i.e. is a fully private insurance.

Selected plan
☐ Indigo Expat WeCare 80
☐ Indigo Expat WeCare 90
☐ Indigo Expat WeCare 100

Maternity Option
☐ Without Maternity
☐ With Maternity

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

Are of Cover

☐ Zone 4: China, Hong Kong, Taiwan + countries of Zones 3, 2, 1

☐ Zone 3: Brazil, Singapore + countries of Zones 2, 1,

☐ Zone 2: South Africa, Albania, Angola, Andorra, Argentina, Australia, Austria, Azerbaijan, Bahrain, Barbados, Belgium, Bolivia, Bosnia-Herzegovina, Bulgaria, Cambodia, Canada, Chile, Cyprus, Colombia, Costa Rica, Croatia, Czech Republic, Denmark, Djibouti, Dominican Republic, Ecuador, Estonia, Faroe (islands), Finland, Germany, Georgia, Gibraltar, Greece, Guatemala, Hungary, Indonesia, Ireland, Iceland, Israel, Italy, Japan, Kazakhstan, Kuwait, Latvia, Liechtenstein, Lithuania, Luxembourg, Macedonia, Malaysia, Malta, Morocco, Mexico, Moldova, Monaco, Montenegro, Mozambique, Netherlands, New-Zealand, Nigeria, Norway, Oman, Panama, Peru, Poland, Polynesia, Portugal, Qatar, Romania, Saint Barthelemy, Saint Martin, Saint Pierre et Miquelon, Serbia, Slovakia, Slovenia, Saudi Arabia, South Korea, Spain, Sweden, Thailand, Turkey, Ukraine, Uruguay, Vanuatu, Vatican, Vietnam and Wallis and Futuna + countries of Zone 1,

☐ Zone 1: Worldwide excluding countries listed in Zones 2 to 4.

Please note that each plan choosen will apply to all policy members. There is one option which can be purchased with this package: Maternity (a spouse/partner must also be insured under the policy if the Maternity option is selected). Your plan selection can only be amended at policy renewal. If you want to increase your level of cover, full medical underwriting may apply as well as waiting period, and an additional premium amount will be payable.

5. Premium and payment details

Calculate and indicate your <u>quarterly</u> premium _____ 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 invoice, send by MSH International.

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

	Annual	Half yearly	Quarterly	Monthly
Direct Debit ** on a bank account located in France or Monaco (the 1st payment corresponds to a 3 months period of cover)	☐	☐	☐	☐
Credit card* for the first payment, and all future payments through your online Member's Area	☐	☐	☐	Not available
Bank transfer	☐	☐	☐	Not available

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 Credit Card, please fill out and sign the following form

Card type ☐ Visa ☐ Mastercard ☐ Amex

Cardholder's name _____

Cardholder's signature _____

Card number _____

Expiration date (MM/YY) ____ / ____ Validation codem (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 the behalf of ACME to charge my credit card account for the payment of quarterly international insurance premium

Amount: _____ Euro

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 **a French or Monesgasque bank account**, please fill out the following direct debit mandate, and enclose your bank details ("Relevé d'Identité Bancaires"):

MSH INTERNATIONAL DIRECT 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'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.
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: Indigo Expat - 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.

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°G0405),

• 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 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 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 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) _____

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; along with the additional medical details if you answered yes to any questions in the medical questionnaire,
- **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 school/university attendance certificate** for children aged between 18 and 23

INCOMPLETE APPLICATION FORM AND FILES WILL NOT BE PROCESSED

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

- An **insurance certificate** showing all our contact details,
- An email explaining how to create and to access your **Members' Area on-line** at www.msh-intl.com,
- Your **notices of information** 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 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:	moncey@moncey-assurances.com

Data protection

According to the Data Protection Act of January 6th 1978, as amended, and in the context of the management of the insurance contract, the personal data of the Insured may be transferred to the Insurer, its administrators, its service providers, its subcontractors or reinsurers. Insured persons are informed that treatments concerning them, as well as those of their potential beneficiaries, are implemented as part of the execution, management and execution of this contract as well as for its commercial management. They may also be used in the context of control, prospecting, anti-fraud and money laundering and terrorist financing operations, the search for beneficiaries of unregulated death contracts, the execution of legal and regulatory provisions. The data collected will be kept for the duration of the contractual relationship increased legal requirements or in respect of the terms provided by the Commission Nationale Informatique et Libertés (CNIL).

The Insured person and / or beneficiaries have the right to access, rectify or erase data, limit the processing of their data, portability, opposition to treatments, as well as the right to define guidelines for their fate after their death. They can exercise their rights by mail addressed to:

- medical: MFPrévoyance - Délégué à la Protection des Données, 4 Promenade du Cœur de Ville, 92130 Issy les Moulineaux, France or by email (urgence.dpofs@MFPrévoyance.fr),
- assistance, personal liability or Individuelle Accident: Tokio Marine Europe S.A. – 36, rue de Châteaudun, CS 30099, 75441 Paris Cedex 09, France, or by email (reclamations@tmhcc.com)

When exercising their rights, the production of an identity document is requested. In case of persistent litigation, they have a right to seize the CNIL on www.cnil.fr or at 3, place de Fontenoy - TSA 80715 - 75334 Paris cedex 7, France.

Renonciation 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.

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

acme

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.

MONCEY ASSURANCES & CONSEILS

TOKIO MARINE HCC

vyv international benefits

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

Indigo Expat WeCare

Medical Questionnaire (pls scan 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 (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

You are	☐ Insured Member	☐ Spouse	☐ Child
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 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) _____

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”)