

FIRST' EXPAT+ APPLICATION FORM



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.

If you require assistance to complete this application for coverage, please contact us on +33 (0)1 44 20 48 77.

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 <input type="checkbox"/> Child <input type="checkbox"/>	Child <input type="checkbox"/>	Child <input type="checkbox"/>	Child <input type="checkbox"/>
First name				
Last name				
Date of birth (DD/MM/YYYY)	/ /	/ /	/ /	/ /
Sex	M <input type="checkbox"/> F <input type="checkbox"/>	M <input type="checkbox"/> F <input type="checkbox"/>	M <input type="checkbox"/> F <input type="checkbox"/>	M <input type="checkbox"/> F <input type="checkbox"/>
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, Singapore, Switzerland and United Kingdom + Zones 1, 2, 3
- Zone 3:** Australia, Austria, Canada, Greece, Ireland, Israel, Italy, Japan, Monaco, New Zealand, Portugal, Qatar, Russia, Taiwan, Turkey, Spain, UAE and Vanuatu + Zones 1, 2
- Zone 2:** Angola, Argentina, Azerbaijan, Bahrain, Barbados, Belgium, Belarus, Bolivia, Bosnia-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, Norway, Nigeria, Oman, Panama, Holland, Peru, Polynesia, Saint Barth, Saint Martin, Saint Pierre and Miquelon, 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

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)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Credit card* for the first payment and all future payments through your online Members' Area	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Not available
Check made payable to ASFE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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"):

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 <input type="checkbox"/> NO <input type="checkbox"/>
2	Over the past three years, have you ever been on sick leave for more than 10 consecutive days?	YES <input type="checkbox"/> NO <input type="checkbox"/>
3	Over the past 10 years, have you ever been hospitalized (in a hospital, clinic, spa facility...) for:	
	- Surgery interventions	YES <input type="checkbox"/> NO <input type="checkbox"/>
	- Follow-up care / medical treatments	YES <input type="checkbox"/> NO <input type="checkbox"/>
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 <input type="checkbox"/> NO <input type="checkbox"/>
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 <input type="checkbox"/> NO <input type="checkbox"/>
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 <input type="checkbox"/> NO <input type="checkbox"/>
7	Are you scheduled, within the next 12 months, to undergo:	
	- A medical or surgery intervention?	YES <input type="checkbox"/> NO <input type="checkbox"/>
	- A medical examination (radiology, laboratory tests, MRI, scans, GP's or specialist visits...)?	YES <input type="checkbox"/> NO <input type="checkbox"/>
	- A medical procedure of any kind (psychology, psychiatry, physiotherapy, radiotherapy, speech therapy, chemotherapy, dental treatment, drug treatment, etc.)	YES <input type="checkbox"/> NO <input type="checkbox"/>
8	Over the past five years, have any of your medical or viral tests yielded abnormal results?	YES <input type="checkbox"/> NO <input type="checkbox"/>

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 18 rue de Courcelles 75008 PARIS, France and also request to be covered under the insurance agreements underwritten by ASFE with the following insurance companies:

- **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 - 18 rue de Courcelles 75384 PARIS Cedex 08, 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):

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"):

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

