MSH INTERNATIONAL
SIACI SAINT HONORE GROUP

MSH INTERNATIONAL on behalf of ASFE

Your application file

Need help to fill out your application file? Please contact us at +33 (0)1 44 20 48 77.

ENROLLMENT FORM

Insured member

Title: ☐ Mrs. ☐ Miss ☐ Mr.

Last name: ______________________ First name: ______________________

Date of birth: _ _ / _ _ / _ _ _ _ Nationality: ______________________

Occupation (in your expatriation country) : ______________________

Other persons to be covered by the plan

		LAST AND FIRST NAMES		GENDER ((M/F)	DATE OF BIRTH DD / MM / YYYY
SPOUSE					_ _ / _ _ / _ _ _ _
DEPENDENT CHILD*	1				_ _ / _ _ / _ _ _ _
	2				_ _ / _ _ / _ _ _ _
	3				_ _ / _ _ / _ _ _ _

*Until age 20 or 25 inclusive and on condition that they are still enrolled in higher education.

The premium is calculated on the basis of the insured member's age or their spouse's if he or she is older.

Your contact details

Home phone no.: ______________________ Mobile phone no.: ______________________

E-mail address (to receive e-mail alerts for reimbursements): ______________ @ ______________

E-mail address (to receive premium invoices): ______________ @ ______________

Mailing address (for your application file and your reimbursement statements):

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Name and mailing address for premium invoices (if different from the above address):

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ASFE's First'Expat Plan

Your insurance plan

- Effective date of coverage requested *(Subject to the acceptance of your application)*:
  - ☐ the first day ASFE receives your complete enrollment form (including your payment)
  - ☐ a subsequent date: _ _ / _ _ / _ _ _ _
- Your coverage: ☐ Single ☐ Family ☐ 1 adult + 1 child
- Your country of expatriation: ____________________

		Basic healthcare	Healthcare + Medical assistance/ repatriation	Healthcare + Medical assistance/repatriation + Death & disability (until age 55)*	Quarterly premiums**
FIRST'EXPAT	Indice 30 Basic coverage	☐	☐	☐	€
	Indice 30 Basic coverage + option	☐	☐	☐	€
	Indice 40 Basic coverage	☐	☐	☐	€
	Indice 40 Basic coverage + option	☐	☐	☐	€
	Indice 50 Basic coverage	☐	☐	☐	€
	Indice 50 Basic coverage + option	☐	☐	☐	€
	Indice 60 Basic coverage	☐	☐	☐	€
	Indice 60 Basic coverage + option	☐	☐	☐	€
				Total 1	€

		Amount selected	Quarterly premiums*
YOUR CUSTOMIZED DEATH & DISABILITY BENEFITS (UNDER AGE 60*)	☐ Lump sum benefit for Death or Absolute and definitive disability, doubled if caused by an accident	€	€
	☐ Education annuity – Number of children:____	per year	€
	☐ Lump sum benefit for Accidental permanent disability	€	€
	☐ Daily allowances/Disability annuity	€	€
		Total 2	€

*excluding American citizens, people living in the USA and in France.
** those rates are applicable until December 31 2015

- Your beneficiary clause in the event of death *(if you have taken out the death benefit option)*:

☐ I hereby designate as my beneficiary my living spouse unless legally separated or divorced, otherwise my living children in equal shares among them, otherwise my father and mother in equal shares among them or the survivor of them, otherwise my other heirs in equal shares among them.

☐ I hereby designate as my beneficiary (includes her/his details) : ____________________

ASFE's First'Expat Plan

Premium payment

FIRST'EXPAT (see page 2)	Total 1	€
+		
DEATH & DISABILITY PACKAGE (OPTION) (SEE PAGE 2)	Total 2	€
=		
	GRAND TOTAL	€

Frequency:

- ☐ annual
- ☐ biannual
- ☐ quarterly

Method of payment:

- ☐ by direct debit on a French bank account *(in this case, please fill out the direct debit authorization form below).*
- ☐ by check made payable to ASFE.
- ☐ by credit card debit (for your first premium) *(in this case, please fill out the credit card debit authorization form on the next page).*

➡ Please note: For your next premiums, you can choose secure on-line payment by credit card on our website (under "Participants' Pages"/"On-line Payment") or by bank transfer.

ASFE SEPA DIRECT DEBIT MANDATE

Unique Mandate Reference (UMR): (will be sent to you 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 **18 rue de Courcelles, 75384 PARIS Cedex 08** **SEPA Creditor Identifier (CI): FR60ZZZ460359**

ACCOUNT HOLDER'S BANK DETAILS	
IBAN (International Bank Account Number): _	
BIC (Bank Identifier Code): _ _ _ _ _ _ _ _ _ _ _	**Name of your bank:**
DATE	**MANDATORY SIGNATURE**

ASFE's First'Expat Plan

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.

In case of a complaint, we recommend that you contact our group first via your usual contact person. You may also send a complaint in writing to our Service réclamation, 82 rue de Villeneuve 92587 CLICHY Cedex, France or to the Complaint Department of your nearest regional headquarter (all contact details are available on our website).

If the problem is still not resolved, you may also contact the Mediator of the Chambre Syndicale des Courtiers d'Assurance [Industrial Union for Insurance Brokers in France], responsible for claims from individuals: 91 rue Saint Lazare, 75009 PARIS, France, or the Autorité de Contrôle Prudentiel [French Regulatory Authority for Prudential Supervision], located 61 rue Taitbout 75009 PARIS, 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
18 rue de Courcelles
75384 PARIS Cedex 08, France

together with a copy of a signed document of identification.

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

CREDIT CARD DEBIT AUTHORIZATION FORM

I hereby authorize MSH INTERNATIONAL / ASFE to debit my credit card for the amount of my insurance premium, i.e.: € ______________________________

Cardholder's details and signature: ______________________________

Type of credit card: ☐ Visa ☐ Mastercard ☐ Amex

Card number: ☐ ☐ ☐ ☐ / ☐ ☐ ☐ ☐ / ☐ ☐ ☐ ☐ / ☐ ☐ ☐ ☐

Expiration Date: _ _ / _ _ and Validation Code: ☐ ☐ ☐ (last three digits on the back of your card, excluding Amex)

In: ______________________
Date: _ _ / _ _ / _ _ _ _

Cardholder signature, or the legal guardian of child under 18
(in the latter case, please indicate your relationship (parent, guardian...) along with your surname and first name)

preceded by "read and approved"

ASFE's
First'Expat
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Signature of the enrollment form

- **I hereby request** coverage with ASFE (Association de Services des Français de l'Etranger – Association of services to French people living abroad), 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:
  - GAN EUROCOURTAGE, acting on behalf of GROUPAMA GAN VIE, for Healthcare coverage FIRST'EXPAT Indice 30, Indice 40, Indice 60
  - AXA France Vie for Healthcare coverage FIRST'EXPAT Indice 50, Death & disability coverage (lump sum benefit for Death or Absolute and definitive disability, Education annuity, lump sum benefit for Accidental permanent disability, Daily allowances/ Disability annuity)
  - EUROP ASSISTANCE for the Medical Assistance & Repatriation coverage
  - CIVIS – AREAS for Legal Protection coverage
  - AXA Courtage for Third-Party Liability Coverage.

- **I hereby acknowledge the following:**
  - 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 2015 that constitute an information guide, from which I have kept a copy, and I agree to the specific terms and conditions of this application file. 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 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: ______________________
Date: _ _ / _ _ / _ _ _ _

Insured member's signature, or the legal guardian of child under 18
(in the latter case, please indicate your relationship (parent, guardian...) along with your surname and first name)

preceded by "read and approved"

ASFE's First'Expat Plan

Completion of your enrollment

To complete your enrollment, you need to send us:

- ☐ the enrollment form completed and signed,
- ☐ the medical questionnaire (on the next 2 pages) 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 waive waiting periods for Indice 50 and Indice 60,
- ☐ a school/university attendance certificate for your children aged 20 to 25.

And for payment of your premium:

- ☐ the direct debit authorization form (for French accounts only) completed and signed,

or

- ☐ the credit card debit authorization form 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 Participants' Pages,
- ☐ your general terms and conditions,
- ☐ 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.

Send your request for coverage together with all required documents to:

ASFE, Service Adhésions (Enrollment Department)
82 rue Villeneuve
92587 CLICHY Cedex
France

ASFE's
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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 will date and sign. For confidentiality reasons, please put it in a closed envelope for the attention of the "Consulting Physician".

Depending on the details provided and after our Consulting Physician has studied your case, we may refuse the request for coverage, or accept it with restricted benefits or an additional premium, as specified in your plan's general terms and conditions. For confidentiality reasons, please put any additional medical details in a closed envelope for the attention of the "Consulting Physician", and send it together with your application file.

	Insured member	Spouse	Child 1	Child 2	Child 3
Last name					
First name					
Height (cm)					
K eight (kg)					
All questions must be answered. Please add all requested details where necessary.					
Are you currently on sick leave?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Over the past three years, have you ever been on sick leave for more than 10 consecutive days?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Over the past 10 years, have you ever been hospitalized (in a hospital, clinic, spa facility…) for : - Surgery interventions?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
- Follow-up care / medical treatments?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
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?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Are you currently under medical supervision (therapy, medical care, medical follow-up care…) and/or are you taking prescribed medication (other than contraceptives)?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Before enrolling in this plan, were you entitled to 100% French Social Security coverage on medical grounds?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

I hereby testify that the foregoing declarations are accurate, complete and fair.
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In: ______________________
Date: _ _ / _ _ / _ _ _ _

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

ASFE's First'Expat Plan

Medical questionnaire (continued)

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 will date and sign. For confidentiality reasons, please put it in a closed envelope for the attention of the "Consulting Physician".

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	Insured member	Spouse	Child 1	Child 2	Child 3
Are you scheduled, within the next 12 months, to undergo:					
- A medical or surgery intervention	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
- A medical examination (radiology, laboratory tests, MRI, scansGP's or specialist visits…)	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
- A medical procedure of any kind (psychology, psychiatry, physiotherapy, radiotherapy, speech therapy, chemotherapy, dental treatment, drug treatment, etc.)	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Over the past five years, have any of your medical or viral tests yielded abnormal results?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
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?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Do you:					
- smoke more than 10 cigarettes a day?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
- drink more than 2 glasses of wine (or equivalent) a day?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Are you or have you been a drug user (marijuana, hashish, etc.)? - If you have quit, since when? _ _ / _ _ _ _	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Have you ever had psychotherapy or consulted a psychiatrist? - If yes, when? _ _ / _ _ _ _	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

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I have been informed and I accept that any intentional withholding of significant information or proven false declaration that might mislead MSH INTERNATIONAL may lead to 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: ______________________________
Date: _ _ / _ _ / _ _ _ _

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