APPLICATION FOR **LIFE & DISABILITY** COVERAGE

TFG GLOBAL
ID: I1735

on behalf of

PLEASE COMPLETE THIS FORM IN CAPITAL LETTERS and return it to us:
By email to: admineurope@asfe-expat.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. PLAN MEMBER INFORMATION

Only persons under the age of 66 may enroll in the plan.

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 (your country of nationality):

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):

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

Telephone number: country code: area code: number:

Email address for premium invoices (mandatory, in capital letters):

Occupation (mandatory, please specify if you are a student or unemployed):

Industry sector:

Preferred language for contractual documents: French ☐ English ☐

2. EFFECTIVE DATE OF ENROLLMENT

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 desired 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.

3. BENEFICIARIES OF THE DEATH / PTD BENEFIT: mandatory

☐ I name as beneficiary: my spouse from whom I am neither divorced nor separated by a final judgment, failing that my surviving children, in equal shares, failing that my parents in equal shares, or the surviving parent, failing that my other heirs in equal shares.

or

☐ I name as beneficiary (last name – first name – telephone number - address)

____

____

____

4. SELECTION OF YOUR LIFE & DISABILITY BENEFITS AND ASSOCIATED OPTIONS

Please note that the currency chosen for the plan (Euro or US Dollar) must be the same for all benefits selected.

Currency of the plan: Euro ☐ US Dollar ☐

Compulsory benefits: Select your Lump Sum in case of Death/Permanent Total Disability (All Causes)

This lump sum must be between €25,000 (or $30,000) and €1,000,000 (or $1,200,000) in multiples of €25,000 (or $30,000)
Selected amount: ____________________________

The beneficiary (or beneficiaries) of this lump sum must be named at the bottom of the previous page.

Select your optional life & disability benefits: all of these options can be purchased individually.

1. **Death/Permanent total disability lump sum to be doubled in case of accident** **Yes** ☐ **No** ☐
2. **Disability lump sum (All Causes)**

   Lump sum paid in the event of certified infirmity with more than 33% disability. This lump sum can be between €25,000 (or $30,000) and €1,000,000 (or $1,200,000) but cannot be more than the amount of the selected death benefit.

   Selected amount: ____________________________________

3. **Income Protection benefits**

   In the event of temporary incapacity to work, this benefit allows you to maintain your standard of living by providing you with an allowance calculated according to the following rules. This allowance is based on your net monthly income (or your net annual income divided by 12).

   The Daily Sick Leave allowance cannot be combined with Short-Term Disability (STD) benefit and/or Long-Term Disability (LTD) benefit. However, these last 2 benefits may be purchased together or individually.

3.1 "French-style" Income Protection benefits (not available if STD and/or LTD benefits have been purchased)

Daily Sick Leave allowance

Benefit which will be paid at the expiration of a mandatory waiting period (see below) and for a maximum period of 24 months and which will be followed by the payment of an annuity if your incapacity to work is recognized as permanent.

Your net monthly income: _________________________

Three waiting periods are available: ☐ **30 days** ☐ **60 days** ☐ **90 days**

Please check the appropriate box. Here the waiting period refers to the period during which you will not yet receive any benefits.

Amount of the daily allowance: amount of between €25 (or $30) and €500 (or $600) (in multiples of €25 or $30), limited to the amount of the selected death lump sum divided by 1,000. It cannot exceed 70% of the daily net income declared for tax purposes (or net monthly income divided by 30). If the maximum amount of benefit falls between two multiples of €25 or $30, the higher amount will be accepted.

Example: Mr. M earns €5,000 per month and purchases a death lump sum of €300,000. His maximum daily allowance is calculated as follows: (5,000 / 30) * 0.7 = 116.66, which is within the limit of the death lump sum (€300,000) / 1,000. Mr. M will therefore be able to select a daily allowance of between €25 (minimum allowance) and €125. In the second case, his allowance would provide him with a monthly income of €3,750.

Selected amount: ______________________________________

3.2 "Anglo-Saxon-style" Income Protection benefits

Your net monthly income: _________________________

a) Short-term disability (not available if Daily Sick Leave benefits have been purchased)

This benefit provides you with an allowance from the 1st day of temporary incapacity to work due to an accident or hospitalization and from the 7th day in case of illness.

This benefit will stop automatically at the end of one of the following 3 periods:

☐ 30 days ☐ 60 days ☐ 180 days

Please check the appropriate box. The allowance you receive is automatically 70% of your income.

Example: Ms. B has a net income of €7,000/month. Her monthly short-term disability allowance will be (7,000*0.7) = €4,900 (or €163.33 per day) for 30, 60 or 180 days depending on the duration she selected.

b) Long-term disability (not available if Daily Sick Leave benefits have been purchased)

This benefit can take over from Short-term disability benefit, although it is not compulsory.

This benefit provides you with an allowance on expiration of one of the periods shown below and up to the 1,080th day. If Short-term disability benefit has been purchased, this period cannot be less than the one selected for the Short-term disability benefit.

☐ 30 days ☐ 60 days ☐ 180 days

Please check the appropriate box. The allowance you receive is automatically 70% of your income.

Example: Ms. B has a net income of €7,000/month. Her monthly Long-term disability allowance will be (7,000*0.7) = €4,900 (or €163.33 per day) from the 30th, 60th or 180th day of sick leave, depending on the length of waiting period she selected.

5 PAYMENT DETAILS

Quarterly premium: ☐☐☐☐ , ☐☐

Currency: Euro ☐ US Dollar ☐

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 which will suit you most:

	ANNUAL	BI-ANNUAL	QUARTERLY	MONTHLY
By SEPA CORE** direct debit on a French bank account (the first payment will have to be paid by credit card, so please complete the next 2 methods of payment)	☐	☐	☐	☐
Credit card* for the first premium and all the other ones through your Members area	☐	☐	☐	Not available
Check made payable to ASFE	☐	☐	☐	Not available

* In case of payment through Credit Card, please fill out this form:

Type of credit card: Visa ☐ Mastercard ☐ Amex ☐

Cardholders'name:

Cardholder signature:

Card number:

Expiration date (MM/YY):

Validation code:

(last 3 digits on the back of your card, excluding Amex)

After the payment of your first term, those credit card information will be destroyed for legal reason.

Credit card debit 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:

☐☐☐☐ , ☐☐ Euros ☐ US Dollars ☐

In (city/country, excluding USA):

Date (MM/DD/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 surname and name) preceded by "read and approved":

** In case of payment through direct debit on a French bank account, please fill out the following SEPA CORE direct debit mandate, join your « Relevé d'identité Bancaire » and please fill out as well the Credit Card authorization form in Page 3 for the first payment of your premium:

ASFE SEPA CORE DIRECT DEBIT 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 18, rue de Courcelles - 75384 PARIS - Cedex 08 SEPA CREDITOR IDENTIFIER (CI): FR60ZZZ460359

ACCOUNT HOLDER'S BANK DETAILS

IBAN

BIC

NAME OF YOUR BANK:

DATE (MM/DD/YYYY)	MANDATORY SIGNATURE

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.

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 reclamation", 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.

7. MEDICAL FORMALITIES TO BE RETURNED TO US

Depending on your age and the amount of death lump sum purchased, you will be required to complete various medical formalities to enable us to confirm your enrollment.

Please refer to the table below to find out which medical formalities you need to return to us, including the information required in each situation as shown in the key below:

Death / Permanent total disability lump sum	€25,000 to €150,000 ($30,000 to $180,000)	€150,001 to €250,000 ($180,001 to $300,000)	€250,001 to €350,000 ($300,001 to $420,000)	€350,001 to €500,000 ($420,001 to $600,000)	€500,001 to €1,000,000 ($600,001 to $1,200,000)
Age					
Age 45 or under	1	1	2	4	5
Age 46 to 55	1	2	4	4	5
Age 56 to 65	2	3	4	5	5

Key:

1: Simplified health questionnaire

2: Comprehensive health questionnaire

3: Comprehensive health questionnaire + Medical Report completed, dated and signed by the examining doctor

4: Comprehensive health questionnaire + Medical Report completed, dated and signed by the examining doctor + the following medical tests: Cholesterol, triglycerides, transaminases (SGOT and SGPT), screening for HIV 1 and 2 and marker of acute hepatitis HCV

5: Comprehensive health questionnaire + Medical Report completed, dated and signed by the examining doctor + the following medical tests: blood count, platelets, ESR, glucose, cholesterol, HDL, triglycerides, creatinine, gamma GT, transaminases (SGOT and SGPT), screening for HIV 1 and 2, marker of acute hepatitis HCV, PSA test for men ≥ 55 + cardiology examination by a cardiologist including an electrocardiograph with a reading and detailed report from the cardiologist on the consultation and the clinical examination

The documents relating to the medical formalities are available on the following pages.

Example 1:
Ms. B is 35 years old and has purchased a death lump sum of € 200,000 and €100 of income protection benefit. She will therefore need to send us the Simplified Health Questionnaire.

Example 2:
Mr. A is 49 years old and has purchased a death lump sum of €400,000. He will therefore need to send us:
- The Comprehensive Health Questionnaire
- The Medical Report completed, dated and signed by the examining doctor
- The results of following panel of medical tests: cholesterol, triglycerides, transaminases (SGOT and SGPT), screening for HIV 1 and 2 and marker of acute hepatitis HCV

These medical formalities can be found on the following pages. Please ensure you return only the ones which are required for your age and selected level of lump sum, as specified in the table above. If you have any questions, please feel free to contact us on +33 (0) 1 44 20 48 77.

8. Simplified health questionnaire

Last name: .... First name(s): .... Date of birth: ....
Address: .... Post/Zip code: .... Town/City: ....
Occupation: ....

VERY IMPORTANT

1) ***Article L.113-8 of the French Insurance code***: Irrespective of the ordinary causes of nullity and subject to the provisions of article L132-26, the insurance plan is **null and void** in the event of concealment or intentional misrepresentation on the part of the member when such concealment or misrepresentation changes the subject of the risk or decreases the insurer's assessment of that risk, even if the risk which the member concealed or distorted has no impact on the claim.

2) ***Read the following questionnaire very carefully***: The insurer draws your attention to the importance of this questionnaire and the necessity of answering all of the questions and dating and signing it. **IF YOU ANSWER YES to one or more of the questions, please provide all the required details (date, reasons, consequences or aftereffects, type of treatment, duration etc.) on a separate sheet of paper which must also be dated and signed.**

3) ***Confidentiality***: Whatever your responses to the health questionnaire are, you may return them in a sealed envelope for the attention of the "Medical advisor". However, if you answered "Yes" to at least one of the questions, **you are formally requested** to return the health questionnaire in a sealed envelope for the attention of the "Medical advisor".

Your height: .... centimeters Your weight: .... kilograms

Question	No	Yes
1 - Over **the *last 10 years***, have you been hospitalized and/or undergone a surgical procedure, including keyhole surgery (other than C-section, appendectomy or the removal of tonsils, adenoids or the gallbladder)?	❑ No	❑ Yes
2 – Over **the last 5 years**, have you: - sought treatment for disorders of the spine such as slipped disk, lumbago, sciatica etc. or for damage to or rheumatism of joints such as the shoulder, knee, hip etc.? - sought treatment for mental disorders such as anxiety, depression, fatigue, stress, overwork etc.? - been prescribed a period of sick leave from work for medical reasons for a period of more than **30 days**?	❑ No ❑ No ❑ No	❑ Yes ❑ Yes ❑ Yes
3 – Do you have or have you ever had 100% coverage (with exemption from the patient's contribution to costs/reimbursement at 100% of medical expenses) for medical reasons from a Social Security organization during the **last 15 years**?	❑ No	❑ Yes
4 - Are you currently on total or partial sick leave from work prescribed for medical reasons (excluding statutory maternity leave)?	❑ No	❑ Yes
5 - Do you require regular medical care and/or medical treatment such as tranquillizers, treatments for cholesterol, diabetes, high blood pressure etc.?	❑ No	❑ Yes
6 – Do you receive a pension, annuity or allowance in respect of incapacity to work or disability or a Disabled Adult's Allowance?	❑ No	❑ Yes
7 - Is it planned (excluding maternity) for you to have any tests over the next **6 months** such as laboratory tests, medical imaging, endoscopy etc. or to have a specialist consultation, be admitted to hospital and/or undergo a surgical procedure?	❑ No	❑ Yes

I declare that these statements have been made accurately and honestly. Your personal data is processed by the insurer in accordance with the French law on Data Protection and Freedom of Information of January 6, 1978, amended. The processing of this data is necessary for the management of your membership and benefits. You have the right to access, rectify, remove and object to this data free of charge by mailing a letter to the insurer's Consumer Relations department at the following address: Groupama Gan Vie – Service des Relations avec les Consommateurs – Immeuble Michelet – 4-8 Cours Michelet – 92082 La Défense Cedex - France or by sending an email to: **src-collectives@ggvie.fr**

You expressly accept the collection and processing of your health-related data. This data is required for your enrollment and the management of your membership and benefits and is processed in compliance with medical confidentiality. It is intended for the exclusive use of the insurer's medical advisor and their medical department, or for authorized persons (such as medical experts or healthcare professionals). However, if you have chosen not to return your health questionnaire under confidential cover, the data it contains will also be passed on to the insurer's administration department. You have the right to access, rectify and object to medical data relating to you by mailing a letter, together with a photocopy of ID, to the insurer's medical advisor at the following address: Service Médical Collectives – Immeuble Michelet – 4-8 Cours Michelet – 92082 La Défense Cedex- France.

Signature of the person applying for membership (preceded by the words "read and approved")

Signed in (Town/City and Country excluding USA)
………………………………………………………………………………………………..

Date ....

9. Comprehensive health questionnaire

Last name: .... First name(s): .... Date of birth: ....
Address: .... Post/Zip Code: .... Town/City : ....
Occupation: ....

VERY IMPORTANT

1) Article L.113-8 of the French insurance code: Irrespective of the ordinary causes of nullity and subject to the provisions of article L132-26, the insurance plan is **null and void** in the event of concealment or intentional misrepresentation on the part of the member when such concealment or misrepresentation changes the subject of the risk or decreases the insurer's assessment of that risk, even if the risk which the member concealed or distorted has no impact on the claim.

2) Read the following questionnaire very carefully: The insurer draws your attention to the importance of this questionnaire and to the need to answer all of the questions. It must be dated and signed. **IF YOU ANSWER YES to one or more questions, please provide all required details (date, reasons, consequences or aftereffects, type of treatment, duration etc.) on a separate sheet of paper which must also be dated and signed.**

3) Confidentiality: Whatever your responses to the health questionnaire, you may return them in a sealed envelope for the attention of the "Medical advisor". However, if you answered "Yes" to at least one of the questions, **you are formally requested** to return the health questionnaire in a sealed envelope for the attention of the "Medical advisor".

1 – Your height: | | | centimeters   Your weight: | | | kilograms

2 - Over **the *last 10 years***, have you been hospitalized and/or undergone a surgical procedure, including keyhole surgery (other than C-section, appendectomy or the removal of tonsils, adenoids or the gallbladder)? ❑ No ❑ Yes
Nature of the hospitalization(s): ....
Date(s): ....
Nature of the surgical procedure(s): ....
Date(s): ....

3- Over **the last 5 years**, have you:
a) sought treatment for disorders of the spine such as slipped disk, lumbago, sciatica etc. or for damage to or rheumatism of joints such as the shoulder, knee, hip etc.?
.... ❑ No ❑ Yes
Please provide details: ....
Date(s): ....
b) sought treatment for mental disorders such as anxiety, depression, fatigue, stress, overwork etc.?
.... ❑ No ❑ Yes
Please provide details: ....
Date(s): ....
c) sought treatment for a heart murmur?
.... ❑ No ❑ Yes
Please provide details: ....
Date(s): ....
d) sought treatment for respiratory disorders such asthma, chronic bronchitis etc.?
.... ❑ No ❑ Yes
Please provide details: ....
Date(s): ....
e) suffered from an illness which led to you being prescribed a period of sick leave for medical reasons and/or a medical treatment (excluding statutory maternity leave) lasting more than **30 days?**
.... ❑ No ❑ Yes
Which illness? ....
Duration of sick leave: ....
Type of medical treatment: ....
Date(s): ....
f) been involved in an accident which led to you being prescribed a period of sick leave for health reasons and/or a medical treatment lasting more than **30 days**? ❑ No ❑ Yes
Date of the accident: ....
Nature of the injuries: ....
Duration of sick leave: ....
Are you still suffering aftereffects? ....
Please specify: ....
Type of medical treatment: ....
g) had treatment using laser, radiotherapy or chemotherapy? ❑ No ❑ Yes
Please specify: ....
Date(s): ....
Duration(s): ....

4 - Have you been screened for one of the human immunodeficiency viruses (HIV), hepatitis B (HBV) and hepatitis C (HCV) where one of the results was **positive**? ❑ No ❑ Yes
Which one(s)? ....
On what date(s)? ....

5 - Do you have or have you ever had 100% coverage (with exemption from the patient's contribution to costs/reimbursement at 100% of medical expenses) for medical reasons from a Social Security organization during **the last 15 years**? ❑ No ❑ Yes
Why? ....
Date(s): ....
Duration(s): ....

6 - Over **the last 12 months**, have you been prescribed more than 3 periods of sick leave of any duration and/or medical examinations such as radiology, cardiology, laboratory tests, etc. other than for routine screening?
.... ❑ No ❑ Yes
Date(s): ....
Duration(s): ....
Which ones?: ....
Why? ....
Results (to be enclosed if possible): ....

7 - Are you currently on total or partial sick leave from work prescribed for medical reasons (excluding statutory maternity leave)?
For what reason? ....
From what date? ....
Scheduled date of return to work: ....

8 – Are you aware that you are suffering from any illnesses and/or disorders?
.... ❑ No ❑ Yes
Please specify: ....
From which date: ....

9 - Do you require regular medical care and/or medical treatment such as tranquillizers, treatments for cholesterol, diabetes, high blood pressure etc.?
.... ❑ No ❑ Yes
For what reason?: ....
Type of medical care and/or treatment: ....
From what date?: ....

10 – Do you receive:
a) a pension, annuity or allowance in respect of incapacity to work or disability?
.... ❑ No ❑ Yes
From what date?: ....
Why?: ....
At what rate or in what category? ....
Which organization provides the benefit? ....
b) a Disabled Adult's Allowance? .... ❑ No ❑ Yes
From what date?: ....
Why?: ....
At what rate?........

11 – Do you suffer from a malformation and/or have you had a limb amputated?
.... ❑ No ❑ Yes
Please specify: ....
Date(s): ....

12 – Do you suffer from a hearing and/or vision disorder (other than short-sightedness, long-sightedness or astigmatism)?
.... ❑ No ❑ Yes
Please specify: ....
Cause(s): ....

13 - Is it planned (excluding maternity) over the **next 12 months** for you to:
a) have any examinations such as laboratory tests, medical imaging, endoscopy etc. other than for the purposes of routine screening?
.... ❑ No ❑ Yes
Nature of the tests: ....
Date(s): ....
b) have a specialist consultation?
.... ❑ No ❑ Yes
Why: ....
Date(s): ....
c) undergo any medical treatments and/or surgical procedures (excluding health check-ups)?
.... ❑ No ❑ Yes
Type of medical treatment: ....
Type of surgical procedure: ....
Date(s): ....
Why? ....

I declare that these statements have been made accurately and honestly. Your personal data is processed by the insurer in accordance with the French law on Data Protection and Freedom of Information of January 6, 1978, amended. The processing of this data is necessary for the management of your membership and benefits. You have the right to access, rectify, remove and object to this data free of charge by mailing a letter to the insurer's Consumer Relations department at the following address: Groupama Gan Vie – Service des Relations avec les Consommateurs – Immeuble Michelet – 4-8 Cours Michelet – 92082 La Défense Cedex – France or by sending an email to: src-collectives@ggvie.fr. You expressly accept the collection and processing of your health-related data. This data is required for your enrollment and the management of your membership and benefits and is processed in compliance with medical confidentiality. It is intended for the exclusive use of the insurer's medical advisor and their medical department or for authorized persons (such as medical experts or healthcare professionals). However, if you have chosen not to return your health questionnaire under confidential cover, the data it contains will also be passed on to the insurer's administration department. You have the right to access, rectify and object to medical data relating to you by mailing a letter, together with a photocopy of ID, to the insurer's medical advisor at the following address: Service Médical Collectives – Immeuble Michelet – 4-8 Cours Michelet – 92082 La Défense Cedex - France.
Signed in (Town/City and Country excluding USA) .... Date ....

***Signature** of the person applying for membership (preceded by the words "read and approved")*

10. MEDICAL REPORT

Last name: .... First names: ....

Date and place of birth: .... Marital status: ....

Address: .... Post/Zipcode: .... Town/City: ....

Current occupation: .... Plan ref. number (if known) ....

STATEMENTS OF THE APPLICANT FOR THE INSURANCE, COLLECTED AND TRANSCRIBED BY THE DOCTOR

These statements must include answers to all questions (scoring out and "nothing to report" are not deemed to be answers) and must be dated and signed, failing which the insurer will not be able to provide coverage.

Very important: Article L.113-8 of the French insurance code: Irrespective of the ordinary causes of nullity and subject to the provisions of article L132-26, the insurance plan is null and void in the event of concealment or intentional misrepresentation on the part of the member when such concealment or misrepresentation changes the subject of the risk or decreases the insurer's assessment of that risk, even if the risk which the member concealed or distorted has no impact on the claim.

---

1 - Are you currently on total or partial sick leave from work prescribed for medical reasons (excluding statutory maternity leave)?
No ☐ Yes ☐
From what date? ....
Cause: ....

2 – Over **the last 5 years**, have you been prescribed a period of total or partial sick leave for health reasons of more than **3 weeks**?
No ☐ Yes ☐
Date(s): ....
Cause(s): ....
Date(s)of return to work: ....

3 – Do you receive a pension, annuity or allowance in respect of incapacity to work or disability?
No ☐ Yes ☐
What rate or category? ....
Date of award: ....
Cause: ....
In what capacity? ☐ General scheme ☐ Military ☐ Occupational illness ☐ Work-related accident

4 – Do you have an infirmity or a disability ?
No ☐ Yes ☐
Please specify: ....
Cause: ....

5 - Do you have or have you ever had 100% coverage (with exemption from the patient's contribution to costs/reimbursement at 100% of medical expenses) for medical reasons from a Social Security organization (Social Security, "Mutualité Sociale Agricole" etc.)?
No ☐ Yes ☐
For what reason? ....
Date of award of 1st exemption: ....

6 – Have you been involved in any accidents?
No ☐ Yes ☐
Date(s): ....
Nature and location of any injuries: ....
Are you still suffering aftereffects? ....
Please specify: ....

7 – Have you ever been admitted to hospital?
No ☐ Yes ☐
Date(s): ....
Cause(s): ....

8 – Have you ever undergone a surgical procedure including with a local anesthetic or keyhole surgery (excluding dental surgery)?
No ☐ Yes ☐
Please specify: ....
Why? ....
Date(s): ....

9 – Have you ever been treated using radiotherapy, laser or chemotherapy?
No ☐ Yes ☐
Date(s): ....
Cause(s): ....
Treatment: ....

10 – Over **the last 12 months**, have you:

– been prescribed more than 3 periods of sick leave from work of any duration?
No ☐ Yes ☐
Please specify: ....
Date(s): ....

– had any medical examinations, other than routine screening, such as Doppler, ECG, PFT, blood tests, endoscopy, medical imaging, radiography, scans etc.?
No ☐ Yes ☐
Date(s): ....
Type: ....
Cause(s): ....
Results: ....

11 – Have you undergone any medical treatment lasting **more than 30 days** over **the last 2 years** or are you currently undergoing any medical treatment?
No ☐ Yes ☐
Date(s): ....
Type: ....
Cause(s): ....

12 – Have you consulted a doctor **over the last 3 months**?
No ☐ Yes ☐
Date(s): ....
Cause(s): ....

13 – Do you drink alcohol (aperitifs, beer, liqueurs, and wine)?
No ☐ Yes ☐
Please specify: wine ☐ beer ☐ aperitifs ☐ liqueurs ☐ other ☐
Quantity per day: ....

14 – Do you smoke?
No ☐ Yes ☐
Since when? .... Number of cigarettes/day: ....
Number of cigars/day: ....
Number of pipes/day: ....

Do you use e-cigarettes, e-cigars, e-pipes etc.?
No ☐ Yes ☐

15 – Have you ever smoked?
No ☐ Yes ☐
Quantity/day: .... Number of years: ....
Date of stopping: .... Reason: ....

16 - Have you been screened for one of the human immunodeficiency viruses (HIV), hepatitis B (HBV) and hepatitis C (HCV) where one of the results was **positive**? — No ☐ Yes ☐ — Which one(s)? .... On what date(s)? ....

17 – To your knowledge, in **the next 6 months**, will you require to consult a specialist, undergo medical tests, be admitted to hospital or undergo a surgical procedure? — No ☐ Yes ☐ — Why? .... Date(s) : .... Nature of tests: .... Type of surgical procedure: ....

HAVE YOU EVER SUFFERED OR ARE YOU CURRENTLY SUFFERING FROM

18- Respiratory or lung disorders such as allergies, asthma, bronchitis, pulmonary embolism, emphysema, pleurisy, pneumonia, tuberculosis etc.? — No ☐ Yes ☐ — Please specify: .... Date of first symptoms: .... Number of attacks per year: ....

19- Neurological, cerebral or neuromuscular disorders such as aneurysm, stroke, epilepsy, fibromyalgia, multiple sclerosis, meningitis, muscular dystrophy, paralysis, even if temporary? — No ☐ Yes ☐ — Please specify: .... Date of first symptoms: .... For epilepsy, number of attacks per year: ....

20 - Mental disorders such as anxiety, depression, fatigue, insomnia, stress, overwork, behavioral problems etc.? — No ☐ Yes ☐ — Please specify: .... Treatment, duration and date: ....

21- Disorders of the heart or blood vessels such as arteritis, chest pain, hypertension, heart attack, coronary heart disease, malformation, edema, palpitations, phlebitis, murmur, heart rhythm disorders etc.? — No ☐ Yes ☐ — Please specify: .... Date(s): ....

22- Digestive or liver disorders such as cirrhosis, irritable bowel syndrome, constipation, Crohn's disease, diarrhea, diverticula, hiatal hernia, hepatitis, heartburn, pancreatitis, parasitic disease, polyps, ulcerative colitis, rectal bleeding, ulcers etc.? — No ☐ Yes ☐ — Please specify: .... Date(s): ....

23- Kidney or urinary tract disorders such as albuminuria, stones, renal colic, dialysis, hematuria, renal cysts, nephritis etc. ? — No ☐ Yes ☐ — Please specify: .... Date(s): ....

24- Inflammatory rheumatic disorders such as spondylitis, rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis etc.? — No ☐ Yes ☐ — Please specify: .... Date(s): ....

25- Musculoskeletal disorders (spine or other joints) such as algodystrophy, osteoarthritis, slipped disk, lower back pain, osteoporosis, prostheses, ruptured ligament, sciatica, scoliosis, vertebral compression etc.? — No ☐ Yes ☐ — Please specify: .... Date(s): ....

26- Endocrine or metabolic disorders such as thyroid disease, cholesterol, diabetes, dyslipidemia, gout etc.? — No ☐ Yes ☐ — Please specify: .... Date(s): ....

27- Blood or lymphatic disorders such as adenopathy, anemia, hemo-chromatose, hemophilia, leukemia, polycythemia, splenomegaly, bleeding disorders etc.? — No ☐ Yes ☐ — Please specify: .... Date(s): ....

28- Skin conditions such as eczema, herpes, cysts, lupus, mycosis, birthmarks, psoriasis, purpura, shingles etc. ? — No ☐ Yes ☐ — Please specify: .... Date(s): ....

29- ENT or eye disorders such as cataracts, glaucoma, laryngitis, ear infections, retinopathy, sinusitis, dizziness etc.? — No ☐ Yes ☐ — Please specify: .... Date(s): ....

QUESTIONS FOR FEMALE APPLICANTS ONLY

30 - Have you ever suffered or are you currently suffering from a disorder of the genitals and/or breast? — No ☐ Yes ☐ — Please specify: .... Date of last consultation: ....

31 - Have you ever had a mammogram or a pelvic ultrasound? — No ☐ Yes ☐ — Mammogram ☐ Ultrasound ☐ Why? .... Date(s): .... Results (please enclose): ....

32 - Are you pregnant? — No ☐ Yes ☐ — Normal pregnancy: No ☐ Yes ☐ How many months? .... C-section planned: No ☐ Yes ☐

Your personal health data is processed in accordance with the French law on Data Protection and Freedom of Information of January 6, 1978, amended. You expressly accept its collection and processing for the purposes of managing your membership and benefits. This data is processed in compliance with medical confidentiality. It is intended for the exclusive use of the insurer's medical advisor and their medical department. You have the right to access, rectify and object to this data by mailing a letter together with a photocopy of your ID to the insurer's medical advisor at Service Médical Collectives – Immeuble Michelet – 4-8 Cours Michelet – 92082 La Défense Cedex- France.

I, the undersigned, Doctor ....
- certify that I have read all of the questions from this questionnaire to the person applying for the insurance and have accurately transcribed opposite each question the answer which they gave to it
- certify that M .... signed the questionnaire in my presence.

In (place) .... date ....

Signature and stamp of the examining doctor

I, the undersigned, M ....

certify that the answers to this questionnaire have been transcribed in my presence and are exactly those which I gave to the questions.

I understand that my accurate and honest statements form the basis of my membership of the plan.

In (place) .... date ....

Signature of the person applying for the insurance

MEDICAL EXAMINATION

Please do not provide the applicant with any opinion which may prejudge the decision of the insurer.

1 GENERAL APPEARANCE

- Height: ....cm Weight: ....kg
- Weight loss or gain over the last year? **No** ☐ **Yes** ☐ Loss: ....kg Gain: ....kg Cause: ....
- Chest measurement: Inhaling: .... Exhaling: ....
- Waist and hip measurements: Waist: .... Hips: ....
- Skin lesions such as birthmarks, suspicious moles or scars **No** ☐ **Yes** ☐ Details: ....
- Signs of alcoholism or other substance abuse? **No** ☐ **Yes** ☐ Please provide details: ....

2 NERVOUS SYSTEM AND MUSCLES

- Are there any signs of disorders of the nervous system or myopathy? **No** ☐ **Yes** ☐ Please provide details: ....

3 MENTAL HEALTH

- Did you detect any behavioral, thought or mood disorders or any signs suggesting a psychiatric or neuropsychic disorder? **No** ☐ **Yes** ☐ Please provide details: ....

4 SENSORY ORGANS

- Are there any disorders or impairment of vision? **No** ☐ **Yes** ☐ Please provide details
  - ***uncorrected R*** .... L ....
  - ***corrected*** R .... with .... diopters
  - L .... with .... diopters
- Impaired hearing? **No** ☐ **Yes** ☐ **In one or both ears**? .... Total or partial? ....
- Other disorders of the ear? **No** ☐ **Yes** ☐ Please provide details ....

5 RESPIRATORY SYSTEM

- Did your examination reveal any abnormalities? **No** ☐ **Yes** ☐ Please provide details ....

6 CARDIO VASCULAR EXAMINATION

- Did auscultation reveal any signs of heart abnormality? **No** ☐ **Yes** ☐ Please provide details ....
- Did auscultation reveal any signs of abnormality of the arterial tree (carotid artery, iliofemoral axis)? **No** ☐ **Yes** ☐ Please provide details ....
- Was the heartbeat irregular? **No** ☐ **Yes** ☐ Please provide details ....
- Were there any abnormalities of the peripheral pulses? **No** ☐ **Yes** ☐ Please provide details: ....
- Disorders of the venous system, edema or trophic disorder? **No** ☐ **Yes** ☐ Please provide details ....
- BLOOD PRESSURE right systolic: .... right diastolic: .... left systolic: .... left diastolic: ....

  Is blood pressure controlled? **No** ☐ **Yes** ☐ If Yes, state type of treatment: ....

If you detected high blood pressure, please test again at rest: right systolic: .... right diastolic: .... left systolic: .... left diastolic: ....

- PULSE RATE: ..../min

7 DIGESTIVE TRACT AND ACCESSORY ORGANS

	No	Yes	Please provide details
Did you detect any abnormalities of the mouth and throat?	☐	☐	....
Did palpation of the abdomen reveal any signs of abnormality?	☐	☐	Please provide details ....
Evidence of enlarged liver?	☐	☐	By how many cm: .... consistency: ....
Evidence of enlarged spleen?	☐	☐	Palpable over .... cm
Evidence of hernia or eventration?	☐	☐	Description: ....

8 CONDITION OF BONES AND JOINTS

	No	Yes	Please provide details
Are there any abnormalities of the bones, joints, spine (malformation, Lasegue, mobility, inflammatory symptoms etc.)?	☐	☐	....

9 ENDOCRINE GLANDS

	No	Yes	Please provide details
Any signs of dysfunction?	☐	☐	....
Abnormalities discernable by palpation?	☐	☐	Please provide details ....

10 LYMPH NODES

	No	Yes	Please provide details
Abnormalities discernable by palpation?	☐	☐	....

11 GENITO-URINARY SYSTEM

- Results of urine test carried out by you using a test strip.
(Please discard any samples brought to the office by the patient).

	No	Yes
Proteins:	☐	☐
Sugars:	☐	☐
Leukocytes:	☐	☐
Blood:	☐	☐

	No	Yes	
Abnormalities of the kidneys discernable by palpation?	☐	☐	Please provide details ....
Any abnormalities of the breasts or testicles?	☐	☐	Please provide details........

12 In your role as Examining doctor, do you know the person being examined?

No ☐ Yes ☐

If Yes, in what capacity? ....

If No, **identity check is mandatory**

ID card ☐ Passport ☐

13 Name and address of Treating doctor:

....

....

....

....

ADDITIONAL REMARKS (OPTIONAL)

If more details are needed, please fill and sign an extra sheet.

....

....

....

....

Signed in (place) .... date .... **Signature and stamp of Examining doctor**

11 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 FIRST'EXPAT+ and RELAIS'EXPAT+ 2015/2016 Life and Disability 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+ 2015/2016 and RELAIS'EXPAT+ 2015/2016 plans.
- I have read and agree to the provisions of the FIRST'EXPAT+ or RELAIS'EXPAT + 2015/2016 general terms & conditions 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 suscribe 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 at any time. If I cannot provide it when asked, a lapse of coverage will apply.

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 (MM/DD/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 surname and name) preceded by "read and approved":

12 COMPLETION OF YOUR ENROLLMENT FORM

To complete your enrollment, you need to send us:

- the enrollment form completed and signed,
- the MEDICAL FORMALITIES required (see page 5) 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,

And for payment of your premium:

- The SEPA CORE direct debit authorization (for French accounts only) completed and signed,

or

- the credit card debit authorization completed and signed

or

- a check payable to ASFE

After payment of your premium, if you haven't already suscribed a health plan, you will receive a Welcome e-mail including:

- a personalized card showing all our contact details (only if you haven't already suscribed a Health insurance plan,
- your login details allowing you to access all our on-line services available at www.asfe-expat.com in your Participants' Pages,
- 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.

THANK YOU FOR SENDING YOUR COMPLETE ENROLLMENT FORM:

By email:
Signing and scanning your complete enrollment form at: admineurope@asfe-expat.com

By mail, see address at the end of this form:
ASFE - Service Adhésions
82, rue Villeneuve
92587 CLICHY Cedex - France

INCOMPLETE ENROLLMENT FORM WILL NOT BE TREATED

MSH INTERNATIONAL, a French insurance brokerage company, a société par actions simplifiée with a capital of €2,500,000. Registered office: 18 rue de Courcelles – 75008 Paris – France. Registered with the Paris Trade and Companies Register under no. 352 807 549, registered with the ORIAS under no. 07 002 751, Intra-community VAT no. FR 78 352 807 549