

LIFEPLAN'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 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 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.

6 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

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 Dollar US

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.

5 SELECTION OF YOUR LIFE & DISABILITY BENEFITS ASSOCIATED OPTIONS all of these options can be purchased individually

Death/Permanent total disability lump sum to be doubled in case of accident YES NO

Disability lump sum (All Causes) (Maximal lump sum paid in the event of certified infirmity with more than 33% disability)

This maximal 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:

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 gross monthly income (or your gross 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.

- **“French-style” Income Protection benefits** (not available if one or more 'Anglo-Saxon style' Income Protection 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 gross 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 gross income declared for tax purposes (or gross 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:

- **“Anglo-Saxon-style” Income Protection benefits** (not available if STD and/or LTD benefits have been purchased)

Your gross 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.

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.

*Example: Ms. B has a gross 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.

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.

*Example: Ms. B has a gross 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.*

11 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 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: Simplified health questionnaire + comprehensive health questionnaire
- 3: Simplified health questionnaire + comprehensive health questionnaire + Medical Report completed, dated and signed by the examining doctor examineur
- 4: Simplified health questionnaire + comprehensive health questionnaire + Medical Report completed, dated and signed by the examining doctor examineur+ The following medical tests: Cholesterol, triglycerides, transaminases (SGOT and SGPT), screening for HIV 1 and 2 and marker of acute hepatitis HCV
- 5: Simplified health questionnaire + comprehensive health questionnaire + Medical Report completed, dated and signed by the examining doctor examineur+ 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.

Examples:

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.
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 at +33 (0) 1 44 20 48 77.

9 SIMPLIFIED HEALTH QUESTIONNAIRE

First name(s):

Last name:

Date of birth: / / (DD/MM/YYYY)

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

- | | | |
|----------|--|--|
| 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 <input type="checkbox"/> YES <input type="checkbox"/> |
| 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 <input type="checkbox"/> YES <input type="checkbox"/>
NO <input type="checkbox"/> YES <input type="checkbox"/>
NO <input type="checkbox"/> YES <input type="checkbox"/> |

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 <input type="checkbox"/> YES <input type="checkbox"/>
4	Are you currently on total or partial sick leave from work prescribed for medical reasons (excluding statutory maternity leave)?	NO <input type="checkbox"/> YES <input type="checkbox"/>
5	Do you require regular medical care and/or medical treatment such as tranquillizers, treatments for cholesterol, diabetes, high blood pressure etc.?	NO <input type="checkbox"/> YES <input type="checkbox"/>
6	Do you receive a pension, annuity or allowance in respect of incapacity to work or disability or a Disabled Adult's Allowance?	NO <input type="checkbox"/> YES <input type="checkbox"/>
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 <input type="checkbox"/> YES <input type="checkbox"/>

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.

In (city/country, excluding USA):

Signature of the member or legal representative of a minor child

(In this case, please indicate the capacity in which you are signing (parent, guardian, etc.) and your first and last names) **"read and approved"**:

Date (DD/MM/YYYY): / /

10 QUESTIONNAIRE DE SANTÉ COMPLET

First name(s):

Last name:

Date of birth: / / (DD/MM/YYYY)

Address:

Post/Zipcode:

Town/City:

Occupation:

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.
- 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.**
- 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

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

Nature of the hospitalization(s):

Date(s):

Nature of the surgical procedure(s):

Date(s):

<p>Over the last 5 years, have you:</p> <p>- 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.?</p>	<p>NO <input type="checkbox"/> YES <input type="checkbox"/></p>	<p>Please specify:</p> <p>Date(s):</p>
<p>- sought treatment for mental disorders such as anxiety, depression, fatigue, stress, overwork etc.?</p>	<p>NO <input type="checkbox"/> YES <input type="checkbox"/></p>	<p>Please specify:</p> <p>Date(s):</p>
<p>- sought treatment for a heart murmur?</p>	<p>NO <input type="checkbox"/> YES <input type="checkbox"/></p>	<p>Please specify:</p> <p>Date(s):</p>
<p>- sought treatment for respiratory disorders such as asthma, chronic bronchitis etc.?</p>	<p>NO <input type="checkbox"/> YES <input type="checkbox"/></p>	<p>Please specify:</p> <p>Date(s):</p>
<p>2 - 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?</p>	<p>NO <input type="checkbox"/> YES <input type="checkbox"/></p>	<p>Which illness?</p> <p>Duration of sick leave:</p> <p>Type of medical treatment:</p> <p>Date(s):</p>
<p>- 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?</p>	<p>NO <input type="checkbox"/> YES <input type="checkbox"/></p>	<p>Date of the accident:</p> <p>Nature of the injuries:</p> <p>Duration of sick leave:</p> <p>Are you still suffering aftereffects?</p> <p>Please specify?</p> <p>Type of medical treatment:</p>
<p>- had treatment using laser, radiotherapy or chemotherapy?</p>	<p>NO <input type="checkbox"/> YES <input type="checkbox"/></p>	<p>Please specify:</p> <p>Date(s):</p> <p>Duration(s):</p>
<p>3 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?</p>	<p>NO <input type="checkbox"/> YES <input type="checkbox"/></p>	<p>Which one(s)?</p> <p>On what date(s)?</p>
<p>4 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?</p>	<p>NO <input type="checkbox"/> YES <input type="checkbox"/></p>	<p>Why?</p> <p>Date(s):</p> <p>Duration(s):</p>
<p>5 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?</p>	<p>NO <input type="checkbox"/> YES <input type="checkbox"/></p>	<p>Date(s):</p> <p>Duration(s):</p> <p>Which ones?</p> <p>Why?</p> <p>Results (to be enclosed if possible):</p>
<p>6 Are you currently on total or partial sick leave from work prescribed for medical reasons (excluding statutory maternity leave)?</p>	<p>NO <input type="checkbox"/> YES <input type="checkbox"/></p>	<p>For what reason?</p> <p>From what date?</p> <p>Scheduled date of return to work:</p>
<p>7 Are you aware that you are suffering from any illnesses and/or disorders?</p>	<p>NO <input type="checkbox"/> YES <input type="checkbox"/></p>	<p>Please specify:</p> <p>From which date:</p>

<p>8 Do you require regular medical care and/or medical treatment such as tranquillizers, treatments for cholesterol, diabetes, high blood pressure etc.?</p>	<p>NO <input type="checkbox"/> YES <input type="checkbox"/></p>	<p>For what reason? Type of medical care and/or treatment: From what date?</p>
<p>9 Do you receive: - a pension, annuity or allowance in respect of incapacity to work or disability?</p>	<p>NO <input type="checkbox"/> YES <input type="checkbox"/></p>	<p>From what date? Why? At what rate or in what category? Which organization provides the benefit?</p>
<p>- a Disabled Adult's Allowance?</p>	<p>NO <input type="checkbox"/> YES <input type="checkbox"/></p>	<p>From what date? Why? At what rate?</p>
<p>10 Do you suffer from a malformation and/or have you had a limb amputated?</p>	<p>NO <input type="checkbox"/> YES <input type="checkbox"/></p>	<p>Please specify: Date(s):</p>
<p>11 Do you suffer from a hearing and/or vision disorder (other than short-sightedness, long-sightedness or astigmatism)?</p>	<p>NO <input type="checkbox"/> YES <input type="checkbox"/></p>	<p>Please specify: Cause(s):</p>
<p>Is it planned (excluding maternity) over the next 12 months for you to: - have any examinations such as laboratory tests, medical imaging, endoscopy etc. other than for the purposes of routine screening?</p>	<p>NO <input type="checkbox"/> YES <input type="checkbox"/></p>	<p>Nature of the tests: Date(s):</p>
<p>12 - have a specialist consultation?</p>	<p>NO <input type="checkbox"/> YES <input type="checkbox"/></p>	<p>Why? Date(s):</p>
<p>- undergo any medical treatments and/or surgical procedures (excluding health check-ups)?</p>	<p>NO <input type="checkbox"/> YES <input type="checkbox"/></p>	<p>Type of medical treatment: Type of surgical procedure: Date(s): Why?</p>

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.

<p>In (city/country, excluding USA):</p> <p>Date (DD/MM/YYYY): / /</p>	<p>Signature of the member or legal representative of a minor child (In this case, please indicate the capacity in which you are signing (parent, guardian, etc.) and your first and last names) "read and approved":</p>
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7	Have you ever been admitted to hospital?	NO <input type="checkbox"/> YES <input type="checkbox"/>	Date(s): Cause(s):
8	Have you ever undergone a surgical procedure including with a local anesthetic or keyhole surgery (excluding dental surgery)?	NO <input type="checkbox"/> YES <input type="checkbox"/>	Please specify: Why? Date(s):
9	Have you ever been treated using radiotherapy, laser or chemotherapy?	NO <input type="checkbox"/> YES <input type="checkbox"/>	Date(s): Cause(s): Treatment:
	Over the last 12 months , have you: -been prescribed more than 3 periods of sick leave from work of any duration?	NO <input type="checkbox"/> YES <input type="checkbox"/>	Please specify: Date(s):
10	-had any medical examinations, other than routine screening, such as Doppler, ECG, PFT, blood tests, endoscopy, medical imaging, radiography, scans etc.?	NO <input type="checkbox"/> YES <input type="checkbox"/>	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 <input type="checkbox"/> YES <input type="checkbox"/>	Date(s): Type: Cause(s):
12	Have you consulted a doctor over the last 3 months ?	NO <input type="checkbox"/> YES <input type="checkbox"/>	Date(s): Cause(s):
13	Do you drink alcohol (aperitifs, beer, liqueurs, and wine)?	NO <input type="checkbox"/> YES <input type="checkbox"/>	Please specify: wine <input type="checkbox"/> aperitifs <input type="checkbox"/> other <input type="checkbox"/> beer <input type="checkbox"/> liqueurs <input type="checkbox"/> Quantity per day:
14	Do you smoke?	NO <input type="checkbox"/> YES <input type="checkbox"/>	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 <input type="checkbox"/> YES <input type="checkbox"/>	
15	Have you ever smoked?	NO <input type="checkbox"/> YES <input type="checkbox"/>	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 <input type="checkbox"/> YES <input type="checkbox"/>	Which one(s)? On what date(s)?

<p>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?</p>	<p>NO <input type="checkbox"/> YES <input type="checkbox"/></p>	<p>Why?</p> <p>Date(s):</p> <p>Nature of tests</p> <p>Type of surgical procedure:</p>
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HAVE YOU EVER SUFFERED OR ARE YOU CURRENTLY SUFFERING FROM:

<p>18 Respiratory or lung disorders such as allergies, asthma, bronchitis, pulmonary embolism, emphysema, pleurisy, pneumonia, tuberculosis etc.?</p>	<p>NO <input type="checkbox"/> YES <input type="checkbox"/></p>	<p>Please specify:</p> <p>Date of first symptoms:</p> <p>For epilepsy, number of attacks per year:</p>
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<p>19 Neurological, cerebral or neuromuscular disorders such as aneurysm, stroke epilepsy, fibromyalgia, multiple sclerosis, meningitis, muscular dystrophy, paralysis, even if temporary?</p>	<p>NO <input type="checkbox"/> YES <input type="checkbox"/></p>	<p>Please specify:</p> <p>Date of first symptoms:</p> <p>For epilepsy, number of attacks per year:</p>
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<p>20 Mental disorders such as anxiety, depression, fatigue, insomnia, stress, overwork, behavioral problems etc.?</p>	<p>NO <input type="checkbox"/> YES <input type="checkbox"/></p>	<p>Please specify:</p> <p>Treatment:</p> <p>Duration:</p> <p>Date:</p>
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<p>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.?</p>	<p>NO <input type="checkbox"/> YES <input type="checkbox"/></p>	<p>Please specify:</p> <p>Date(s):</p>
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<p>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.?</p>	<p>NO <input type="checkbox"/> YES <input type="checkbox"/></p>	<p>Please specify:</p> <p>Date(s):</p>
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<p>23 Kidney or urinary tract disorders such as albuminuria, stones, renal colic, dialysis, hematuria, renal cysts, nephritis etc.?</p>	<p>NO <input type="checkbox"/> YES <input type="checkbox"/></p>	<p>Please specify:</p> <p>Date(s):</p>
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<p>24 Inflammatory rheumatic disorders such as spondylitis, rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis etc.?</p>	<p>NO <input type="checkbox"/> YES <input type="checkbox"/></p>	<p>Please specify:</p> <p>Date(s):</p>
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<p>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.?</p>	<p>NO <input type="checkbox"/> YES <input type="checkbox"/></p>	<p>Please specify:</p> <p>Date(s):</p>
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<p>26 Endocrine or metabolic disorders such as thyroid disease, cholesterol diabetes, dyslipidemia, gout etc.?</p>	<p>NO <input type="checkbox"/> YES <input type="checkbox"/></p>	<p>Please specify:</p> <p>Date(s):</p>
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<p>27 Blood or lymphatic disorders such as adenopathy, anemia, hemochromatose, hemophilia, leukemia, polycythemia, splenomegaly, bleeding disorders etc.?</p>	<p>NO <input type="checkbox"/> YES <input type="checkbox"/></p>	<p>Please specify:</p> <p>Date(s):</p>
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28 Skin conditions such as eczema, herpes, cysts, lupus, mycosis, birthmarks, psoriasis, purpura, shingles etc.?	NO <input type="checkbox"/> YES <input type="checkbox"/>	Please specify: Date(s):
29 ENT or eye disorders such as cataracts, glaucoma, laryngitis, ear infections, retinopathy, sinusitis, dizziness etc.?	NO <input type="checkbox"/> YES <input type="checkbox"/>	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 <input type="checkbox"/> YES <input type="checkbox"/>	Please specify: Date of last consultation:
31 Have you ever had a mammogram or a pelvic ultrasound?	NO <input type="checkbox"/> YES <input type="checkbox"/>	Mammogram <input type="checkbox"/> Ultrasound <input type="checkbox"/> Why? Date(s): Results (please enclose):
32 Are you pregnant?	NO <input type="checkbox"/> YES <input type="checkbox"/>	Normal pregnancy: YES <input type="checkbox"/> NON <input type="checkbox"/> How many months? C-section planned: YES <input type="checkbox"/> NON <input type="checkbox"/>

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 LaDéfense 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.

<p>In (place):</p> <p>Date (DD/MM/YYYY): / /</p>	<p>Signature and stamp of the examining doctor</p>
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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.

<p>In (place):</p> <p>Date (DD/MM/YYYY): / /</p>	<p>Signature of the person applying for the insurance</p>
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DIGESTIVE TRACT AND ACCESSORY ORGANS					
19	Did you detect any abnormalities of the mouth and throat?	YES <input type="checkbox"/> NO <input type="checkbox"/>	Please provide details:		
20	Did palpation of the abdomen reveal any signs of abnormality?	YES <input type="checkbox"/> NO <input type="checkbox"/>	Please provide details:		
21	Evidence of enlarged liver?	YES <input type="checkbox"/> NO <input type="checkbox"/>	By how many cm? Consistency:		
22	Evidence of enlarged spleen?	YES <input type="checkbox"/> NO <input type="checkbox"/>	Palpable over (cm):		
23	Evidence of hernia or eventration?	YES <input type="checkbox"/> NO <input type="checkbox"/>	Description:		
CONDITION OF BONES AND JOINTS					
24	Are there any abnormalities of the bones, joints, spine (malformation, Lasegue, mobility, inflammatory symptoms etc.)?	YES <input type="checkbox"/> NO <input type="checkbox"/>	Please provide details:		
ENDOCRINE GLANDS					
25	Any signs of dysfunction?	YES <input type="checkbox"/> NO <input type="checkbox"/>	Please provide details:		
26	Abnormalities discernable by palpation?	YES <input type="checkbox"/> NO <input type="checkbox"/>	Please provide details:		
GANGLIONS LYMPHATIQUES					
27	Abnormalities discernable by palpation?	YES <input type="checkbox"/> NO <input type="checkbox"/>	Please provide details:		
GENITO-URINARY SYSTEM					
28	Results of urine test carried out by you using a test strip. (Please discard any samples brought to the office by the patient)	Proteins: YES <input type="checkbox"/> NO <input type="checkbox"/>	Sugars: YES <input type="checkbox"/> NO <input type="checkbox"/>	Leukocytes: YES <input type="checkbox"/> NO <input type="checkbox"/>	Blood: YES <input type="checkbox"/> NO <input type="checkbox"/>
29	Abnormalities of the kidneys discernable by palpation?	YES <input type="checkbox"/> NO <input type="checkbox"/>	Please provide details:		
30	Any abnormalities of the breasts or testicles?	YES <input type="checkbox"/> NO <input type="checkbox"/>	Please provide details:		
31	In your role as Examining doctor, do you know the person being examined?	YES <input type="checkbox"/> NO <input type="checkbox"/>	If yes, in what capacity? If no., identity check is mandatory ID card <input type="checkbox"/> Passport <input type="checkbox"/>		
Name and address of Treating doctor					

Additional remarks (optional):

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<p>In (place):</p> <p>Date (DD/MM/YYYY): / /</p>	<p>Signature and stamp of the examining doctor</p>
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12 SIGNATURE OF THE APPLICATION FOR COVERAGE

I HEREBY APPLY for membership of ASFE (Association of Services for Expatriates), an association governed by the French law of 1901 with its registered office in Season, 39 rue Mstislav Rostropovitch 75815 PARIS Cedex 17, as well as the insurance agreements entered into by the association with the following insurance companies:

- **GROUPAMA GAN VIE**, for LIFEPLAN'EXPAT Life and Disability benefits

I ACKNOWLEDGE THE FOLLOWING:

- I have noted the advice provided by MSH INTERNATIONAL and wish to follow it. MSH INTERNATIONAL is a French insurance broker (registered with ORIAS under number 07 002 751) which designs and manages the entire range of insurance on behalf of ASFE including the LIFEPLAN'EXPAT policy.
- I have read and accepted the provisions of the terms and conditions of the LIFEPLAN 'EXPAT policy, serving as the information booklet, have retained a copy of it and accept the terms of this application which serves as the schedule. I am aware of my right to cancel.
- I am aware that my telephone calls to the MSH INTERNATIONAL administration teams may be recorded for the requirements of internal administration and in order to improve their services. I may access recordings of my calls by writing to MSH INTERNATIONAL - ASFE Administration - 23 allées de l'Europe - 92587 Clichy Cedex - France enclosing ID. Each recording is kept for a period of 90 days.
- I hereby acknowledge that membership of ASFE does not exempt me from paying contributions to any mandatory scheme to which I may belong.
- I am aware that no payments can be made directly or indirectly to a country which is subject to sanctions imposed, for example, by the United Nations, the Office of Foreign Assets Control (OFAC) of the US Treasury or the European Union.
- I have been informed that the information collected is intended to formally identify me in order to provide me with access to a secure area or to gather details to enable MSH INTERNATIONAL to provide me with solutions and answers. This information is intended solely for MSH INTERNATIONAL and may be processed in order to comply with its legal obligations and the execution, promotion, administration and implementation of the insurance contracts. Under the French Data Protection Act of January 6th 1978 amended in 2004, you have the right to access, amend, rectify and object to information concerning you by writing to: MSH INTERNATIONAL - Legal Department (Direction juridique) - Season, 39 rue Mstislav Rostropovitch - 75815 PARIS Cedex 17 enclosing a copy of a signed identity document.
- 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 CERTIFY that I have answered the questions in this application form accurately and honestly and have neither declared nor omitted anything that could mislead MSH INTERNATIONAL and lead to the application of Articles L.113-8 and L.113- 9 of the French Insurance Code.

In (city/country, excluding USA):

Date (DD/MM/YYYY): / /

Signature of the member or legal representative of a minor child

(in this case, please indicate your relationship (parent, guardian...) along with your first name and name preceded by "read and approved"):

13 COMPLETION OF YOUR APPLICATION FOR COVERAGE

To complete your application, you need to send us by email or mail:

- the enrollment form filled out and signed,
- the supporting documents required in accordance with the table page 6, according to your age and the benefit amounts selected,
- a copy of your identity card or passport,

Your premium can be paid through:

- SEPA CORE 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 Member's Area,
- your member's guide, including your general terms and conditions and all the necessary information for your plan.

PLEASE SEND YOUR ENROLLMENT FORM AND ALL REQUIRED DOCUMENTS:

By email:

Signing and scanning your complete enrollment form to: newapplication@msh-intl.com

By mail:

ASFE - Service Adhésions
23, allées de l'Europe
92587 CLICHY Cedex - France

INCOMPLETE ENROLLMENT FORMS WILL NOT BE PROCESSED



MSH INTERNATIONAL

on behalf of



ASFE - MSH INTERNATIONAL: société Française de courtage d'assurance, société par actions simplifiées au capital de 2 500 000 euros, dont le siège social est
Season, 39 rue Mstislav Rostropovitch - 75815 Paris Cedex 17, 352 807 549 - RCS paris, enregistrée to l'ORIAS sors le n°07 002 751, n° de TVA intracommunautaire
FR 78 352 807 549