



Life and Disability

YOUR TAILOR-MADE
INTERNATIONAL INSURANCE



MSH INTERNATIONAL



WHO ARE WE?

OUR MISSION

For more than 40 years, MSH INTERNATIONAL has been designing and managing international health insurance solutions for globally-mobile individuals: expatriate employees and freelancers, young adults living abroad (internships, studies or working holiday visas), active seniors, etc.

Our mission is to provide solutions for all expatriates worldwide by offering coverage of healthcare, life & income protection, medical assistance/repatriation and third party liability.



KEY FIGURE

5th global player

330,000 members

92% customer satisfaction
(based on a survey carried out in December 2012)

Available

24/7

2,000 companies covered

SOLUTIONS FOR INDIVIDUALS AND COMPANIES

With its comprehensive range of tailor-made solutions, MSH INTERNATIONAL is able to meet the specific needs of Individuals, as well as Companies and Organizations, by reflecting their diversity: Micro-businesses and SMEs, Mid-cap companies, Multinationals, International Organizations and NGOs.

MSH INTERNATIONAL
VALUES



As a specialist in international health insurance, MSH INTERNATIONAL strives to be your true local healthcare partner abroad. Four core values characterize our commitment to provide you with the level of service you deserve, day after day.



PROXIMITY

4 regional head offices in Paris, Calgary, Dubai and Shanghai

10 local offices in Toronto, Houston, Geneva, Lyon, Abu Dhabi, Bangkok, Beijing, Shenzhen, Guangzhou and Singapore

A medical network of **6,700** approved healthcare providers worldwide and **860,000** in North America



DIVERSITY

More than **40** languages spoken

More than **60** nationalities

Reimbursements in more than **150** currencies



FLEXIBILITY

SOLUTIONS FOR INDIVIDUALS

- Young adults plan
- 1st Dollar expatriates plans
- CFE top-up expatriates plan

SOLUTIONS FOR COMPANIES & INTERNATIONAL ORGANIZATIONS

- Health
- Life & Income protection
- Repatriation Assistance
- Moving Insurance
- Personal Third-Party Liability
- Pension plans



EMPATHY

92 % of individual members satisfied

91 % of corporate members satisfied

Certified **ISO 9001**

Practical services **online**

INTERNATIONAL LIFE & DISABILITY INSURANCE FROM MSH INTERNATIONAL, IT'S SO SIMPLE!

The life & disability benefits have been designed to support you through life's difficult times: sick leave from work, loss of autonomy, death... These benefits allow you to maintain your standard of living and protect your loved ones from financial hardship.

01 /

BASIC COVERAGE: DEATH/PERMANENT TOTAL DISABILITY BENEFIT

The sudden, accidental loss of a loved one is, unfortunately, often accompanied by financial difficulties. In the event of death or Permanent Total Disability, your designated beneficiary (or beneficiaries) will receive the lump sum specified by you in your enrollment form.

Choose your level of Death/Permanent Total Disability benefit (All Causes). This is the only compulsory Life & Disability benefit you need to select in order to access the other optional benefits.

This lump sum can be of any amount between **\$30,000** and **\$1,200,000** (in multiples of €25,000/\$30,000).

You can also opt to double this lump sum in case of Accident.

02 /

OPTIONAL: DISABILITY BENEFIT (ALL CAUSES)

Your Disability Benefit (All Causes) is a cash payment which is paid as a lump sum if you are disabled and if the degree of disability is greater than 33% according to the scale set out in the plan.

This lump sum can be of any amount between **€\$30,000** et **\$1,200,000** (in multiples of €25,000/\$30,000).

OPTIONAL: INCOME PROTECTION

In case of temporary total incapacity to work, your level of income may fall sharply. Our income Protection benefit allows you to maintain your standard of living and honor your financial commitments by paying you a daily allowance.

This daily allowance will replace 70% of your income.

There are two types of benefits which can be taken out individually.

Short-term disability: you will be covered from the 1st day in the event of sick leave from work due to hospitalization or accident, and from the 7th day in the event of illness.

Payment of this allowance will end on the day on which you completely recover from the accident or illness but no later than after expiration of a period of time chosen by the insured member: **30 days**, **60 days** or **180 days**.

Long-term disability: this allowance can supplement the Short-term disability benefit but is not compulsory. Therefore the benefit can be purchased even if you have not opted for the Short-term disability benefit. This benefit will be paid after expiration of a total and uninterrupted period of sick leave from work known as the "waiting period", which can be chosen from these options: **30 days**, **60 days**, or **180 days**, for a maximum duration of 24 months.

APPLICATION FOR LIFE & DISABILITY COVERAGE

PLEASE COMPLETE THIS FORM IN CAPITAL LETTERS and return it to us:

By email to: admin@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 (if different from the email address above, mandatory):

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. **Sick Leave benefit**

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 benefit and/or Long-term disability benefit. However, these last 2 benefits may be purchased together or individually.

3.1 "French-style" Sick Leave benefits (not available if one or more "Anglo-Saxon-style" Sick Leave 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" Sick Leave 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 90 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 90 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.

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 sick leave coverage. 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 the "ES1" panel of medical tests, namely: 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.

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

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

Nature of the hospitalization(s):

Date(s):

Date(s):

Duration(s):

Nature of the surgical procedure(s):

Which one(s):

Date(s):

Why?

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

Results (to be enclosed if possible):

Please provide details:

7 - **Are you currently on total or partial sick leave from work prescribed for medical reasons (excluding statutory maternity leave)?**

Date(s):

For what reason?

b) sought treatment for mental disorders such as anxiety, depression, fatigue, stress, overwork etc.?
 No Yes

From what date?

Please provide details:

Scheduled date of return to work:

Date(s):

8 - **Are you aware that you are suffering from any illnesses and/or disorders?**
 No Yes

Please provide details:

Please specify:

c) sought treatment for a heart murmur?
 No Yes

From which date:

Please provide details:

9 - **Do you require regular medical care and/or medical treatment such as tranquilizers, treatments for cholesterol, diabetes, high blood pressure etc.?**
 No Yes

Date(s):

For what reason?:

d) sought treatment for respiratory disorders such as asthma, chronic bronchitis etc.?
 No Yes

Type of medical care and/or treatment:

Please provide details:

From what date?:

Date(s):

10 - **Do you receive:**
 a) a pension, annuity or allowance in respect of incapacity to work or disability?
 No Yes

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

From what date?:

Which illness?

Why?:

Duration of sick leave:

At what rate or in what category?

Type of medical treatment:

Which organization provides the benefit?

Date(s):

b) a Disabled Adult's Allowance? No Yes

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

From what date?:

Date of the accident:

Why?:

Nature of the injuries:

At what rate?

Duration of sick leave:

11 - **Do you suffer from a malformation and/or have you had a limb amputated?**
 No Yes

Are you still suffering aftereffects?

Please specify:

Please specify:

Date(s):

Type of medical treatment:

12 - **Do you suffer from a hearing and/or vision disorder (other than short-sightedness, long-sightedness or astigmatism)?**
 No Yes

g) had treatment using laser, radiotherapy or chemotherapy? No Yes

Please specify:

Please specify:

Cause(s):

Date(s):

13 - **Is it planned (excluding maternity) over the next 12 months for you to:**

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

a) have any examinations such as laboratory tests, medical imaging, endoscopy etc. other than for the purposes of routine screening?
 No Yes

Which one(s)?

Nature of the tests:

On what date(s)?

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

b) have a specialist consultation?
 No Yes

Why?

Why:

Date(s):

Date(s):

Duration(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 after effects? 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, hemochromatose, 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 (continued)

7 DIGESTIVE TRACT AND ACCESSORY ORGANS

	No	Yes	Please provide details
Did you detect any abnormalities of the mouth and throat?	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>			
	No	Yes	Please provide details
Did palpation of the abdomen reveal any signs of abnormality?	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>			
	No	Yes	By how many cm: consistency:
Evidence of enlarged liver?	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>			
	No	Yes	Palpable over cm
Evidence of enlarged spleen?	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>			
	No	Yes	Description:
Evidence of hernia or eventration?	<input type="checkbox"/>	<input type="checkbox"/>

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.)?	<input type="checkbox"/>	<input type="checkbox"/>

9 ENDOCRINE GLANDS

	No	Yes	Please provide details
Any signs of dysfunction?	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>			
	No	Yes	Please provide details
Abnormalities discernable by palpation?	<input type="checkbox"/>	<input type="checkbox"/>

10 LYMPH NODES

	No	Yes	Please provide details
Abnormalities discernable by palpation?	<input type="checkbox"/>	<input type="checkbox"/>

11 GENITO-URINARY SYSTEM

	No	Yes		No	Yes		No	Yes		No	Yes
Results of urine test carried out by you using a test strip. <i>(Please discard any samples brought to the office by the patient). Proteins:</i>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
			<i>Sugars:</i>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Leukocytes:</i>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Blood:</i>	<input type="checkbox"/>	<input type="checkbox"/>

	No	Yes	Please provide details
Abnormalities of the kidneys discernable by palpation?	<input type="checkbox"/>	<input type="checkbox"/>

	No	Yes	Please provide details
Any abnormalities of the breasts or testicles?	<input type="checkbox"/>	<input type="checkbox"/>

	No	Yes	If Yes, in what capacity?
12 In your role as Examining doctor, do you know the person being examined?	<input type="checkbox"/>	<input type="checkbox"/>	If No, identity check is mandatory
			ID card <input type="checkbox"/> Passport <input type="checkbox"/>

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 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 plan.
- I have read and agree to the provisions of the 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 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 at any time. If I cannot provide it when asked, a lapse of coverage will apply.

I HEREBY AUTHORIZE MSH INTERNATIONAL to receive on my behalf reimbursement statements for hospitalization expenses paid for me by direct payment agreement.

I HEREBY TESTIFY that the foregoing declarations are accurate, complete and fair. I have been informed and I accept that any intentional withholding of significant information or proven false declaration that might mislead MSH INTERNATIONAL may result in the cancellation of the insurance cover and to the reduction of benefits in accordance with the provisions of Articles L.113-8 and L.113-9 of the French Insurance Code (Code des Assurances).

In (city/country, excluding USA):

Date (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,
- a bank account slip for your healthcare reimbursements from ASFE,

And for payment of your premium:

- The 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 subscribed 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 subscribed 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

WHAT YOU CAN EXPECT
FROM US



We know that healthcare procedures are more complex for people living abroad, so we provide a whole range of practical services to help you manage your healthcare day after day.

WELCOME PACKAGE



Your certificate of insurance

Your insurance card

Members' guide

General conditions

Your login and password for the Members' Area

ACCESSING THE MSH MEDICAL NETWORK



Find an MSH-approved hospital near your place of residence

Geolocate healthcare professionals belonging to the MSH medical network in your area

Get information on the country's healthcare system

Access specific advice on prevention

MEMBERS' AREA



Submit your claims online by scanning and attaching your bills

Check your reimbursements

Fill out a precertification request

Request a certificate of insurance or a new insurance card

Access our global network of healthcare professionals approved by MSH INTERNATIONAL

MANAGING YOUR CLAIMS FOR REIMBURSEMENT



Administration services available 24/7, certified ISO 9001

Direct precertification in case of hospitalization

Direct billing for all medical treatments in the USA

Medical second opinions from our 20 doctors

A multilingual and multicultural team at your service (60 nationalities and 40 languages spoken)

Reimbursements in more than 150 currencies



MSH INTERNATIONAL HEALTH INSURANCE. FOR YOU. WHEREVER. WHENEVER

YOUR CONTACTS

For further information or to apply for coverage,
you can reach us using the contact details below :

- Telephone: +1 (403) 232-8545
- E-mail: sales@americas.msh-intl.com
- Website: <http://americas.msh-intl.com/>
- LinkedIn: MSH INTERNATIONAL CANADA

YOUR INSURANCE ADVISOR



MSH INTERNATIONAL

SIACI SAINT HONORE GROUP

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