Association for international mobility / Individual membership application

ACS Health in Asia Plan

I the undersigned _____ Usual / married name _____ First name _____

DOB |_|_|_|_|_|_|_|_| in _____ Nationality _____

Sex : ☐ F ☐ M

Marital status : ☐ single ☐ married ☐ widow ☐ divorced ☐ marital life ☐ civil union

Address of residence abroad _____

_____

Address in country of origin _____

_____

Phone _____ Fax _____ E-mail _____

Passport n° _____

• request membership of the « health » coverage schemes

☐ for myself alone, ☐ for myself and my family of which the beneficiaries are as follows :

Kinship	Sex (M or F)	Family name	First names	DOB (dd/mm/yyyy)
Spouse	☐ F ☐ M			
1st child	☐ F ☐ M			
2nd child	☐ F ☐ M			
3rd child	☐ F ☐ M			
4th child	☐ F ☐ M			

Healthcare Plan	Annual contribution 1

Coverage level ☐ Bronze ☐ Silver ☐ Gold

Deductible ◉ None ○ 100 USD ○ 500 USD ○ 1 000 USD *1

Co-Insurance *2 ☐ None ☐ 10% ☐ 20%

_____ USD

Annual limit ☐ 500 000 USD ☐ 1 000 000 USD

Length of cover ☐ Lifetime (Policy #011767/007) ☐ Non lifetime (Policy #011767/006)

Area of coverage ☐ Zone 1 ☐ Zone 2

Zone 1 : Cambodia, Indonesia, Laos, Malaysia, Myanmar, Philippines, Taiwan, Vietnam, Thailand and for stays of less than 120 consecutive days in one of the countries that belong to the European Economic Area (EEA) except the United Kingdom,

Zone 2 : Same countries as Zone 1 plus the United Kingdom for stays of less than 120 consecutive days

**1 : Deductible of 1 000 USD option is only available for Silver and Gold plans*

**2 : Co-Insurance option is only available for Silver and Gold plans*

IMPORTANT : The combination of deductible and co-insurance options is not possible under this plan

• request membership of the Assistance and Civil Liability coverage

Assistance and Civil Liability - Policy n° 78 931 579	Annual contribution 2

Assistance cover ☐ yes ☐ no _____ USD

Civil liability ☐ yes ☐ no _____ USD

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Association for international mobility / Individual membership application (continuation)

- request membership of the individual Contingency coverage

Contingency (only one choice possible) - Policy n° 080225/112	Annual contribution 3

Gross annual income in USD (if contingency coverage) _____ USD

1 - Death option

☐ Essential (25 000 USD) ☐ Comfort (50 000 USD) ☐ Excellence (100 00 USD) _____ USD

(complementary to health cover - cannot exceed 2 times the stated gross annual income)

Beneficiary designation in the event of death

☐ 1st formula : I choose the type designation below :

In the event of death, the lump sum shall be paid to : the no separated spouse of married policy holder, or failing, to the children born or to be born of the policy holder, In equal shares between them, the predeceased share being allotted to his own children or brothers and sisters if he or she has no children, failing, the father and mother in equal fractions, the precedeceased's share being paid to the survivor, or failing, the heirs.

☐ 2nd formula : I do not opt for the 1st formula and designate as my beneficiary _____

_____

2 - Disability option

☐ Essential (Benefits 25 USD/day) ☐ Comfort (Benefits 50 USD/day) ☐ Excellence (Benefits 100 USD/day) _____ USD

(complemetary to death option - cannot exceed 70 % of the stated gross annual income)

Grace period ☐ 90 days ☐ 180 days

The amount of my first annual contribution for **Health (1) + Assistance + Civil liability (2) + Contingency (3)** is 0 **USD**	Annual contribution 4

I want my membership to become effective on |_|_|_|_|_|_|_|_|

Contributions are payable in advance. **Annual AMI Association membership costs : 30 USD per contract.**

Payment method : ☐ debit of credit card ☐ bank transfer

Frequency : ☐ calendar year ☐ calendar half-year ☐ calendar quarter year ☐ month

Instalment : I settle the amount of _____ USD payable to **ACS**, corresponding to the premium pro rated to time between the effective date and the first calendar insurance period + **30 USD** membership fees by :

☐ debit of credit card ☐ bank transfer

In _____ on |_|_|_|_|_|_|_|_|

Signature of member preceded by hand-written « read and approved » and dated.

References of broker

BML Services (ehealthscanner)

You have the right to access, rectify and object, in accordance with ACT 78-17 dated 06.01.1978. This right can be exercised by contacting Allianz Vie. Your information is used for the purpose of the contract and canvassing by the Group Allianz and its representatives.

ACS
Courtier d'Assurances
153, rue de l'Université
75007 Paris - France

www.acs-ami.com
E-mail : contact@acs-ami.com

Tél. : 00 33 (0) 1 40 47 91 00 - Fax : 00 33 (0) 1 40 47 61 90

S.A.S. au capital de 150 000 euros
B 317 218 188 RCS Paris

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Payment Information

CREDIT CARD DEBIT AUTHORIZATION

I the undersigned, Mr, Mrs, Miss, _____ , holder of the below mentioned credit card, authorize the establishment where is located my bank account to proceed, if this situation permits, with the debits requested for by the hereafter mentioned company. In case of dispute, I can ask the establishment where is located my bank account to suspend any debits on my card and I will settle the dispute directly with the creditor company.

Name, first name and address of the card holder	National bank drawer number	Creditor company
Name and first name _____ Address _____ _____ ZIP code ⌊_⌊_⌊_⌊_⌊_⌋ City _____ Country _____	Bank 494888	ACS Société de Courtages d'Assurances 153, rue de l'Université 75007 Paris - France

Account to be debited

Type of credit card : ☐ Visa ☐ Mastercard ☐ Eurocard ☐ AMEX

Number of the card to be debited ⌊_⌊_⌊_⌊_⌋ ⌊_⌊_⌊_⌊_⌋ ⌊_⌊_⌊_⌊_⌋ ⌊_⌊_⌊_⌊_⌋

Expiration date (month/year) ⌊_⌊_⌋/⌊_⌊_⌋ Security code ⌊_⌊_⌊_⌋ (3 digits on the back of the card)

Frequency of debit : ☐ annual ☐ half-yearly ☐ quarterly ☐ monthly

Date _____

Signature of the card holder

Claim Reimbursement by Wire Transfer

To avoid delays associated with reimbursement of your expenses under your health insurance, please complete the following information for your refunds to be wire-transferred to your account directly.

BANKING INFORMATION

Bank Name : _____

Bank Address : _____

IBAN Number : _____ Swift Code : _____

Other Routing Code : _____

Currency Requested (must be in same currency as bank account) : _____

ACCOUNT HOLDER INFORMATION

Name on Account : _____

Phone Number : _____

Applicant 1 — Medical questionnaire (document to print)

You must answer all of the questions below. Further information you consider important about your health may be communicated to us on a separate sheet of paper.

Cover is subject to our medical approval.

Please fill out one questionnaire per person and send us as many forms as there are people to be insured. To download another form, please click here.

Usual / Married name : **First name :** **DOB (DD/MM/YYYY):** |_|_|/|_|_|/|_|_|_|_|

Occupation :

- What are your usual height, weight and blood pressure?

Height _____m Weight _____ kg Blood pressure _____

- What is your daily consumption of alcohol ? Beer : _____ glasses / day ; Wine : ____ glasses / day ; Spirits : ____ drinks / day

- Do you currently smoke pipes, cigars or cigarettes? □ yes □ no If so, how many per day? Pipes:_____ Cigars:_____ Cigarettes:_____
- Have you ever smoked? □ yes □ no If so, for how many years? _____ years
- When did you stop and why? _____

Please reply with either YES or NO

1- Do you have or have you ever had a congenital or hereditary disorder ?	□ yes	□ no	If YES, please indicate which disorder, onset date & treatment:_____ _____
2- Does your present state of health prevent you from performing your full time profession?	□ yes	□ no	Therapeutic Part Time leave _____ Total leave of absence _____ Reasons _____
3- Have you undergone or been advised to undergo surgery, other than for the extraction of the appendix, tonsils or adenoids ?	□ yes	□ no	Details of surgery? _____ Date(s) _____
4- During the last 5 years, have you had / do you have any medical treatment (medication, acupuncture, physiotherapy, medical appliances, psychotherapy…), excluding birth control ? Are you currently undergoing diagnostic tests ?	□ yes	□ no	Details _____ _____ _____ _____
5- During the past 5 years, have you been prescribed sick leave or a medical treatment exceeding 3 weeks?	□ yes	□ no	Please give reasons? _____ _____ Nature and duration of treatment : _____ _____
6- Have you received care or undergone tests during the past 5 years which have led to stay in a medical establishment (hospital, clinic, convalescent home, physiotherapy, dietary needs or treatment centre, sanatorium…) ?	□ yes	□ no	Date(s) _____ (Please attach photocopies of post-operative and cell reports).
7- During the last 24 months, have you had any symptoms for which you did not consult a health professional and which should have been treated ?	□ yes	□ no	Details _____ _____
8- Over the next 6 months, is it planned for you to have any medical examinations (laboratory tests, medical imaging, endoscopy…) consult a specialist or undergo medical and / or surgical treatment on an inpatient or outpatient basis ?	□ yes	□ no	Details _____ _____ _____
9- During the past ten years have you experienced any of the following? a) High blood pressure /hypertension, diabetes, cholesterol problem, stroke, lung, heart or circulatory disease b)Respiratory or allergic condition, emphysema, bronchitis, pneumonia, sleep apnea, asthma c) Anxiety, headaches, drug or alcohol abuse, neurological or psychological illness (including depression) d) Gastritis, gastro-esophageal reflux, stomach or intestinal ulcers, hernias, urinary tract or liver disorders (hepatitis, gallstones and kidney stones, renal failure, lithiasis…), prostate, thrombosis e) Sciatica, herniated discs, lumbar pain, rheumatism (including the vertebrae) arthritis, any skin condition such as keratosis, melanoma...	□ yes	□ no	If you answer YES to this question, please indicate which illness and state clearly all relevant details (date, duration, treatment, recovery date, after-effects, comments). Please attach photocopies of medical reports. _____ _____ _____ _____ _____ _____

f) Any hormonal or glandular disease, blood or immune system disease, cancer, leukemia or other blood related illness
g) For women only : have you in the past ten years had any gynecological disorder ?
h) have you had any other medical problems not mentioned on the questionnaire ?

_____
_____
_____

10- Do you plan to get hospitalized in the upcoming 12 months? □ yes □ no If YES, indicate the nature of the hospitalization _____

11- Have you had a screening for the AIDS, hepatitis virus or for one of the human Immuno-deficiency viruses? □ yes □ no If YES, please indicate the date, nature of the test and result : _____

12- Have you had any after-effects resulting from an accident or illness? □ yes □ no Details _____
_____

13- Do you suffer from a disability or are you entitled to a disablement pension (civilian or military) or old age pension ? □ yes □ no Nature of disability : _____
Rate (please attach notification): _____

14- Are you currently covered by any medical or Life policy ? □ yes □ no
Has any medical or Life insurance application been declined, rated, restricted, or cancelled? □ yes □ no

I hereby declare that the above statements are full, complete and true to the best of my knowledge and belief, and that I have not declared or omitted to declare any particular that may mislead the insurer. It is fully agreed that the penalties provided for in articles L 113-8 and 9 of the French Insurance Code which apply in the case of false statement, concealment or inaccuracy, are the nullity of the contract or the reduction of the level of coverage.

Please handwrite the following formula:

I agree that in the case of false or incomplete statement, the insurer has the right to reduce the level of, or refuse, coverage.

I agree that in the case of false or incomplete statement, the insurer has the right to reduce the level of, or refuse, coverage.

_____

_____

Signed in (town or city) _____ Date (DD/MM/YYYY) |_|_|_|_|_|_|_|_|

Signature of the Applicant (or legal representative for applicant under age 18) preceded by the words 'I have read, understood and accepted the policy documents and terms'.

Applicant 2 — Medical questionnaire (document to print)

You must answer all of the questions below. Further information you consider important about your health may be communicated to us on a separate sheet of paper.

Cover is subject to our medical approval.

Please fill out one questionnaire per person and send us as many forms as there are people to be insured. To download another form, please click here.

Usual / Married name : **First name :** **DOB (DD/MM/YYYY):** |_|_| |_|_| |_|_|_|_|

Occupation :

- What are your usual height, weight and blood pressure?

Height _____m Weight _____ kg Blood pressure _____

- What is your daily consumption of alcohol ? Beer : _____ glasses / day ; Wine : ____ glasses / day ; Spirits : ____ drinks / day

- Do you currently smoke pipes, cigars or cigarettes? □ yes □ no If so, how many per day? Pipes:_____ Cigars:_____ Cigarettes:_____
- Have you ever smoked? □ yes □ no If so, for how many years? _____ years
- When did you stop and why? _____

Please reply with either YES or NO

1- Do you have or have you ever had a congenital or hereditary disorder ?	□ yes	□ no	If YES, please indicate which disorder, onset date & treatment:_____ _____
2- Does your present state of health prevent you from performing your full time profession?	□ yes	□ no	Therapeutic Part Time leave _____ Total leave of absence _____ Reasons _____
3- Have you undergone or been advised to undergo surgery, other than for the extraction of the appendix, tonsils or adenoids ?	□ yes	□ no	Details of surgery? _____ Date(s) _____
4- During the last 5 years, have you had / do you have any medical treatment (medication, acupuncture, physiotherapy, medical appliances, psychotherapy…), excluding birth control ? Are you currently undergoing diagnostic tests ?	□ yes	□ no	Details _____ _____ _____ _____
5- During the past 5 years, have you been prescribed sick leave or a medical treatment exceeding 3 weeks?	□ yes	□ no	Please give reasons? _____ _____ Nature and duration of treatment : _____ _____
6- Have you received care or undergone tests during the past 5 years which have led to stay in a medical establishment (hospital, clinic, convalescent home, physiotherapy, dietary needs or treatment centre, sanatorium…) ?	□ yes	□ no	Date(s) _____ (Please attach photocopies of post-operative and cell reports).
7- During the last 24 months, have you had any symptoms for which you did not consult a health professional and which should have been treated ?	□ yes	□ no	Details _____ _____
8- Over the next 6 months, is it planned for you to have any medical examinations (laboratory tests, medical imaging, endoscopy…) consult a specialist or undergo medical and / or surgical treatment on an inpatient or outpatient basis ?	□ yes	□ no	Details _____ _____ _____
9- During the past ten years have you experienced any of the following? a) High blood pressure /hypertension, diabetes, cholesterol problem, stroke, lung, heart or circulatory disease b)Respiratory or allergic condition, emphysema, bronchitis, pneumonia, sleep apnea, asthma c) Anxiety, headaches, drug or alcohol abuse, neurological or psychological illness (including depression) d) Gastritis, gastro-esophageal reflux, stomach or intestinal ulcers, hernias, urinary tract or liver disorders (hepatitis, gallstones and kidney stones, renal failure, lithiasis…), prostate, thrombosis e) Sciatica, herniated discs, lumbar pain, rheumatism (including the vertebrae) arthritis, any skin condition such as keratosis, melanoma...	□ yes	□ no	If you answer YES to this question, please indicate which illness and state clearly all relevant details (date, duration, treatment, recovery date, after-effects, comments). Please attach photocopies of medical reports. _____ _____ _____ _____ _____ _____

f) Any hormonal or glandular disease, blood or immune system disease, cancer, leukemia or other blood related illness
g) For women only : have you in the past ten years had any gynecological disorder ?
h) have you had any other medical problems not mentioned on the questionnaire ?

_____
_____
_____

10- Do you plan to get hospitalized in the upcoming 12 months? □ yes □ no If YES, indicate the nature of the hospitalization _____

11- Have you had a screening for the AIDS, hepatitis virus or for one of the human Immuno-deficiency viruses? □ yes □ no If YES, please indicate the date, nature of the test and result : _____

12- Have you had any after-effects resulting from an accident or illness? □ yes □ no Details _____
_____

13- Do you suffer from a disability or are you entitled to a disablement pension (civilian or military) or old age pension ? □ yes □ no Nature of disability : _____
Rate (please attach notification): _____

14- Are you currently covered by any medical or Life policy ? □ yes □ no
Has any medical or Life insurance application been declined, rated, restricted, or cancelled? □ yes □ no

I hereby declare that the above statements are full, complete and true to the best of my knowledge and belief, and that I have not declared or omitted to declare any particular that may mislead the insurer. It is fully agreed that the penalties provided for in articles L 113-8 and 9 of the French Insurance Code which apply in the case of false statement, concealment or inaccuracy, are the nullity of the contract or the reduction of the level of coverage.

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Signed in (town or city) _____ Date (DD/MM/YYYY) |_|_|_|_|_|_|_|_|

Signature of the Applicant (or legal representative for applicant under age 18) preceded by the words 'I have read, understood and accepted the policy documents and terms'.

Applicant 3 — Medical questionnaire (document to print)

You must answer all of the questions below. Further information you consider important about your health may be communicated to us on a separate sheet of paper.

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Usual / Married name : **First name :** **DOB (DD/MM/YYYY):** |_|_|/|_|_|/|_|_|_|_|

Occupation :

- What are your usual height, weight and blood pressure?

Height _____m Weight _____ kg Blood pressure _____

- What is your daily consumption of alcohol ? Beer : _____ glasses / day ; Wine : ____ glasses / day ; Spirits : ____ drinks / day

- Do you currently smoke pipes, cigars or cigarettes? □ yes □ no If so, how many per day? Pipes:_____ Cigars:_____ Cigarettes:_____
- Have you ever smoked? □ yes □ no If so, for how many years? _____ years
- When did you stop and why? _____

Please reply with either YES or NO

1- Do you have or have you ever had a congenital or hereditary disorder ?	□ yes	□ no	If YES, please indicate which disorder, onset date & treatment:_____ _____
2- Does your present state of health prevent you from performing your full time profession?	□ yes	□ no	Therapeutic Part Time leave _____ Total leave of absence _____ Reasons _____
3- Have you undergone or been advised to undergo surgery, other than for the extraction of the appendix, tonsils or adenoids ?	□ yes	□ no	Details of surgery? _____ Date(s) _____
4- During the last 5 years, have you had / do you have any medical treatment (medication, acupuncture, physiotherapy, medical appliances, psychotherapy…), excluding birth control ? Are you currently undergoing diagnostic tests ?	□ yes	□ no	Details _____ _____ _____ _____
5- During the past 5 years, have you been prescribed sick leave or a medical treatment exceeding 3 weeks?	□ yes	□ no	Please give reasons? _____ _____ Nature and duration of treatment : _____ _____
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9- During the past ten years have you experienced any of the following? a) High blood pressure /hypertension, diabetes, cholesterol problem, stroke, lung, heart or circulatory disease b)Respiratory or allergic condition, emphysema, bronchitis, pneumonia, sleep apnea, asthma c) Anxiety, headaches, drug or alcohol abuse, neurological or psychological illness (including depression) d) Gastritis, gastro-esophageal reflux, stomach or intestinal ulcers, hernias, urinary tract or liver disorders (hepatitis, gallstones and kidney stones, renal failure, lithiasis…), prostate, thrombosis e) Sciatica, herniated discs, lumbar pain, rheumatism (including the vertebrae) arthritis, any skin condition such as keratosis, melanoma...	□ yes	□ no	If you answer YES to this question, please indicate which illness and state clearly all relevant details (date, duration, treatment, recovery date, after-effects, comments). Please attach photocopies of medical reports. _____ _____ _____ _____ _____ _____

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g) For women only : have you in the past ten years had any gynecological disorder ?
h) have you had any other medical problems not mentioned on the questionnaire ?

_____
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10- Do you plan to get hospitalized in the upcoming 12 months? □ yes □ no If YES, indicate the nature of the hospitalization _____

11- Have you had a screening for the AIDS, hepatitis virus or for one of the human Immuno-deficiency viruses? □ yes □ no If YES, please indicate the date, nature of the test and result : _____

12- Have you had any after-effects resulting from an accident or illness? □ yes □ no Details _____
_____

13- Do you suffer from a disability or are you entitled to a disablement pension (civilian or military) or old age pension ? □ yes □ no Nature of disability : _____
Rate (please attach notification): _____

14- Are you currently covered by any medical or Life policy ? □ yes □ no
Has any medical or Life insurance application been declined, rated, restricted, or cancelled? □ yes □ no

I hereby declare that the above statements are full, complete and true to the best of my knowledge and belief, and that I have not declared or omitted to declare any particular that may mislead the insurer. It is fully agreed that the penalties provided for in articles L 113-8 and 9 of the French Insurance Code which apply in the case of false statement, concealment or inaccuracy, are the nullity of the contract or the reduction of the level of coverage.

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Signed in (town or city) _____ Date (DD/MM/YYYY) |_|_|_|_|_|_|_|_|

Signature of the Applicant (or legal representative for applicant under age 18) preceded by the words 'I have read, understood and accepted the policy documents and terms'.

Applicant 4 — Medical questionnaire (document to print)

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Please fill out one questionnaire per person and send us as many forms as there are people to be insured. To download another form, please click here.

Usual / Married name : **First name :** **DOB (DD/MM/YYYY):** |_|_|/|_|_|/|_|_|_|_|

Occupation :

- What are your usual height, weight and blood pressure?

Height _____m Weight _____ kg Blood pressure _____

- What is your daily consumption of alcohol ? Beer : _____ glasses / day ; Wine : ____ glasses / day ; Spirits : ____ drinks / day

- Do you currently smoke pipes, cigars or cigarettes? □ yes □ no If so, how many per day? Pipes:_____ Cigars:_____ Cigarettes:_____
- Have you ever smoked? □ yes □ no If so, for how many years? _____ years
- When did you stop and why? _____

Please reply with either YES or NO

1- Do you have or have you ever had a congenital or hereditary disorder ? □ yes □ no
If YES, please indicate which disorder, onset date & treatment:_____

2- Does your present state of health prevent you from performing your full time profession? □ yes □ no
Therapeutic Part Time leave _____
Total leave of absence _____
Reasons _____

3- Have you undergone or been advised to undergo surgery, other than for the extraction of the appendix, tonsils or adenoids ? □ yes □ no
Details of surgery? _____
Date(s) _____

4- During the last 5 years, have you had / do you have any medical treatment (medication, acupuncture, physiotherapy, medical appliances, psychotherapy…), excluding birth control ? □ yes □ no
Are you currently undergoing diagnostic tests ?
Details _____

5- During the past 5 years, have you been prescribed sick leave or a medical treatment exceeding 3 weeks? □ yes □ no
Please give reasons? _____
Nature and duration of treatment :

6- Have you received care or undergone tests during the past 5 years which have led to stay in a medical establishment (hospital, clinic, convalescent home, physiotherapy, dietary needs or treatment centre, sanatorium…) ? □ yes □ no
Date(s) _____
(Please attach photocopies of post-operative and cell reports).

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Details _____

8- Over the next 6 months, is it planned for you to have any medical examinations (laboratory tests, medical imaging, endoscopy…) consult a specialist or undergo medical and / or surgical treatment on an inpatient or outpatient basis ? □ yes □ no
Details _____

9- During the past ten years have you experienced any of the following?

a) High blood pressure /hypertension, diabetes, cholesterol problem, stroke, lung, heart or circulatory disease
b)Respiratory or allergic condition, emphysema, bronchitis, pneumonia, sleep apnea, asthma
c) Anxiety, headaches, drug or alcohol abuse, neurological or psychological illness (including depression)
d) Gastritis, gastro-esophageal reflux, stomach or intestinal ulcers, hernias, urinary tract or liver disorders (hepatitis, gallstones and kidney stones, renal failure, lithiasis…), prostate, thrombosis
e) Sciatica, herniated discs, lumbar pain, rheumatism (including the vertebrae) arthritis, any skin condition such as keratosis, melanoma...

□ yes □ no

If you answer YES to this question, please indicate which illness and state clearly all relevant details (date, duration, treatment, recovery date, after-effects, comments).
Please attach photocopies of medical reports.

f) Any hormonal or glandular disease, blood or immune system disease, cancer, leukemia or other blood related illness
g) For women only : have you in the past ten years had any gynecological disorder ?
h) have you had any other medical problems not mentioned on the questionnaire ?

_____
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10- Do you plan to get hospitalized in the upcoming 12 months? □ yes □ no If YES, indicate the nature of the hospitalization _____

11- Have you had a screening for the AIDS, hepatitis virus or for one of the human Immuno-deficiency viruses? □ yes □ no If YES, please indicate the date, nature of the test and result : _____

12- Have you had any after-effects resulting from an accident or illness? □ yes □ no Details _____
_____

13- Do you suffer from a disability or are you entitled to a disablement pension (civilian or military) or old age pension ? □ yes □ no Nature of disability : _____
Rate (please attach notification): _____

14- Are you currently covered by any medical or Life policy ? □ yes □ no
Has any medical or Life insurance application been declined, rated, restricted, or cancelled? □ yes □ no

I hereby declare that the above statements are full, complete and true to the best of my knowledge and belief, and that I have not declared or omitted to declare any particular that may mislead the insurer. It is fully agreed that the penalties provided for in articles L 113-8 and 9 of the French Insurance Code which apply in the case of false statement, concealment or inaccuracy, are the nullity of the contract or the reduction of the level of coverage.

Please handwrite the following formula:

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I agree that in the case of false or incomplete statement, the insurer has the right to reduce the level of, or refuse, coverage.

_____

_____

Signed in (town or city) _____ Date (DD/MM/YYYY) |_|_|_|_|_|_|_|_|

Signature of the Applicant (or legal representative for applicant under age 18) preceded by the words 'I have read, understood and accepted the policy documents and terms'.

Applicant 5 — Medical questionnaire (document to print)

You must answer all of the questions below. Further information you consider important about your health may be communicated to us on a separate sheet of paper.

Cover is subject to our medical approval.

Please fill out one questionnaire per person and send us as many forms as there are people to be insured. To download another form, please click here.

Usual / Married name : **First name :** **DOB (DD/MM/YYYY):** |_|_|/|_|_|/|_|_|_|_|

Occupation :

- What are your usual height, weight and blood pressure?

Height _____m Weight _____ kg Blood pressure _____

- What is your daily consumption of alcohol ? Beer : _____ glasses / day ; Wine : ____ glasses / day ; Spirits : ____ drinks / day

- Do you currently smoke pipes, cigars or cigarettes? □ yes □ no If so, how many per day? Pipes:_____ Cigars:_____ Cigarettes:_____
- Have you ever smoked? □ yes □ no If so, for how many years? _____ years
- When did you stop and why? _____

Please reply with either YES or NO

1- Do you have or have you ever had a congenital or hereditary disorder ?	□ yes	□ no	If YES, please indicate which disorder, onset date & treatment:_____ _____
2- Does your present state of health prevent you from performing your full time profession?	□ yes	□ no	Therapeutic Part Time leave _____ Total leave of absence _____ Reasons _____
3- Have you undergone or been advised to undergo surgery, other than for the extraction of the appendix, tonsils or adenoids ?	□ yes	□ no	Details of surgery? _____ Date(s) _____
4- During the last 5 years, have you had / do you have any medical treatment (medication, acupuncture, physiotherapy, medical appliances, psychotherapy…), excluding birth control ? Are you currently undergoing diagnostic tests ?	□ yes	□ no	Details _____ _____ _____ _____
5- During the past 5 years, have you been prescribed sick leave or a medical treatment exceeding 3 weeks?	□ yes	□ no	Please give reasons? _____ _____ Nature and duration of treatment : _____ _____
6- Have you received care or undergone tests during the past 5 years which have led to stay in a medical establishment (hospital, clinic, convalescent home, physiotherapy, dietary needs or treatment centre, sanatorium…) ?	□ yes	□ no	Date(s) _____ (Please attach photocopies of post-operative and cell reports).
7- During the last 24 months, have you had any symptoms for which you did not consult a health professional and which should have been treated ?	□ yes	□ no	Details _____ _____
8- Over the next 6 months, is it planned for you to have any medical examinations (laboratory tests, medical imaging, endoscopy…) consult a specialist or undergo medical and / or surgical treatment on an inpatient or outpatient basis ?	□ yes	□ no	Details _____ _____ _____
9- During the past ten years have you experienced any of the following? a) High blood pressure /hypertension, diabetes, cholesterol problem, stroke, lung, heart or circulatory disease b)Respiratory or allergic condition, emphysema, bronchitis, pneumonia, sleep apnea, asthma c) Anxiety, headaches, drug or alcohol abuse, neurological or psychological illness (including depression) d) Gastritis, gastro-esophageal reflux, stomach or intestinal ulcers, hernias, urinary tract or liver disorders (hepatitis, gallstones and kidney stones, renal failure, lithiasis…), prostate, thrombosis e) Sciatica, herniated discs, lumbar pain, rheumatism (including the vertebrae) arthritis, any skin condition such as keratosis, melanoma...	□ yes	□ no	If you answer YES to this question, please indicate which illness and state clearly all relevant details (date, duration, treatment, recovery date, after-effects, comments). Please attach photocopies of medical reports. _____ _____ _____ _____ _____ _____

f) Any hormonal or glandular disease, blood or immune system disease, cancer, leukemia or other blood related illness
g) For women only : have you in the past ten years had any gynecological disorder ?
h) have you had any other medical problems not mentioned on the questionnaire ?

_____
_____
_____

10- Do you plan to get hospitalized in the upcoming 12 months? □ yes □ no If YES, indicate the nature of the hospitalization _____

11- Have you had a screening for the AIDS, hepatitis virus or for one of the human Immuno-deficiency viruses? □ yes □ no If YES, please indicate the date, nature of the test and result : _____

12- Have you had any after-effects resulting from an accident or illness? □ yes □ no Details _____
_____

13- Do you suffer from a disability or are you entitled to a disablement pension (civilian or military) or old age pension ? □ yes □ no Nature of disability : _____
Rate (please attach notification): _____

14- Are you currently covered by any medical or Life policy ? □ yes □ no
Has any medical or Life insurance application been declined, rated, restricted, or cancelled? □ yes □ no

I hereby declare that the above statements are full, complete and true to the best of my knowledge and belief, and that I have not declared or omitted to declare any particular that may mislead the insurer. It is fully agreed that the penalties provided for in articles L 113-8 and 9 of the French Insurance Code which apply in the case of false statement, concealment or inaccuracy, are the nullity of the contract or the reduction of the level of coverage.

Please handwrite the following formula:

I agree that in the case of false or incomplete statement, the insurer has the right to reduce the level of, or refuse, coverage.

I agree that in the case of false or incomplete statement, the insurer has the right to reduce the level of, or refuse, coverage.

_____

_____

Signed in (town or city) _____ Date (DD/MM/YYYY) |_|_|_|_|_|_|_|_|

Signature of the Applicant (or legal representative for applicant under age 18) preceded by the words 'I have read, understood and accepted the policy documents and terms'.

Applicant 6 — Medical questionnaire (document to print)

You must answer all of the questions below. Further information you consider important about your health may be communicated to us on a separate sheet of paper.

Cover is subject to our medical approval.

Please fill out one questionnaire per person and send us as many forms as there are people to be insured. To download another form, please click here.

Usual / Married name : **First name :** **DOB (DD/MM/YYYY):** |_|_|/|_|_|/|_|_|_|_|

Occupation :

- What are your usual height, weight and blood pressure?

Height _____m Weight _____ kg Blood pressure _____

- What is your daily consumption of alcohol ? Beer : _____ glasses / day ; Wine : ____ glasses / day ; Spirits : ____ drinks / day

- Do you currently smoke pipes, cigars or cigarettes? □ yes □ no If so, how many per day? Pipes:_____ Cigars:_____ Cigarettes:_____
- Have you ever smoked? □ yes □ no If so, for how many years? _____ years
- When did you stop and why? _____

Please reply with either YES or NO

1- Do you have or have you ever had a congenital or hereditary disorder ?	□ yes	□ no	If YES, please indicate which disorder, onset date & treatment:_____ _____
2- Does your present state of health prevent you from performing your full time profession?	□ yes	□ no	Therapeutic Part Time leave _____ Total leave of absence _____ Reasons _____
3- Have you undergone or been advised to undergo surgery, other than for the extraction of the appendix, tonsils or adenoids ?	□ yes	□ no	Details of surgery? _____ Date(s) _____
4- During the last 5 years, have you had / do you have any medical treatment (medication, acupuncture, physiotherapy, medical appliances, psychotherapy…), excluding birth control ? Are you currently undergoing diagnostic tests ?	□ yes	□ no	Details _____ _____ _____ _____
5- During the past 5 years, have you been prescribed sick leave or a medical treatment exceeding 3 weeks?	□ yes	□ no	Please give reasons? _____ _____ Nature and duration of treatment : _____ _____
6- Have you received care or undergone tests during the past 5 years which have led to stay in a medical establishment (hospital, clinic, convalescent home, physiotherapy, dietary needs or treatment centre, sanatorium…) ?	□ yes	□ no	Date(s) _____ (Please attach photocopies of post-operative and cell reports).
7- During the last 24 months, have you had any symptoms for which you did not consult a health professional and which should have been treated ?	□ yes	□ no	Details _____ _____
8- Over the next 6 months, is it planned for you to have any medical examinations (laboratory tests, medical imaging, endoscopy…) consult a specialist or undergo medical and / or surgical treatment on an inpatient or outpatient basis ?	□ yes	□ no	Details _____ _____ _____
9- During the past ten years have you experienced any of the following? a) High blood pressure /hypertension, diabetes, cholesterol problem, stroke, lung, heart or circulatory disease b)Respiratory or allergic condition, emphysema, bronchitis, pneumonia, sleep apnea, asthma c) Anxiety, headaches, drug or alcohol abuse, neurological or psychological illness (including depression) d) Gastritis, gastro-esophageal reflux, stomach or intestinal ulcers, hernias, urinary tract or liver disorders (hepatitis, gallstones and kidney stones, renal failure, lithiasis…), prostate, thrombosis e) Sciatica, herniated discs, lumbar pain, rheumatism (including the vertebrae) arthritis, any skin condition such as keratosis, melanoma...	□ yes	□ no	If you answer YES to this question, please indicate which illness and state clearly all relevant details (date, duration, treatment, recovery date, after-effects, comments). Please attach photocopies of medical reports. _____ _____ _____ _____ _____ _____

f) Any hormonal or glandular disease, blood or immune system disease, cancer, leukemia or other blood related illness
g) For women only : have you in the past ten years had any gynecological disorder ?
h) have you had any other medical problems not mentioned on the questionnaire ?

_____
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_____

10- Do you plan to get hospitalized in the upcoming 12 months? □ yes □ no If YES, indicate the nature of the hospitalization _____

11- Have you had a screening for the AIDS, hepatitis virus or for one of the human Immuno-deficiency viruses? □ yes □ no If YES, please indicate the date, nature of the test and result : _____

12- Have you had any after-effects resulting from an accident or illness? □ yes □ no Details _____
_____

13- Do you suffer from a disability or are you entitled to a disablement pension (civilian or military) or old age pension ? □ yes □ no Nature of disability : _____
Rate (please attach notification): _____

14- Are you currently covered by any medical or Life policy ? □ yes □ no
Has any medical or Life insurance application been declined, rated, restricted, or cancelled? □ yes □ no

I hereby declare that the above statements are full, complete and true to the best of my knowledge and belief, and that I have not declared or omitted to declare any particular that may mislead the insurer. It is fully agreed that the penalties provided for in articles L 113-8 and 9 of the French Insurance Code which apply in the case of false statement, concealment or inaccuracy, are the nullity of the contract or the reduction of the level of coverage.

Please handwrite the following formula:

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_____

_____

Signed in (town or city) _____ Date (DD/MM/YYYY) |_|_|_|_|_|_|_|_|

Signature of the Applicant (or legal representative for applicant under age 18) preceded by the words 'I have read, understood and accepted the policy documents and terms'.

Applicant 7 — Medical questionnaire (document to print)

You must answer all of the questions below. Further information you consider important about your health may be communicated to us on a separate sheet of paper.

Cover is subject to our medical approval.

Please fill out one questionnaire per person and send us as many forms as there are people to be insured. To download another form, please click here.

Usual / Married name : **First name :** **DOB (DD/MM/YYYY):** |_|_| |_|_| |_|_|_|_|

Occupation :

- What are your usual height, weight and blood pressure?

Height _____m Weight _____ kg Blood pressure _____

- What is your daily consumption of alcohol ? Beer : _____ glasses / day ; Wine : ____ glasses / day ; Spirits : ____ drinks / day

- Do you currently smoke pipes, cigars or cigarettes? □ yes □ no If so, how many per day? Pipes:_____ Cigars:_____ Cigarettes:_____
- Have you ever smoked? □ yes □ no If so, for how many years? _____ years
- When did you stop and why? _____

Please reply with either YES or NO

1- Do you have or have you ever had a congenital or hereditary disorder ?	□ yes	□ no	If YES, please indicate which disorder, onset date & treatment:_____ _____
2- Does your present state of health prevent you from performing your full time profession?	□ yes	□ no	Therapeutic Part Time leave _____ Total leave of absence _____ Reasons _____
3- Have you undergone or been advised to undergo surgery, other than for the extraction of the appendix, tonsils or adenoids ?	□ yes	□ no	Details of surgery? _____ Date(s) _____
4- During the last 5 years, have you had / do you have any medical treatment (medication, acupuncture, physiotherapy, medical appliances, psychotherapy…), excluding birth control ? Are you currently undergoing diagnostic tests ?	□ yes	□ no	Details _____ _____ _____ _____
5- During the past 5 years, have you been prescribed sick leave or a medical treatment exceeding 3 weeks?	□ yes	□ no	Please give reasons? _____ _____ Nature and duration of treatment : _____ _____
6- Have you received care or undergone tests during the past 5 years which have led to stay in a medical establishment (hospital, clinic, convalescent home, physiotherapy, dietary needs or treatment centre, sanatorium…) ?	□ yes	□ no	Date(s) _____ (Please attach photocopies of post-operative and cell reports).
7- During the last 24 months, have you had any symptoms for which you did not consult a health professional and which should have been treated ?	□ yes	□ no	Details _____ _____
8- Over the next 6 months, is it planned for you to have any medical examinations (laboratory tests, medical imaging, endoscopy…) consult a specialist or undergo medical and / or surgical treatment on an inpatient or outpatient basis ?	□ yes	□ no	Details _____ _____ _____
9- During the past ten years have you experienced any of the following? a) High blood pressure /hypertension, diabetes, cholesterol problem, stroke, lung, heart or circulatory disease b)Respiratory or allergic condition, emphysema, bronchitis, pneumonia, sleep apnea, asthma c) Anxiety, headaches, drug or alcohol abuse, neurological or psychological illness (including depression) d) Gastritis, gastro-esophageal reflux, stomach or intestinal ulcers, hernias, urinary tract or liver disorders (hepatitis, gallstones and kidney stones, renal failure, lithiasis…), prostate, thrombosis e) Sciatica, herniated discs, lumbar pain, rheumatism (including the vertebrae) arthritis, any skin condition such as keratosis, melanoma...	□ yes	□ no	If you answer YES to this question, please indicate which illness and state clearly all relevant details (date, duration, treatment, recovery date, after-effects, comments). Please attach photocopies of medical reports. _____ _____ _____ _____ _____ _____

f) Any hormonal or glandular disease, blood or immune system disease, cancer, leukemia or other blood related illness
g) For women only : have you in the past ten years had any gynecological disorder ?
h) have you had any other medical problems not mentioned on the questionnaire ?

_____
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10- Do you plan to get hospitalized in the upcoming 12 months? □ yes □ no If YES, indicate the nature of the hospitalization _____

11- Have you had a screening for the AIDS, hepatitis virus or for one of the human Immuno-deficiency viruses? □ yes □ no If YES, please indicate the date, nature of the test and result : _____

12- Have you had any after-effects resulting from an accident or illness? □ yes □ no Details _____
_____

13- Do you suffer from a disability or are you entitled to a disablement pension (civilian or military) or old age pension ? □ yes □ no Nature of disability : _____
Rate (please attach notification): _____

14- Are you currently covered by any medical or Life policy ? □ yes □ no
Has any medical or Life insurance application been declined, rated, restricted, or cancelled? □ yes □ no

I hereby declare that the above statements are full, complete and true to the best of my knowledge and belief, and that I have not declared or omitted to declare any particular that may mislead the insurer. It is fully agreed that the penalties provided for in articles L 113-8 and 9 of the French Insurance Code which apply in the case of false statement, concealment or inaccuracy, are the nullity of the contract or the reduction of the level of coverage.

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_____

_____

Signed in (town or city) _____ Date (DD/MM/YYYY) |_|_|_|_|_|_|_|_|

Signature of the Applicant (or legal representative for applicant under age 18) preceded by the words 'I have read, understood and accepted the policy documents and terms'.