Global Care International

- TO FILL OUT YOUR FORM YOU CAN:

- Print it and fill it out manually
- Or fill it out in a software program like Acrobat.
  Once the pdf is open, click on «Fill and sign myself» in the «Sign electronically» menu

The medical questionnaire (parts 9 to 11) must be completed by all persons to be insured.

If you fill in the questionnaire electronically, we advise you to download as many forms as there are persons to be insured.

If you fill it out manually, print as many medical questionnaires as there are people to be insured.

- PLEASE SEND US YOUR APPLICATION FORM DULY COMPLETED & SIGNED WITH ALL REQUIRED DOCUMENTS (See details chapter 6):

- By email: newapplication@msh-intl.com
- Or by post: MSH INTERNATIONAL - Service Adhésions Individuelles, 23 allées de l'Europe, 92587 Clichy Cedex – France

Global Care International | MSH INTERNATIONAL

Broker's name:
Broker's code:

Global Care International Insurance Plans
INDIVIDUAL APPLICATION FORM

☐ New Membership ☐ Modification

A COPY MUST BE KEPT BY THE MEMBER

1 Member

☐ Mrs. ☐ Mr.

Surname: _____ First Name: _____ Date of birth: __/__/____ *(dd/mm/yyyy)*

Family situation : ☐ Married ☐ Divorced ☐ Widow ☐ Single ☐ Partner

Nationality (country for which you own a valid passeport) _____

Fiscal Address: _____

City + zip code: _____ Country: _____

HOME country: _____HOST country: _____

Phone number: _____ Occupation: _____

Email (to receive email alerts for reimbursements) : _____@ _____

Email for premium invoices (if different from the above) : _____@ _____

2 Beneficiaries

Status	Surname	First Name	Date Of Birth	City Of Birth	Country Of Birth
Spouse					
1st child					
2nd child					
3rd child					
4th child					
5th child					

3 Policy

On what date would you like cover to start : __/__/____ *(dd/mm/yyyy)*

- **Currency :**
  ☐ US Dollar ☐ Euro
- **Health, Assistance and Life benefits**
  ☐ Care+ & Death benefit USD 5,000 / EUR 4 350
  ☐ Comfort+ & Death benefit USD 8,000 / EUR 7 000
  ☐ Executive+ & Death Benefit USD 12,000 / EUR 10 400
  ☐ Elite+ & Death Benefit USD 15,000 / EUR 13 000
- **Deductible :**
  ☐ USD 500 / EUR 435 ☐ USD 1,000 / EUR 870 ☐ USD 1,500 / EUR 1 300 ☐ USD 3,000 / EUR 2 600
- **Your Healthcare reimbursements**
  Please mention your bank account currency _____ and provide us with your bank details.

4 Zone of coverage

☐ Zone 1: Worldwide
☐ Zone 2: Worldwide excluding USA
☐ Zone 3: Worldwide excluding USA, Canada, China, United Kingdom, Hong Kong, Singapore, Switzerland, Australia, Brazil, Chile, Mexico

5 Payment details

Payment options : **please note that there is a 5% surcharge for quarterly and monthly payments (included in quarterly and monthly rates)**

☐ Annually ☐ Bi-annually ☐ Quarterly ☐ Monthly

Quality	Annual Premium Due $ / €
Main insured	
Spouse	
1st child	
2nd child	
3rd child	
4th child	
5th child	

Total annual amount due: $ / € _____

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FREQUENCY AND METHOD OF PAYMENT (please select the frequency and method of payment best suited to your situation)				
	Annually	Bi-annually	Quarterly	Monthly
Credit card for the first payment and all future payments through your online Member Area	☐	☐	☐	☐
Bank transfer	☐	☐	☐	☐
By direct debit (only on a French or Monegasque bank account)	☐	☐	☐	☐

6 Completion of your application form

To finalize your enrollment, you need to send us:

- the Individual application form completed and signed,
- the Medical questionnaire completed and signed, along with the additional medical details if you answered yes to any questions in the medical questionnaire,
- the Nomination of beneficiaries in case of death completed and signed,
- a copy of your identity card or passport,
- a bank account slip for your healthcare reimbursements from MSH International.

For payment of your premium, you will be contacted by MSH International

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.msh-intl.com*** in your Member Area,
- 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.

PLEASE SEND US YOUR APPLICATION FORM DULY COMPLETED & SIGNED WITH ALL REQUIRED DOCUMENTS:

By email: newapplication@msh-intl.com

By post : MSH INTERNATIONAL - Service Adhésions Individuelles, 23 allées de l'Europe, 92587 Clichy Cedex – France

7 Declaration and signature

The Insured, on his/her own behalf and on behalf of his/her dependants if relevant, hereby certifies that the replies are honest and true and declares that nothing has been concealed that may mislead the Insurer or distort the decision that it must make concerning the proposed insurance. Any false declaration or omission will entail the invalidity of this policy. This questionnaire is valid for 3 months from the date of signature of the person to be insured.

☐ *I hereby apply for membership to the Global Care International Insurance Plans underwritten by the Insurer who reserves the right to cancel the membership of this Plan if any amount due is not paid by or on the due date concerned,*

☐ *I agree to the processing of my health data as part of the management of my insurance contract. By not ticking this box, I am informed that the elements related to my health will not be considered, which may call into question my membership and the execution of my contract. I may withdraw my consent at any time without the withdrawal compromising the lawfulness of the pre-withdrawal processing based on consent,*

☐ *I certify that the statements made by me in answering the above questions are true, complete and to the best of my knowledge and belief. I understand that nullity of the insurance or reduction of the insured capital sum might be applied if it were proved that the person to be insured had established a false declaration. I confirm that I have checked and found correct any statements in this form that are not in my own handwriting,*

☐ *I agree to give the Insurer immediate written notice should any changes material to the assessment of this application occur before the date upon which MGEN grants written acceptance. This will give the Insurer the opportunity to reconsider the terms of acceptance.*

Place: _____ *Date* __/__/____ *(dd/mm/yyyy)*

(signature of the person to be insured preceded by the words « read and approved »)

Insured member's signature

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Broker's name:
Broker's code:

8 Nomination of beneficiaries in case of death

MAIN INSURED MEMBER

☐ Mrs ☐ M. Surname: _____ First Name: _____
Address: _____
Email: _____@_____ Phone: _____

DEPENDENT

☐ Mrs ☐ M. Surname: _____ First Name: _____
Address: _____
Email: _____@_____ Phone: _____

☐ 1°) I opt for nomination type listed below:
In case of death, the lump sum will be allocated in the order of preference:

- To the spouse, not legally separated of the married insured, or else, to the partner under a PACS or a cohabitant;
- Otherwise, to the children of the insured born or unborn, equally between them, the share of the pre-deceased reverting to his own children or to his siblings if he has no children;
- Otherwise, to the father and mother equally between them, the share of the pre-deceased reverting to the survivor;
- Otherwise, to the heirs.

☐ 2°) I do not opt for the First formula and name as beneficiary:

Surname	First name	Birth date	Address, Phone	Share (%)
		TOTAL		**100 %**

By opting for the 2nd formula, the Insured shall provide several successive beneficiaries based on the standard clause and if he wishes for an exact breakdown between each beneficiary, he should indicate the share accruing to each and terminate the nomination of beneficiaries by; otherwise, to my heirs. If neither option is chosen, the 1st formula will be applied. It is reminded that the Insured may always change the above nomination and assign the benefit of his insurance to one or more individuals or entities after his admission to the insurance (by completing this document).

RECOMMENDATIONS FOR DESIGNATING BENEFICIARIES IN THE CASE OF DEATH

NB: End your designation of beneficiaries in the event of death with "failing that, to my heirs". Regardless of the chosen beneficiary, it is important not to designate using the name and status (e.g.: Mr. X, my spouse).

Designation of spouse: It is recommended not to name the spouse, but to indicate: "my spouse, not legally separated". In the event of a second marriage, the capital will be paid to the last spouse and, in the event of divorce or legal separation, the capital will be paid to the second beneficiary.

Designation of common law partner or PACS (pact of civil union) partner (or equivalent): depending on the case, indicate simply "my common law partner", or "my PACS partner". The person with this status at the time of the death of the Insured Party will be able to claim the capital. The common law partner must be able to prove his/her status by presenting a certificate of cohabitation or any other proof of joint residency of a contractual nature or issued by an administrative body. The PACS (or equivalent) partner must present the court-approved PACS agreement.

Designation of children: if you name your children, any unborn children will be excluded. It is recommended to indicate: "My born or unborn children, alive or represented, in equal shares", the share of the predeceased being paid to his/her own children or siblings if there are no children.

Designation of parents: it is recommended to indicate "my father and my mother, in equal shares, the share of the predeceased being paid to the survivor" or, if you want to designate just one parent, "my father, failing that, my mother".

Other designations: if you designate several beneficiaries, it is recommended to specify the degree of priority among them.

1. If you want all the capital to be paid to the first person designated and if he/she is deceased, indicate: "Mr. X…, failing that, Mrs. Y, etc."
2. If you want the capital to be divided equally between the different beneficiaries, indicate: "Mr. X…, Mrs. Y…, in equal shares". If one dies, his/her share will be paid to the survivor.
3. If you want the capital to be divided unequally between the different beneficiaries, up to 100% of the capital, indicate: "30% for Mr. X, 50% for Mrs. Y and 20% for Mr. Z".

It is recommended to stipulate who should get the share of any predeceased beneficiaries.

Modification of the nomination: you can modify the standard designation at any time (1st option), and designate any individual or legal entity of your choosing by private agreement or notarised deed. You should inform us in writing of the beneficiary designation. Changes to the beneficiaries should be notified in an identical manner, the beneficiary clause being modifiable whenever it is ceases to be appropriate. If you designate any beneficiaries by name, you must give their full contact details (surname, maiden name, date and place of birth, address, etc.). This information will be used in the event of death, by the Insurer.

Information on acceptance: designation of a beneficiary becomes irrevocable by the acceptance of the latter and may only be applied with your agreement. We must be notified of the acceptance, by notarised deed or private agreement, by yourself and the beneficiary in order to be effective. Signature of the person to be insured preceded by the words "read and approved" affixed in his handwriting.

It cancels and replaces the previous nomination if any

Place: Date: _ _ / _ _ / _ _ _ _ *(dd/mm/yyyy)*
Insured member's Signature :

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Broker's name:
Broker's code:

⑨ Medical Questionnaire

The answers to this questionnaire must be hand written by the person to be insured or his/her legal representative, who must be aware of all the questions and answer them. Tick "Yes" or "No". For each answer to which you tick "Yes", provide all relevant details on the following page, specifying the number of the question, the name of the person to be insured, the date of the event or result, the date of cure or consolidation, the type of treatment or hospitalization, the duration of the illness or treatment, any after-effects and any relevant justifying documents.

INFORMATION

Surname: _____ First Name: _____ Gender: ☐ F ☐ M Date of Birth: _ _ / _ _ / _ _ _ _ *(dd/mm/yyyy)*

QUESTIONS

1	What is your height, weight, usual blood pressure?	Height.....m Weight..... kg Blood pressure: ...../.....
2	In the course of the 10 past years, have you been diagnosed with cardiovascular disease, digestive system, respiratory system, nervous system, genitourinary tract, endocrine or metabolic disease, psychiatric illness, bone and joint disease or tumor? Please specify on the following page: illness, date of diagnosis, treatment, evolution and sequelae.	☐ Yes ☐ No
3	In the course of the 5 past years, have you followed or are you currently undergoing treatment for more than 2 weeks? Please specify what treatment on the following page	☐ Yes ☐ No
4	In the course of the five past years, have you been prescribed one or more sick leaves lasting for more than three consecutive weeks or been prescribed medical treatment that lasted for at least three consecutive weeks? Please specify on the following page the date, duration of the sick leave and the reason.	☐ Yes ☐ No
5	In the course of the five past years, have you been hospitalized for more than a week or should you be hospitalized soon?	☐ Yes ☐ No
6	Do you have any sequels as a result of an illness or accident?	☐ Yes ☐ No
7	Do you have a disability or do you receive a civil or military invalidity allowance or an old age pension?	☐ Yes ☐ No
8	Have you been screened for serology, particularly for the hepatitis B and C viruses or for the human immunodeficiency virus (HIV), which has been positive? Which one? When? Please specify on the following page	☐ Yes ☐ No
9	Do you drink alcoholic beverages daily? Please specify on the following page the quantity in alcohol unit (a unit corresponding to a glass of wine (10cl), a glass of beer (25 cl) or a dose of strong alcohol.	☐ Yes ☐ No
10	Do you smoke more than 10 cigarettes a day? If yes, please specify on the following page for how long do you smoke	☐ Yes ☐ No
11	Have you been accepted under special conditions for or been refused a life insurance policy?	☐ Yes ☐ No
12	Do you, as pilot or passenger, use air craft (off regular commercial lines)?	☐ Yes ☐ No

⑩ Data protection

The personal data collection is necessary for the management of the insurance contract by the Insurer, its TPA, its service providers, its subcontractors or its reinsurers. The data processing is intended to: issue, manage and execute insurance contracts; the development of statistics and actuarial studies; the recourses, management of claims and litigation; the implementation of the legal and regulatory provisions in force in particular the fight against money laundering, the financing of terrorism and against fraud; operations related to customer management and business development. The recipients of these data are the duly authorized staff of the Insurer, TPA, service providers, subcontractors or respective reinsurers and the insurance intermediaries. These personal data may be transferred to service providers or subcontractors established in countries outside the European Union. These transfers may only concern countries recognized by the European Commission as having an adequate level of protection for personal data, or recipients with appropriate safeguards. These data will be kept throughout the duration of the contract, until the expiry of both the limitation periods and the deadlines provided by the storage obligations.

The Insured has a right of access, rectification and erasure of his personal data. When consent is necessary for processing, he has the right to withdraw it. Under regulatory conditions, the Insured has the right to request the limitation of data processing or to oppose it. The Insured may exercise these rights by contacting MGEN International Benefits – Service clients - 7 Square Max-Hymans, 75748 Paris Cedex 15, France, clients@mgen-ib.com. The Insured may also request the portability of the data transmitted when it was necessary for the contract or when its consent was required. He/she also has the right to provide guidelines regarding the fate of the personal data after the death. Complaints relating to the collection or processing of the personal data may be addressed to the customer service whose contact details have been specified above. In the event of persistent disagreement concerning these data, the Insured can refer to the CNIL, 3 place of Fontenoy 75007 Paris, France, https://www.cnil.fr/fr/vous-souhaitez-contacter-la-cnil/ You wish to contact the CNIL, 01 53 73 22 22.

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Broker's name:
Broker's code:

For all positive answers on the medical questionnaire, please specify all additional clarification (*according to the number of the question, the name of the person to be insured, the date of the event or result, the date of cure or consolidation, the type of treatment or hospitalization, the duration of the illness or treatment, any after-effects and any relevant justifying documents, etc)*

1:
2:
3:
4:
5:
6:
7:
8:
9:
10:
11:

11 Declaration and signature

☐ *I certify that the statements made by me in answering the above questions are true, complete and to the best of my knowledge and belief. I understand that nullity of the insurance or reduction of the insured capital sum might be applied if it were proved that the person to be insured had established a false declaration. I confirm that I have checked and found correct any answers or statements in this application that are not in my own handwriting,*

☐ *I authorise my medical practitioner, health professional or other relevant medical establishment to provide relevant medical information relating to me, if requested by us, our medical advisers, appointed representatives, or to any third-party expert(s) in case of disputes, subject to any legal restrictions which may apply,*

☐ *I accept the benefits, terms, conditions and limits provided for in the terms of the insurance policy and I agree to be bound by such terms,*

☐ *I understand that this application is subject to written acceptance by the Insurer,*

☐ *I confirm the correctness of the statements and information contained in this application and confirm the correctness of all other documents submitted now or in the future concerning this application. This clause will constitute a condition precedent to the payment of the benefits provided for in the terms of the Plan. I accept that the Insurer will be relying on such statements and information when agreeing to accept this application. The Insurer reserves the right to investigate where uncertainty exists about the validity of information provided.*

☐ *I, the applicant and the listed dependents, agree to being called upon to submit such medical examinations and tests as the Insurer deems necessary.*

☐ *I agree to give the Insurer immediate written notice should any changes material to the assessment of this application occur before the date upon which MGEN grants written acceptance. This will give the Insurer the opportunity to reconsider the terms of acceptance.*

Place: _____ *Date:* __/__/____ *(dd/mm/yyyy)*

(Signature of the person to be insured preceded by the words « read and approved »)

Insured member's Signature

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