

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 individual « 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	<input type="checkbox"/> F <input type="checkbox"/> M	_____	_____	_ _ _ _
1 st child	<input type="checkbox"/> F <input type="checkbox"/> M	_____	_____	_ _ _ _
2 nd child	<input type="checkbox"/> F <input type="checkbox"/> M	_____	_____	_ _ _ _
3 rd child	<input type="checkbox"/> F <input type="checkbox"/> M	_____	_____	_ _ _ _
4 th child	<input type="checkbox"/> F <input type="checkbox"/> M	_____	_____	_ _ _ _

Health cover (only one choice possible)	Annual contribution ¹
Coverage level : _____ € - Expatriate insurance plan <input type="checkbox"/> Essential <input type="checkbox"/> Comfort <input type="checkbox"/> Excellence - Health cover 1 st € - Coverage area B Zone	B Zone : France

• request membership of the Assistance and Civil Liability coverage

Assistance and Civil Liability	Annual contribution ²
Coverage area B Zone (France) Assistance cover <input type="checkbox"/> yes <input type="checkbox"/> no Civil liability <input type="checkbox"/> yes <input type="checkbox"/> no	_____ € _____ €

Please complete the health questionnaire (page 3)

Medical questionnaire (document to print)

The insured must fill out this questionnaire by hand. Any extra information regarding the state of your health may be added on additional sheets of paper and attached to this form.

1 What are you usual height, weight and blood pressure ?

Insured : Height m Weight kg Blood pressure _____ Spouse : Height m Weight kg Blood pressure _____
 1st child : Height m Weight kg 2nd child : Height m Weight kg
 3rd child : Height m Weight kg 4th child : Height m Weight kg

What is your daily consumption of alcohol ? Insured : _____ drinks/day Spouse : _____ drinks/day
 What is your daily consumption of tobacco ? Insured : _____ cigarettes/day Spouse : _____ cigarettes/day

Please reply with either YES or NO

	Insured	Spouse	1 st child	2 nd child	3 rd child	4 th child	If the response is YES, please provide full details clearly stating the person to which the information relates
2 Does your present state of health prevent you from performing your full time profession ? _____	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> 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 ? _____	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	Details of surgery ? _____ Date(s) _____ _____
4 During the past 5 years, have you been prescribed sick leave or a medical treatment exceeding 3 weeks ? _____	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	Please give reasons ? _____ Nature and duration of treatment _____ _____
5 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...)? _____	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	Date(s) _____ (Please attach photocopies of post-operative and cell reports).
6 During the past ten years have you experienced any of the following : neurological or psychological illness (including depression), rheumatism (affecting the vertebrae), cancer, leukaemia or other blood related illness, or have you had any other medical problems not mentioned on the questionnaire ? _____	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> 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) _____ _____
7 Do you plan to get hospitalized in the upcoming 12 months ? _____	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	If YES, indicate the nature of the hospitalization : _____ _____
8 Have you had a screening for the AIDS, hepatitis virus or for one of the human immunodeficiency viruses ? _____	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	If YES, please indicate : Date _____ Nature of the test _____ Result _____
9 Have you had any after-effects resulting from an accident or illness ? _____	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	Description ? _____ Date of event _____ Nature of effect _____ Recovery date _____ After-effects _____
10 Do you suffer from a disability or are you entitled to a disablement pension (civilian or military) or old age pension ? _____	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	Nature of disability _____ Nature of pension or annuity _____ Rate _____ (Please attach notification)
11 Have you ever been accepted on special conditions or refused life insurance ? _____	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	Reason for and date of rejection _____ _____

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. I also certify having been informed of the cover granted by the insurance Company policy.

In _____ Date

Signature of the Applicant preceded by « read and approved ».

Please return this document to the following address after having made a copy for yourself :

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

