Individual membership application - ACS World

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 _____
Social security n° (if necessary) |_|_|_|_|_|_|_|_|_|_|_|_|_| 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	☐ F ☐ M			
1st child	☐ F ☐ M			
2nd child	☐ F ☐ M			
3rd child	☐ F ☐ M			
4th child	☐ F ☐ M			

Health cover (only one choice possible)	Annual contribution [1]

Coverage level : choose between Package Expatriate Insurance Plans and Customized Expatriate Insurance Plans _____ €

- **Package Expatriate Insurance Plans** ☐ Confort ☐ Excellence ☐ Excellence Plus

or

- **Customized Expatriate Insurance Plans** ☐ Module 1 (Hospitalization only) ☐ Module 2 (Hospitalization + routine medical expenses + optical expenses)

Deductible ☐ Without deductible ☐ Deductible of 150 €/year ☐ Deductible of 300 €/year

- **Health cover** ☐ 1st € ☐ in complement of the CFE
- **Coverage area** ☐ A Zone ☐ B Zone ☐ C Zone

C Zone : Africa, Asia (exc. Japan, Taïwan, Hong Kong, Singapore and China), Middle East (exc. Israel)
B Zone : C Zone + Europe (exc. Switzerland), Australia, Americas (exc. USA, Canada), China, Taïwan
A Zone : B Zone + USA, Canada, Switzerland, Israel, Japan, Hong Kong, Singapore

• request membership of the Assistance and Civil Liability coverage

Assistance and Civil Liability	Annual contribution [2]

Coverage area ☐ A Zone ☐ B Zone ☐ C Zone
Assistance cover ☐ yes ☐ no _____ €
Civil liability ☐ yes ☐ no _____ €

Please complete the health questionnary (page 3)

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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Individual membership application - ACS World (continuation)

- request membership of the individual Contingency coverage

Contingency (only one choice possible)	Annual contribution 3

Gross annual income in Euro (if contingency coverage) _____€

1 - Death option

☐ Essential (25 000 €) ☐ Comfort (50 000 €) ☐ Excellence (100 000 €) _____ €

(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€/day) ☐ Comfort (Benefits 50€/day) ☐ Excellence (Benefits 100€/day) _____ €

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

Scheme ☐ 1st € ☐ in complement of the CFE

Grace period ☐ 90 days ☐ 180 days

The amount of my first annual contribution for **Health (1) + Assistance (2) + Contingency (3)** is 0,00 €	Annual contribution 4

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

Contributions are payable in advance. **Annual AMI Association membership costs : 20 € 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 EUR _____ payable to **ACS**, corresponding to the premium pro rated to time between the effective date and the first calendar insurance period + **EUR 20** membership fees by :

☐ debit of credit card ☐ bank transfer

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

Read and approved

_____

Signature of member

References of broker

_____

Pursuant to the French data protection law ("loi informatique et libertés") of 6 January 1978, as amended by the law of 6 August 2004, you are entitled to access, amend, rectify, delete and object to the data concerning you by sending a written request to ACS – Informatique et Libertés, 153 rue de l'Université, 75007, Paris, FRANCE. We inform you that the information collected is processed for the purposes of handling the present application. This processing may be performed by service providers inside or outside Europe. Unless you object, your data may also be used by us, for prospecting purposes for the insurance products that we distribute.

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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
Spouse : Height |_|_|_|m Weight |_|_|_|kg
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	1st child	2nd child	3rd child	4th 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 ? __	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ 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	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ 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 ? _____	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ 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...) ? __	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ 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 ? _____	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ 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) _____
7 Do you plan to get hospitalized in the upcoming 12 months ? _____	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ 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 immuno-deficiency viruses ? _____	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	If YES, please indicate : Date _____ Nature of the test _____ Result _____
9 Have you had any after-effects resulting from an accident or illness ? _____	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ 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 ? _____	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ 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 ? _____	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	Reason for and date of rejection _____

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

In _____ Date |_|_|_|_|_|_|_|_|

Read and approved

_____
Signature of member

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

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

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E-mail : contact@acs-ami.com

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

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Standing order authorization

Please fill out the form that corresponds to the payment method of your choice.

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	Creditor company
Name and first name _____ Address _____ _____ ZIP code ⌊_⌊_⌊_⌊_⌊_⌋ City _____ Country _____	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

For payments via standing order (valid only for holders of bank accounts located in France), please complete the standing order mandate you will find in the next page.

SEPA DIRECT DEBIT MANDATE

The information contained in this transfer order, which must be completed, must only be used by the creditor for the purpose of managing the relationship with the customer. Customers may exercise their right to access, rectify or refuse the processing of this information provided for under articles 38 and following of the French data protection law, no. 78.17, dated 6 January 1978.

Unique Mandate Reference (UMR)	Creditor's name and logo ACS Assurances Courtages et Services

By signing this mandate form, you authorise the creditor to send instructions to your bank to debit your account, and you authorise your bank to debit your account in accordance with the instructions from the creditor.
You are entitled to a refund from your bank under the terms and conditions of your agreement with your bank. A refund must be claimed within 8 (eight) weeks following the date on which your account was debited

*Please complete the fields marked **

Your name * ....
Debtor's family name and given names Maximum name lenght 70 characters

Your address * ....
Number and road name This line is a maximum of 35 characters long

* ....
Post code *Town/City* *Country*

Your bank account details *
International Bank Account Number - IBAN

*
Bank Identifier Code for your bank - BIC

Creditor's name * ASSURANCES COURTAGES ET SERVICES
Creditor's name

SCI * FR 44 ZZZ 494888
SEPA Creditor Identifier (SCI)

* 153 RUE DE L'UNIVERSITE
Number and road name

* 75007 PARIS FRANCE
Post code *Town/City* *Country*

Type of payment * ☑ Recurrent payment ☐ Punctual payment

Signed at * ....
Place *Date (DD/MM/YYYY)*

Signature(s) * *Please sign here* ➔

Note: Your rights regarding the above mandate are explained in a statement that you can obtain from your bank.

Details regarding the contract between the creditor and the debtor - [illegible]

Debtor identification code
Write any code number here which you wish to have quoted by your bank

Party on whose behalf the payment is made (if not the debtor)
Name of the third-party debtor: if your payment relates to an arrangement between the creditor and a third party (for example if you are paying a bill on behalf of another person), please write the other person's name here. If you are paying on your behalf leave blank.
Identification code of third-party debtor

Name of third-party creditor: the creditor must complete this section if collecting payment on behalf of another party
Identification code of third-party creditor

In respect of the contract EXPATRIATE CONTRACT
Description of contract *Contract identification number*

Please return to: ASSURANCES COURTAGES ET SERVICES 153 RUE DE L'UNIVERSITE 75007 PARIS	For creditor's use only

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