

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

DOB..... in..... Nationality.....

Sex : F M

Marital status : Single Married Widow Divorcee Marital life Civil Union

Address of residence abroad.....

Address in country of origin.....

Gross annual income in Euro (if contingency coverage).....

Phone..... Fax..... E-mail.....

Passport n°.....

• After reading the General Provisions, the coverage level and application terms as well as respective prices,

• 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
1st child
2nd child
3rd child
4th child

Health cover (only one choice possible)

Coverage level : choose between Packaged Expatriate Insurance Plans and Customized Expatriate Insurance Plans

- Packaged Expatriate Insurance Plans Comfort Excellence Excellence Plus
- or**
- Customized Expatriate Insurance Plans Module 1 (Hospitalization only)
- Module 2 (Hospitalization + routine medical expenses + optical expenses)
- Module 3 (Module 2 + dental expenses)

Coverage area A zone B zone C zone

• Request membership of the Assistance and Civil Liability coverage :

Assistance and Civil Liability

- Coverage area A zone B zone C zone
- Assistance yes no
- Civil liability yes no

• Request membership of the individual Contingency coverage :

Contingency (only one choice possible)

- 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 non separated spouse of married policy holder, or failing, to the children born or to be born of the policyholder, 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 predeceased'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.....

- Disability option Essential (Benefits 25 €/day) Comfort (Benefits 50€ /day) Excellence (Benefits 100€ /day)
- (complementary to death option - cannot exceed 70 % of the stated gross annual income)

Grace period 90 days 180 days

I want my membership to become effective on [] [] [] [] [] [] [] [] [] []

The amount of my first annual contribution for health **1** + Assistance **2** + contingency **3** is :€ **4**

Contributions are payable in advance. Annual AMI Association membership costs : 20 € per contract.

- Payment method debit of credit card bank transfer cheque
- Frequency : calendar year calendar half-year calendar quarter year month (standing order only for a bank account in a bank located in France)

Instalment : I enclose a payment 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

In on.....

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

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.

References of broker

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 your 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

Please reply with either yes or no :

Insured	Spouse	1st child	2nd child	If the response is YES, please provide full details clearly stating the person to which the information relates
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2 Does your present state of health prevent you from performing your full time profession ? 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 ? Details of surgery
 Date(s)

4 During the past 5 years, have you been prescribed sick leave or a medical treatment exceeding 3 weeks ? 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...)? 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 ? 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 ? 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 ? If YES, please indicate :
 Date :
 Nature of the test :
 Result :

9 Have you had any after-effects resulting from an accident or illness ? 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 ? 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 ? 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 »