



## STANDARD GROUP MEDICAL SERVICE PROGRAM 15A SMS 000069

If you have any questions or need any assistance in completing this form contact us by mail at [contact@aoc-insurancebroker.com](mailto:contact@aoc-insurancebroker.com)

Please complete clearly in BLOCK CAPITALS.

### 1. APPLICANT DETAILS

**Principal member**

It is important that you notify us of any change of contact details so we can ensure that correspondence reaches you.

Mr\_ Mrs. \_ Ms.\_ Miss \_ Other \_\_\_\_\_ First name \_\_\_\_\_

Other initials \_\_\_\_\_ Name \_\_\_\_\_

Date of birth (dd/mm/yy) \_\_\_\_\_ Gender: Male \_ Female \_

Correspondence address \_\_\_\_\_  
\_\_\_\_\_

Home telephone \_\_\_\_\_ (country code) \_\_\_\_\_ (area code) \_\_\_\_\_

Office telephone \_\_\_\_\_ (country code) \_\_\_\_\_ (area code) \_\_\_\_\_

Mobile telephone \_\_\_\_\_ (country code) \_\_\_\_\_ (area code) \_\_\_\_\_

Fax \_\_\_\_\_ (country code) \_\_\_\_\_ (area code) \_\_\_\_\_

Email address (mandatory) \_\_\_\_\_

Occupation \_\_\_\_\_

Home country \_\_\_\_\_  
*(A country for which you hold a current passport and to which you would want to be repatriated)*

Country of residence \_\_\_\_\_  
*(The country in which you occupy the majority of your time for the period of your insurance cover)*

Nationality \_\_\_\_\_

Please indicate the language in which you wish to receive your policy documentation: English \_ French \_

**Next of kin:**

Name \_\_\_\_\_

Address \_\_\_\_\_

Home telephone \_\_\_\_\_ (country code) \_\_\_\_\_ (area code) \_\_\_\_\_

Mobile telephone \_\_\_\_\_ (country code) \_\_\_\_\_ (area code) \_\_\_\_\_

Email address \_\_\_\_\_

**Information concerning any current domestic or international health insurance:**

Are you enrolled under Caisse des Français de l'Etranger (CFE): Yes      No





Social security number \_\_\_\_\_

Nom of insurer \_\_\_\_\_

Policy number \_\_\_\_\_ Start date (dd/mm/yy) \_\_\_\_\_

*The following details are only to be completed if you are applying to join an existing group scheme:*

Group name \_\_\_\_\_

Group number \_\_\_\_\_

**Dependant To Be Covered**

**Dependant 1:**

Mr\_ Mrs. \_ Ms.\_ Miss \_ Other \_\_\_\_\_ First name \_\_\_\_\_

Other initials \_\_\_\_\_ Name \_\_\_\_\_

Date of birth (dd/mm/yy) \_\_\_\_\_ Gender: Male \_ Female \_

Relationship to principal member: Spouse \_ Child \_ Occupation \_\_\_\_\_

Home country \_\_\_\_\_

*(A country for which you hold a current passport and to which you would want to be repatriated)*

Country of residence \_\_\_\_\_

*(The country in which you occupy the majority of your time for the period of your insurance cover)*

Nationality \_\_\_\_\_

**Information concerning any current domestic or international health insurance:**

If dependant 1 is the spouse, please mention his/her social security number \_\_\_\_\_

Name of insurer \_\_\_\_\_

Policy number \_\_\_\_\_ Start date (dd/mm/yy) \_\_\_\_\_

**Dependant 2 :**

Mr\_ Mrs. \_ Ms.\_ Miss \_ Other \_\_\_\_\_ First name \_\_\_\_\_

Other initials \_\_\_\_\_ Name \_\_\_\_\_

Date of birth (dd/mm/yy) \_\_\_\_\_ Gender: Male \_ Female \_

Relationship to principal member: Spouse \_ Child \_ Occupation \_\_\_\_\_

Home country \_\_\_\_\_

*(A country for which you hold a current passport and to which you would want to be repatriated)*

Country of residence \_\_\_\_\_

*(The country in which you occupy the majority of your time for the period of your insurance cover)*

Nationality \_\_\_\_\_

**Information concerning any current domestic or international health insurance:**

Nom of insurer \_\_\_\_\_

Policy number \_\_\_\_\_ Start date (dd/mm/yy) \_\_\_\_\_

**Dependant 3 :**

Mr\_ Mrs. \_ Ms.\_ Miss \_ Other \_\_\_\_\_ First name \_\_\_\_\_





Other initials \_\_\_\_\_ Name \_\_\_\_\_  
 \_\_\_\_\_

Date of birth (dd/mm/yy) \_\_\_\_\_ Gender: Male \_ Female \_  
 Relationship to principal member: Spouse \_ Child \_ Occupation \_\_\_\_\_  
 \_\_\_\_\_

Home country \_\_\_\_\_

*(A country for which you hold a current passport and to which you would want to be repatriated)*

Country of residence \_\_\_\_\_

*(The country in which you occupy the majority of your time for the period of your insurance cover)*

Nationality \_\_\_\_\_

**Information concerning any current domestic or international health insurance:**

Name of insurer \_\_\_\_\_  
 \_\_\_\_\_

Policy number \_\_\_\_\_ Start date (dd/mm/yy) \_\_\_\_\_

**Dependant 4 :**

Mr\_ Mrs. \_ Ms.\_ Miss \_ Other \_\_\_\_\_ First name \_\_\_\_\_

Other initials \_\_\_\_\_ Name \_\_\_\_\_

Date of birth (dd/mm/yy) \_\_\_\_\_ Gender: Male \_ Female \_

Relationship to principal member: Spouse \_ Child \_ Occupation \_

Home country \_\_\_\_\_

*(A country for which you hold a current passport and to which you would want to be repatriated)*

Country of residence \_\_\_\_\_

*(The country in which you occupy the majority of your time for the period of your insurance cover)*

Nationality \_\_\_\_\_

**Information concerning any current domestic or international health insurance:**

Nom of insurer \_\_\_\_\_

Policy number \_\_\_\_\_ Start date (dd/mm/yy) \_\_\_\_\_

**2. Policy commencement date**

Please indicate the month and year on which you wish your cover to commence (individual policies must commence on the first day of the month) :

However, if you are applying to join a group scheme, you can specify the date you require cover from :

Cover is conditional upon acceptance of your application, which is only confirmed when an Insurance Certificate is issued to you.

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**3. Plans details**

Categorie 2 (THAILAND, CHINA, MALAYSIA)

Number of Ensures :           x **520 euros** = \_\_\_\_\_

Categorie 3 (INDONESIE, MYANMAR)

Number of Ensures :           x **740 euros** = \_\_\_\_\_







### 4.3 Credit card and funds transfert payment details

#### Payment details

International SOS does not accept liability for any payment which does not clearly identify the policyholder  
Bank transfers must be clearly marked with the policyholder's name and programs number 15 SMS 000069 AOC Insurance Broker - International SOS

If you have chosen to pay by bank transfer, please ensure that payments are received in time, based on your chosen payment frequency, to avoid any possible delays to claims processing

We will only accept payment by credit card via MasterCard or VISA

If Insurance Premium Tax and other Government Levies apply, these will be stated on your Invoice / Payment details

As the principal member, I sign this declaration on behalf of all persons included in this Application Form.

Principal member's signature

Date(dd/mm/yy)

Please return this form fully completed to the following address (PDF email accepted) :



AOC Insurance Broker

60 rue de Strasbourg  
92400 Courbevoie - FRANCE

Email : [contact@aoc-insurancebroker.com](mailto:contact@aoc-insurancebroker.com)

Website : <http://www.aoc-insurancebroker.com>

