SAAM
VERSPIEREN GROUP

SAAM EUROPE – PILOT PROTECT ASSOCIATION
Membership application/modification

Contract No: A 5045.0001 ☐ Membership application
☐ Request for amendment if amendment, member No.:

IDENTIFICATION

Name: ....Surname(s): ....

Date of birth: ....Place: ....

Gender: M ☐ F ☐ Nationality: ....

Address: ....

Zip code: ....City: ....Country: ....

Email: ....Telephone: ....

Profession: Pilot ☐ Co-pilot ☐ since: .. ..

Employer: ....

Employer's address: ....

Nature of the employment contract:
1) Freelance ☐
2) Fixed term ☐ Contract start date: end date:
3) Open ended ☐ Activity rate:................%

Net annual salary: .... Currency: ....

Documents to be attached to your application

- Your valid medical aptitude certificate issued by the competent aeromedical Centre
- The duly completed and signed questionnaire
- Your authorisation to serve as flight crew (or your Licence)
- Your bank details, if payments are made by direct debit
- A sworn oath of service activity without reductions of hours for health reasons

YOUR COVERAGE AND PAYMENTS

Subscription to the contract shall only be effective subject to acceptance by the medical advisor of the representative according to the duly completed health questionnaire. **Inception date desired:**

DEATH/TOTAL AND IRREVERSIBLE LOSS OF AUTONOMY (TILA)	
Death/TILA sum insured (mandatory coverage)	Amount selected: ....€ *Minimum: €50,000* *Maximum: €600,000 within the limit of 5 times your net annual salary*
PERMANENT LOSS OF LICENCE	
Permanent Loss of licence sum insured	Amount selected: ....€ *Maximum: €600,000 to the limit of 5 times your net annual salary*
	☐Option A (without deduction of daily allowances) ☐Option B (with deduction of daily allowances)
TEMPORARY UNFITNESS	
Amount of the daily allowance	Amount selected: ....€ *Minimum: €50* *Maximum: €500 to the limit of 100% of your annual net salary*
Excess period (illness and accident)	☐30 days ☐60 days ☐90 days

Association PILOT PROTECT ASSOCIATION 8 avenue du stade de France 93218 La Plaine Saint-Denis cedex
SWISSLIFE PREVOYANCE ET SANTE 7 rue Belgrand 92 300 Levallois-Perret - PLC with share capital of €150.000,000 - a Business governed by the Insurance Code - 322.215.021 RCS Nanterre
SERVICE DE ASSURANCES DE L'AVIATION MARCHANDE 8 avenue du stade de France 93218 La Plaine Saint-Denis cedex – a simplified joint stock company with share capital of €139,261.77 - 572.031.870 RCS Bobigny - Orias No.: 07 003 050

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Instalments:	☐Monthly ☐Quarterly	☐Half yearly ☐Yearly
Premium payment :	☐Transfer ☐ Debit via credit card ☐ Direct debit (complete the SEPA direct debit authorisation)	☐Credit card (via the website)

BENEFICIARY CLAUSE

➔ I designate as beneficiary(ies) of the death/TILA capital:

INDICATE: name, surnames, date and place of birth, address of main residence and distribution percentage if there are several beneficiaries**.**

When a specified beneficiary accepts the benefit of the contract under the conditions set out in regulations in force, its designation becomes irrevocable (article L.132-9 of the Insurance Code).

Warning - **Acceptance must be made according to one of the following two methods: either through an amendment signed by the insurer, the subscriber and the beneficiary, or by a deed or private agreement signed solely by the subscriber and the beneficiary, but this second method only has any effect on the insurer when it has been notified thereof.**

➔ Failing designation of a beneficiary in the subscription request, or if this designation lapses, I opt for the following designation:

- the spouse of the subscriber, not legally separated;
- failing this, a civil partner or equivalent in other European countries;
- failing this, in equal shares between them, the children of the subscriber, born or unborn, living or represented;
- failing this, the mother and father of the subscriber, in equal shares between them, or the surviving one of them;
- failing this, to the heirs of the subscriber in order of succession.

DECLARATIONS

- **I request and declare membership of the Association PILOT PROTECT ASSOCIATION** 8 avenue du stade de France 93218 La Plaine Saint-Denis cedex
- **I certify that I have accurately and honestly answered the questions in this subscription file, and know that** any omission or inaccurate declaration, as well as the withholding of information or intentional false declaration by me may cause, respectively, a proposed adjustment to tariffs or cancellation of subscription pursuant to articles L. 113-8 and L. 113-9 of the Insurance Code.
- **I acknowledge having read and accepted the provisions of the informative notes of the SAAM Europe contract No.: A 5045.0001,**
- I understand that French law applies to my subscription to the contract**,**
- **I declare having duly completed and signed the health questionnaire attached to this application.**
- **I recognise that subscription to the contract does not exempt me from contributions due under the mandatory system that may cover me.**

Cancellation of subscription: under articles L 112-9 of the Insurance Code and L121-20-12 of the Consumption Code, I recognise having been informed, and know that I have a period of 14 consecutive calendar days, as of the conclusion date of my subscription (indicated on the membership certificate) to cancel my subscription to the contract.

Pursuant to the "data processing" act of 6 January 1978, the body of the Swiss Life Group mentioned herein is responsible for processing the information collected. Data is used for the management and monitoring of your records by this entity, and the sending of documents concerning products of companies of the SwissLife Group, recipients, with their representatives, partners and re-insurers, of the information. They are also processed within the framework of the fight against money laundering and the financing of terrorism. The failure to provide mandatory information may result in your file being closed. Optional data is indicated. You have a right of access and rectification to data concerning you, and the right to oppose their processing for a legitimate reason. Please send any requests to the Marketing department of Swiss Life, 1 rue du Mal de Lattre de Tassigny 59671 Roubaix Cedex 01. In case of a request linked to medical data, please mark this for the attention of Médecin conseil, 7 rue Belgrand 92300 Levallois-Perret Cedex.

Concluded in .... , on................................

Signature of the subscriber, preceded by the mention "Read and Approved"

SAAM EUROPE – HEALTH & WELFARE
FLIGHT CREW HEALTH QUESTIONNAIRE

STRICTLY CONFIDENTIAL DOCUMENT INTENDED FOR THE MEDICAL ADVISOR

NAME: .... **SURNAME(S):** .... **MEMBERSHIP N°:** ....

For reasons of confidentiality, you must submit this health questionnaire in a confidential envelope to the medical advisor of the insurer's representative:

Médecin conseil du Service médical – SAAM – 8, avenue du Stade de France - 93210 Saint-Denis - France.

For any response to a question requiring clarification, we invite you to write them on blank paper, referring to the number of the question they pertain to. For reasons of confidentiality, please send them in a confidential envelope to the medical advisor of the SAAM Medical department.

WE MUST INSIST ON THE FOLLOWING TWO ELEMENTS:
- A response must be made to all questions posed (please check with an "**X**" the appropriate box)
- A line or a blank does not constitute a response (indicate "**NONE**" when this is the case)

Are you in a service activity, *without reduction of hours for health reasons*? **YES** **NO**
If **NO**, what is the medical reason for being off work: ....
What medical fitness certificates do you hold? ....
Indicate the Licence authorising your current job: ....
Is this a European Licence?..

Indicate, as applicable, what Licence it is, as well as any other Licences held:

....

Before your admission, were you refused by an aeromedical centre (CEMPN in France)? **YES** **NO**

If **YES**, give the reason: …………………………………………………………. Date: ....
Address of this aeromedical Centre (CEMPN in France): ....

A – Are you currently insured, or have you already been covered for permanent Loss of Licence?
YES **NO**

If **YES**: sum insured for permanent Loss of Licence: € ……………………………………..
Insurance Company: …………………………………… Reason and date of cessation: ……………………………………………

Or accepted for this risk with a surcharge, adjourned or with exclusion? **YES** **NO**
If **YES**: Date: ………………………
Reason:..

B – Do you receive an invalidity allowance? **YES** **NO**

If **YES**, which one: ILLNESS Category: …………………… Since when: …………………

MILITARY Category: …………………… Since when: …………………

WORKPLACE ACCIDENT Category: …………………… Since when: …………………

Reason: ……

1) HAVE YOU HAD, SINCE OBTAINING YOUR LICENCE:

A – One or several suspensions of medical fitness by an aeromedical centre? **YES** **NO**

If **YES**, reason: ……………………………………………………………………………… Date: ……………………………………

Address of this aeromedical centre: ……………………………………………………………………………………………

B – One or several special derogations? **YES** **NO**

If **YES**, reason: ……………………………………………………………………………… Date: ……………………………………

Address of this aeromedical centre: ……………………………………………………………………………………………

C – One or several validity limitations? **YES** **NO**

If **YES**, reason: ……………………………………………………………………………… Date: ……………………………………

Address of this aeromedical centre: ……………………………………………………………………………………………

2) HAVE YOU BEEN OFF WORK FOR ACCIDENT/ILLNESS? *(including thermal cures)* **YES** **NO**

A – If **YES**, please indicate 30 continuous days and more time off over the last 3 years: [date(s), duration(s) and reason(s)]

B – If **YES**, please indicate less than 30 days time off on 1 or several occasions over the last 12 months: [date(s), duration(s) and reason(s)]

3) HAVE YOU SUFFERED FROM, OR HAVE BEEN TREATED FOR, OR DO YOU CURRENTLY SUFFER FROM:

A – Spinal problems?

Lumbago	**YES**	**NO**	Sciatica	**YES**	**NO**
Vertebral compression	**YES**	**NO**	Discal hernia	**YES**	**NO**
Osteoarthritis	**YES**	**NO**	Osteoporosis	**YES**	**NO**
Neck pain	**YES**	**NO**	Scoliosis	**YES**	**NO**

Other(s) (specify): ……….

If **YES**, reports and dates of x-rays taken: …………………………………………………………………………………………

B – Joint Infections? **YES** **NO**

If **YES**, which one(s): ……

C – Problems with your digestive system? **YES** **NO**

If **YES**, which one(s): ……

Dates and result of laboratory examinations and x-rays taken: ……………………………………………………………….

D – Cardiovascular problems? **YES** **NO**

If **YES**, which one(s): ……

E – Date of the last electro cardiogram? ………………………… Result:…………………………………………………………

F – Problems with your respiratory system? **YES** **NO**

If **YES**, which one(s): ……

G – ENT Problems? **YES** **NO**

If **YES**, reason: ………………………………………………………… N° of days: …………………. Date: ……………………

reason: ………………………………………………………… N° of days: …………………. Date: ……………………

reason: ………………………………………………………… N° of days: …………………. Date: ……………………

H – Hearing problems? **YES** **NO**

In the case of an audiogram indicating a problem, date and result of the last one: ……………………………………

I – Vision problems? **YES** **NO**

If **YES**, which one(s): ……

Do you use corrective glasses or lenses? **YES** **NO**

Indicate vision BEFORE correction: RE: LE: AFTER correction: RE: LE:

J – From?

Nervous depression	**YES**	**NO**	Asthenia	**YES**	**NO**
Mental problems	**YES**	**NO**	Insomnia	**YES**	**NO**
Neuro vegetative problems	**YES**	**NO**	Spasmophilia	**YES**	**NO**
Anxiety	**YES**	**NO**			

If **YES**, date: ……………………………………………. Treatment:……………………………………………………………

K – Hormonal problems? **YES** **NO**

If **YES**, date: ……………………………………………..

Nature of investigations: ……………………………………… Treatment: ………………………………………………………….

Operation report: ………

L – Genital or urinary system problems? **YES** **NO**

If **YES**, date: ………………………………………….. Treatment: ………………………………………………………….

4) DIFFERENT LABORATORY EXAMINATIONS (carried out to date have given the following results):

Blood count	NORMAL →	**YES**	**NO**	Creatinine	NORMAL →	**YES**	**NO**
Leukocyte formula	NORMAL →	**YES**	**NO**	Glucose	NORMAL →	**YES**	**NO**
Platelet count	NORMAL →	**YES**	**NO**	Gamma GT	NORMAL →	**YES**	**NO**
Urea	NORMAL →	**YES**	**NO**	Cholesterol	NORMAL →	**YES**	**NO**
Triglycerides	NORMAL →	**YES**	**NO**	Transaminase	NORMAL →	**YES**	**NO**
Uric acid	NORMAL →	**YES**	**NO**				

5) WHAT ARE: Your weight: ……………………………..kg Your height: …………………………….cm

What is your blood pressure? : ……………………………………………..

What are your habits *(daily consumption)* concerning:

TOBBACCO: ………………………………………………………. **ALCOHOL**: ………………………………………………………..

Have you undergone one or several SURGICAL INTERVENTIONS? **YES** **NO**

If **YES**, date(s) and reason(s):

……

……

To your knowledge, are you required to undergo a surgical intervention in *the next 3 months*? **YES** **NO**

If **YES**, which one(s): ……………………………………………… Reason: ………………………………………………………….

6) ARE YOU CURRENTLY UNDER MEDICAL SUPERVISION OR UNDERGOING ANY SPECIFIC TREATMENT? YES NO

If **YES**, which one(s):

7) HAVE YOU SUFFERED FROM, OR ARE YOU CURRENTLY SUFFERING FROM PROBLEMS OTHER THAN THOSE MENTIONED? **YES** **NO**

If **YES**, which one(s):

I certify that I have accurately and honestly answered the questions in this health questionnaire, and know that any omission or inaccurate declaration, as well as the withholding of information or intentional false declaration by me may cause, respectively, a proposed adjustment to tariffs or cancellation of subscription pursuant to articles L. 113-8 and L. 113-9 of the Insurance Code.

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